Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 28-Mar-2019 | Report No: PIDISDSA25722

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Djibouti	P168250	Djibouti Improving Health Sector Performance Project Second Additional Financing	P131194
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
DJ Improving Health Sector Performance	MIDDLE EAST AND NORTH AFRICA	01-Apr-2019	25-Apr-2019
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Republic of Djibouti	Ministry of Health

Proposed Development Objective(s) Parent

The project development objective is to improve the utilization of quality health care services for maternal and child health andcommunicable disease control programs (HIV/AIDS, tuberculosis and malaria).

Proposed Development Objective(s) Additional Financing

The project development objective is to improve the utilization of quality maternal and child health services.

Components

Improving health services delivery performance
Strengthening health system management
Strengthening program management and monitoring and evaluation capacity

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	6.00
Total Financing	6.00
of which IBRD/IDA	6.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	6.00
IDA Credit	1.00
IDA Grant	5.00

Environmental Assessment Category

B-Partial Assessment

Decision

B. Introduction and Context

Country Context

1. **Djibouti is a small (23,200 square kilometers), lower-middle-income country with a per-capita income of US$1,927 in 2017 and a population of 956,985.**[1] While resources such as arable land and water are scarce, economic growth has accelerated over the recent years, reaching 6.5 percent annual growth rate in 2016, mostly due to an increase in Foreign Direct Investments (FDI), ports services and rents from foreign countries for their military bases.

2. **Djibouti's recent economic growth has not translated to reduced poverty or shared prosperity, and the country lags behind on human development indicators.** In 2017, Djibouti ranked 172 of 189 countries on the Human Development Index and life expectancy remains relatively low (62.6 years) compared to countries in the region with a lower GDP (Ethiopia: US$767 in 2017, life expectancy: 65.9 years).[2] Almost half of the population (40.7 percent; 2013) lives in poverty,[3] 23 percent living in conditions of extreme poverty, particularly in rural areas (44 percent). Unemployment remains alarmingly high reaching 39 percent in 2015, particularly among young people.

Refugee crisis

3. **Djibouti hosts more than 150,000 displaced individuals including refugees, asylum seekers and migrants (15 percent of total population), fleeing conflict, political instability and environmental degradation in the surrounding countries.**[4] Djibouti has hosted large numbers of displaced populations from the Horn of Africa (HOA) since the late 1970s, many of which seek asylum or transit to the Gulf countries in search of better living conditions. More recently, displacements of individuals towards Djibouti has been exacerbated by the recurrent conflicts in Somalia, more recent conflict in Yemen and recurrent droughts, ethnic conflicts and rising poverty levels in Ethiopia and Eritrea. For example, since

[1] WDI 2018
[2] WDI 2018, United Nations Development Programme. 2017. Human Development Report 2017. New York: UNDP
[3] Poverty: defined as consumption less than US$2.98 per day (2011 purchasing power parity, PPP)
[4] IDA 18 Refugee Sub-Window Board consultation on Eligibility AFR, MNA, SAR, September 2017.

March 2015, there has been an influx of approximately 37,000 people, including 19,636 Yemenis (54 percent).[5]

4. **Of the more than 150,000 displaced individuals in Djibouti, only an estimated 17,683 refugees (±11. percent)[6] have been registered as refugees and asylum seekers by the UNHCR**.[7] In December 2016, only 20 percent of 19,000 Yemenis who arrived in Djibouti accepted to be registered as refugees by UNHCR.[8] The proportion of unregistered refugees and asylum seekers from Somalia and Ethiopia is estimated to be much higher than those from Yemen. Displaced individuals resist getting registered for a number of social and economic reasons, including; (i) the lack of economic opportunities within refugee camps; (ii) the perception of being locked in the camps or being at risk of deportation at any moment; (iii) fear of stigmatization; and (iv) pride amongst displaced individuals from Somalia and Ethiopia with ethnic or tribal links to Djibouti.

