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

Appraisal Stage | Date Prepared/Updated: 20-Apr-2017 | Report No: PIDISDSA21572

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Jordan	P163387	Jordan Emergency Health Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
MIDDLE EAST AND NORTH AFRICA	06-Apr-2017	11-Jul-2017	Health, Nutrition & Population
Lending Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Planning and International Cooperation	Ministry of Planning and International Cooperation	

Proposed Development Objective(s)

The Project development objective (PDO) is to support the Government of Jordan in maintaining the delivery of primary and secondary health services to poor uninsured Jordanians and Syrian refugees at Ministry of Health facilities.

Components

Results based financing to deliver health care services at primary and secondary care facilities of MOH for the target population
Independent verification and institutional capacity building to improve efficiency of health services delivered

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.
Yes

Financing (in USD Million)

Financing Source	Amount
Concessional Financing Facility	34.90
International Bank for Reconstruction and Development	36.10
Islamic Development Bank	79.00
Total Project Cost	**150.00**

Environmental Assessment Category

C - Not Required

Decision

Other Decision (as needed)

B. Introduction and Context

Country Context

1. Despite substantial economic and social progress, Jordan is currently facing fiscal challenges which have been exacerbated by the Syrian crisis. Jordan's economy has proved sluggish the past couple of years, confronting various challenges and exogenous shocks, most recently repercussions from the Syrian crisis. Economic growth has averaged 2.5 percent since 2010, a lower plateau from the 6.5 percent average growth for the preceding 10 years (2000-2009). A number of exogenous shocks have confronted Jordan starting with fallout from the 2007-2008 global financial crisis. Disruption of Egyptian gas supplies meant that National Electric Power Company (NEPCO), the electricity utility, resorted to more expensive oil imports, which led to a 95 percent debt-to-GDP by end-2016. The Syrian crisis led to total closures of land routes to Iraq and Syria in mid-2015, significantly reducing exports. Tourism was also affected in 2015 and 2016, resulting in a current account deficit of 7.9 percent of GDP from 2014-2016. The Government of Jordan's generosity in hosting and providing public services to large number of refugees from Syria, Iraq, Yemen, and South Sudan has further compounded stresses on the fiscal situation and increased demand for public services such as education, health, solid, and wastewater management.

2. Major macroeconomic challenges include stimulating growth and reigning in the fiscal deficit. This is even more imperative as labor market indicators deteriorate and as inflationary pressures appear. Unemployment reached a historical high of 15.3 percent in 2016 with the labor force participation rate and employment rates worsening as well to 36.0 and 30.5 percent (compared to 36.7 and 31.9 percent in 2015, respectively). While Jordan's fiscal deficit has improved from 11.5 percent of GDP in 2013 to an estimated 3.2 percent of GDP in 2016, the fiscal situation remains dependent on grants. Since August 2016, Jordan is engaged in an Extended Fund Facility Program with the IMF, which aims at maintaining macroeconomic stability and fiscal consolidation in order to reduce the debt-to-GDP ratio to 77 percent by 2021. Following four years of expansionary monetary policy, the Central Bank raised rates in December 2016 and February 2017 by 25 and 50 bps respectively. The stock of foreign reserves held at the central bank declined to reach US$ 12.9 billion (7.7 months of imported goods, excluding re-exports) by end-2016, 9.0 percent lower than end-2015.

3. According to the latest census, the Syrian population in Jordan is 1.3 million, of which 656,170 are considered refugees by the United Nations High Commissioner for Refugees (UNHCR). The remaining Syrians are considered to have either been living in Jordan for several generations or were living in Jordan prior to the crisis. Based on their nationality and insurance status they will receive care at public facilities at the different rates set for "insured Jordanians" (almost free), "uninsured Jordanians" (some free services, about 20 percent copay for remaining services), or "foreigners" (all out of pocket). Of the total number of refugees, about 20 percent live in camps (e.g., Za'atari, Al Azraq) and the rest live in the community. About 331,000 refugees have Ministry of Interior (MOI) cards, which allows them access to several benefits including highly discounted care at Ministry of Health (MOH) facilities. The large number of Syrian refugees, of which more than 80 percent are women and children, has significant implications on the Jordanian health system. Since 86 percent live below the national poverty line, and 78 percent depend on external assistance they are considered an extremely vulnerable group.

4. The Syrian crisis threatens to reverse gains made by the Jordanian health sector and exacerbate existing limitations of MOH institutional capacity. The influx of Syrian refugees has increased demand for health services and has implications on the three outcomes of a health system—health status, citizen satisfaction, and financial protection.

Sectoral and Institutional Context

5. In terms of health outcomes, the reemergence of communicable diseases affects both Syrian refugees and their host communities. Communicable diseases had been successfully controlled by the Government of Jordan prior to the Syrian refugee crisis. Their reemergence risks the substantial health gains achieved prior to the start of the Syrian conflict and have serious ramifications for both Syrian refugees and their host communities. The incidence of communicable diseases such as measles, leishmaniasis, pulmonary tuberculosis, and diarrhea is higher in the Syrian refugee population than among the Jordanian host community. A total of 34,314 communicable disease cases were reported among the Syrian population between 2013 