5. **More than 80 percent of refugees registered by UNHCR reside in three refugee sites (Markazi, Ali-Addeh and Holl Holl)**[9] where they are dependent on humanitarian assistance. The three camps are situated in underserved border regions with strong development needs among refugees and host populations. Access to basic services, land, water, and other natural resources and economic activities are limited, thereby hampering self-reliance and prospects for integration. Refugees in camps survive on aid, and services such as education, health, and water are delivered through parallel systems funded by UNHCR and coordinated by the ONARS. There are often significant inequalities in access to services between refugees – who benefit from external resources – and host communities. The remaining refugees, asylum seekers and migrant population live amongst the host community in the peri-urban zone of Djibouti-Ville, mostly in the slums of Balbala, or in new towns and villages they create, most of which are in a very poor condition.

6. **The ethnic and tribal links between populations in the HOA have led to an integration of these societies within the host community**, which has resulted in better economic and social integration of displaced populations and refugees in the communities. However, the continued influx of displaced individuals has had a number of negative impacts on hosting areas, including: increased competition—direct and indirect—for basic social services such as health, education, and drinking water; a degraded physical and natural environment due to high pressure on biomass to meet energy and construction needs; limited livelihood opportunities; decreasing water availability evidenced by deeper boreholes and increased costs for water transport; crowded health centers and classrooms; and increased distance, time, and/or cost for collecting wood for cooking and lighting. This has led to increasing frustrations amongst the local population, and social tensions have emerged between refugees and the local population that could worsen if left unaddressed.[10]

[5] Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017
[6] UNHCR (June 2018) Registered refugees represent an estimated 3 percent of the total population in Djibouti. Source: http://www.globalcrrf.org/crrf_country/dji/
[7] Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017
[8] Idem.
[9] IDA 18 Refugee Sub-window Board consultation on Eligibility AFR, MNA, SAR, September 2017
[10] Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017

Sectoral and Institutional Context

7. **Despite improvements in Djibouti's health status in the last few years, the health indicators remain among the lowest, not only in the region, but in the world.** For example, infant and maternal mortality ratios remain higher than those of economically comparable nations as well as those countries within Djibouti's geographic region.[11] Only 23 percent of women receive four or more antenatal care visits, while only 54 percent of women receive any form of postnatal care.[12] Maternal mortality, although decreasing, is still estimated at 229 per 100,000 live births, markedly higher than the target of 185 set for 2015 for the Millennium Development Goals. The leading causes of death are attributed to communicable diseases and poor maternal, neonatal and nutritional conditions.[13] Maternal and infant malnutrition are the number one cause of death and disability in Djibouti, while wasting diarrheal disease due to poor access to quality water in rural areas and acute respiratory infections are the most common causes of morbidity and infant mortality.[14] These indicators are indicative of the challenges that still remain in improving access and quality of maternal and child health and nutrition services.

8. **In terms of service delivery, institutional child delivery with skilled health personnel reached 87 percent in 2012 compared to 40 percent in 2002,** and the proportion of children 12-23 months of age who are vaccinated with the diphtheria, pertussis and tetanus 3 vaccine before 12 months of age has increased from 45 percent in 2002 to 93 percent in 2012. Moreover, HIV/AIDS prevalence among young pregnant women (15 to 24 years old) has decreased to 1.4 percent in 2010, compared to 2.9 percent in 2002. However, despite the improvement in the delivery of health services, the availability of health service providers, the increase in drug availability, and the increase in management capacity, the sector is still in need of strengthening its health service delivery system and management capacity.

9. **Vertical healthcare programs in refugee camps, running parallel to the Djiboutian healthcare system, have led to inefficiencies that have ultimately affected quality of services provided to the beneficiaries.** Up until December 2017 two health sub-systems existed in Djibouti: (i) health facilities within refugee camps, managed by UNHCR and its implementing partners, which received substantial resources from humanitarian partners; and (ii) the public health system under the authority of the MOH with limited resources to provide quality services to local and displaced populations.[15]Refugees (both registered and unregistered) also seek care in state health facilities, which has further overburdened health facilities in the public sector. The new refugee law and the transfer of health facilities in refugee camps to the Government will deepen the integration between host communities and refugees by getting rid of the parallel health system and reducing the inefficiencies.

10. **In its National Health Development Plan (2013-2017 and 2018-2022), the Government of Djibouti identifies Performance-based financing (PBF) as a central strategy for health system strengthening, as well as to improve the performance of health services and the quality of health service delivery.** The PBF approach aims to correct market failures to attain health gains by focusing on results defined

[11] World Bank Group, "World Development Indicators."
[12] Ministère De La Santé Djibouti, Direction De La Statistique Et Des Etudes Démographiques, and Pan Arab Project for Family Health, "DEUXIEME ENQUETE DJIBOUTIENNE SUR LA SANTE DE LA FAMILLE EDSF//PAPFAM 2 – 2012 : Rapport Final
[13] IHME (2017). Source : http://www.healthdata.org/djibouti
[14] Ibid.

as the quality and quantity of service outputs, and inclusion of vulnerable persons.[16, 17] In addition, it uses a bottom-up approach to help health systems move to greater accountability and channels more resources from the central level to the point of service delivery at primary health care facilities. This has been shown to enhance motivation among health personnel. Improvement in staff attitude and morale is closely linked to the increase in resources, goods and equipment acquired through PBF funds. The financial bonuses received by health facility staff serve as a strong motivator for staff members to meet and exceed the expectations given via their assigned designations and roles within facilities.

11. **The PBF approach takes the form of a contractual relationship between different actors of the health system**. It stipulates that the purchaser (e.g. payment agency) will pay financial incentives to health care providers and regulatory bodies in accordance with their performance, as measured by the quantity and quality of predefined health services provided to the target population. By implementing and progressively scaling up PBF in Djibouti through the PAPSS project, the Government seeks to change the behavior of health providers at the facility level to promote delivery of better quality services by (i) providing incentives to facilities in order to increase productivity and quality of care, especially for the identified key indicators, and (ii) providing financial resources at the facility level to cover the local operations and maintenance costs.

C. Proposed Development Objective(s)

Original PDO

The project development objective is to improve the utilization of quality health care services for maternal and child health andcommunicable disease control programs (HIV/AIDS, tuberculosis and malaria).

Current PDO

The project development objective is to improve the utilization of quality maternal and child health services.

Key Results

12. The target values of the PDO indicators have been revised to reflect the addition of new beneficiaries and the extended project duration, and the HIV indicator will be converted to an intermediate results indicator in line with the revised PDO.
    - Original indicators
        - Number of women completing 2 or more prenatal visits (target revised, rephrased from “number of women receiving prenatal visits 2-4”);
        - Percentage of children fully immunized before their first birthday (target revised);
        - Average facility quality (target revised).
    - Original PDO indicator converted to an intermediate results indicator
        - Number of HIV+ pregnant women receiving ARV therapy according to protocol (target revised)

[16] Soeters, R. et al, Performance-based financing in Action theory and instruments. Version March 2018. Source : www.sina-health.com

[17] Ministère De La Santé (2018) Plan National de Développement Sanitaire (2018-2022)

D. Project Description

13. The proposed AF will support the continuation of activities initiated under the parent project (Components 1, 2 and 3) to: (i) mitigate the health and economic impact of the influx of more than 150,000 displaced populations; (ii) meet the increasing health needs of refugees, asylum seekers, migrants and vulnerable Djiboutians to increase and protect their human capital; and (iii) enhance the effectiveness, quality and ownership of the project. In addition, the following new activities will be introduced under each component:

- **Component 1: Improving health service delivery performance:**
  The AF will support: (a) scaling up of the PBF component of the project to health facilities in the refugee camps of Holl Holl, Ali-Addeh and Obock, and the pediatric ward of the Peltier Hospital in Djibouti-Ville; and (b) support the Directorate of Health Regions (*Direction des Régions Sanitaires*) in providing mobile "Caravan" clinics for the provision of specialized health services for refugees and host populations.

- **Component 2: Strengthening health system management:**
  The AF will support: (a) the MOH to reinforce the routine Health Management Information System through selection of core indicators, harmonization of data collection tools, and introduction of District Health Information Software (DHIS2) as a data management tool (storage, analysis and feedback report production and dissemination); (b) conduct surveys on the quality of health services; and (c) support implementation of selected health care waste management measures specifically the installation of small artisanal incinerators at five health facilities in Dikhil, Tadjourah, Obock, and Arta regions.

- **Component 3: Strengthening project management and monitoring and evaluation capacity:**
  The AF will support an enhanced PBF capacity building program at national, regional and facility levels.

- **Component 4: Contingent Emergency Response Component – CERC:**
  A CERC will be included under the project in accordance with paragraphs 12 and 13 of the Bank Policy for Investment Project Financing for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact affecting public health. Environmental and Social Management aspects specific to CERC has been reflected in the revised Environment and Social Impact Assessment. In addition, an "Emergency Response Operational Manual" (EROM) will be added as part of the Project Operational Manual (POM) before effectiveness. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this activity will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made.

E. Implementation

Institutional and Implementation Arrangements

14. The institutional arrangements for implementation, technical assistance and oversight arrangements will remain the same as for the parent project.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The proposed AF2 will mainly finance incentives to health providers for specific quantifiable outputs of the health facilities that are directly linked to the achievement of the health-related SDGs, through an RBF mechanism. It will also finance technical assistance and limited medical equipment. The AF2 will finance some civil works related to the construction of artisanal incinerators in five health facilities in Dikhil, Tadjourah, Obock, and Arta regions (previously planned to be funded by the governmental under the parent project). All the health centers where the incinerators will be installed are located in urbanized areas such as in Obock, Tadjourah, Arta and Damerjog or in the city center, such as in Dikhil. In all the 5 cases, the presence of dwellings in the vicinity of the health centers is noted. It has been confirmed that the AF2 will not finance any activities requiring the involuntary acquisition of land and/or the involuntary displacement of people leading potentially to loss of resources and income. Therefore, the project will not trigger OP 4.12. Improving the performance of the health sector would increase the overall production of medical waste, which is the main environmental impact of the project. The project is given environmental category “B” according to the World Bank’s Environmental Assessment Operational Policy (OP 4.01).

G. Environmental and Social Safeguards Specialists on the Team

Antoine V. Lema, Social Specialist
Eloise Sophie Fluet, Social Specialist
Mohamed Adnene Bezzaouia, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The proposed AF2 is Scaling up Component 1 (the PBF component) to include health facilities in new areas, namely, the refugee camps of Holl Holl, Ali Addeh and Obock, the pediatric ward of the Peltier Hospital in Djibouti-Ville and support mobile

		"Caravan" clinics for the provision of specialized health services for refugees and host populations, as well as funding improved small artisanal incinerators in five health facilities in Dikhil, Tadjourah, Obock, and Arta regions (previously planned to be funded by the government). These activities will generate Environmental risks/impacts related essentially to medical waste management and Occupational and Community health and Safety during the construction and operation of the incinerators. The AF project is still categorized as B. The impacts are site-specific, few (if any) are irreversible, and can easily be mitigated. An Environmental Impact Assessment with a Medical Waste Management Plan was produced for the parent project. This assessment has been updated to take into account the new areas covered by the AF and the improved small artisanal incinerators to be built at the five selected health facilities. The draft ESIA has been consulted with local communities representatives between Novenber 1st and 5th and with other stakeholders and authorities between November 6-15th . The final version taking in account the consultation results has been disclosed in the MoH and WB websites on March 15, 2019. Paper versions of the ESIA will be made available to beneficiary populations at the related health structures.
Performance Standards for Private Sector Activities OP/BP 4.03	No	The project will not finance activities related to performance standards for the private sector.
Natural Habitats OP/BP 4.04	No	The project will not finance subprojects impacting critical habitats or protected areas.
Forests OP/BP 4.36	No	The project will not finance subprojects impacting forests areas and forest resources.
Pest Management OP 4.09	No	The project will not support the use or involve investments in Pesticides or other related products.
Physical Cultural Resources OP/BP 4.11	No	Physical and cultural resources, if located in the project areas, will not be impacted. All the small civil works related to incinerators will be carried out inside Health facilities grounds.
Indigenous Peoples OP/BP 4.10	No	The project beneficiaries are the entire population in Djibouti. Djibouti does not have a population identified as indigenous.

Involuntary Resettlement OP/BP 4.12	No	The project would not finance civil works or any activities requiring the involuntary acquisition of land and/or the involuntary displacement of people leading potentially to loss of resources and income.
Safety of Dams OP/BP 4.37	No	The project will not construct or rely on a dam.
Projects on International Waterways OP/BP 7.50	No	The project will not affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project is not located in a disputed area.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The Project along with the proposed AF is still categorized “B” according to the Bank’s Environmental Assessment Policy (OP 4.01). The main risks/impacts identified are related to medical waste management from the sorting phase to the treatment and disposal phases. To mitigate these risks/impacts. The Environmental and Social Impact Assesement (ESIA) prepared for the parent project has been updated to include the new areas covered by the project and the construction of 5 new artisanal incinerators in the five health facilities of Dikhil, Tadjourah, Obock, and Arta.

The ESIA produced (i) has updated the existing medical waste management plan in Djibouti; (ii) has proposed mitigation measures in the form of an Environmental and Social Management Plan (ESMP); and (iii) has proposed a monitoring plan for the implementation of mitigation measures. The ESIA includes training and capacity building in environmental aspects, including on medical waste sorting management, especially in the five health facilities wich will benefit from the new incinerators.

In the ESMP, the selection of incinerators for the treatment of medical waste was based on the conclusions of previous studies and experience showing that incineration is the most appropriate technology to be used in the context of Djibouti, compared to the use of autoclaves and shredding units, which would be affected by the intermittent power cuts in the country. The ESMP includes a detailed budget for construction, operation and maintenance and training of operators. The project will provide support to implement the ESMP and will finance the procurement and installation of incinerators. The ESMP also includes information regarding the improvement/enforcement of health and safety measures for people in contact with waste and people who will operate the incinerators, as the ESIA pointed out to community health concerns related to existing waste management practices. A community awareness campaign about child immunization, nutrition and maternal and child health services, as well as the risks related to the medical waste manipulation, will be conducted in all sites covered by the project. Moreover, a grievance redress is currently being discussed with the PIU to cover all project locations and be coordinated at the PIU level. Complaints will be monitored by the PIU through the review of these locally-based grievance redress systems and consultations with the residents and refugee population at the project sites.

Further, a CERC will be included under the project in accordance with paragraphs 12 and 13 of the Bank Policy for Investment Project Financing for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will

allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact affecting public health. Environmental and Social Management aspects specific to CERC has been reflected in the revised Environment and Social Impact Assessment. In addition, an "Contingency Emergency Response Manual" (CER Manual) will be added as part of the Project Operational Manual (POM) before effectiveness. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this activity will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
NA.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
NA.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
For the parent project, the PIU has been carrying out the Environmental and Social Safeguards management. The safeguard performance is rated moderately satisfactory. The project team has revised periodic reports concerning the implementation of the environmental safeguards. These reports need to be improved, in particular by giving more details on the team's follow-up activities; however, this challenge is due to the fact that there is no dedicated focal point to E&S monitoring. For the parent project, a plan for medical waste management was prepared in collaboration with the National Institute of Public Health of Djibouti and validated after consultation with other stakeholders in the Ministry of Health. Some training sessions on the plan were organized targeting employees managing medical waste.

For the proposed AF2, to ensure diligent management and monitoring of Environmental and Social Safeguards risks, a dedicated E&S focal point will be designated in the PIU to monitor and report on measures provided in the ESMP of the updated ESIA, particularly regarding the 5 artisanal incinerators, which were not funded in the parent project. The focal point will be given hands on training and/or formal support as needed.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
NA.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
05-Mar-2019	15-Mar-2019	

"In country" Disclosure

Djibouti
15-Mar-2019

Comments

A revised Environmental and Social Impact Assessment was disclosed in country and on the World Bank's web site on March 15, 2019.

If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?
Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes
Have costs related to safeguard policy measures been included in the project cost?
Yes
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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APPROVAL

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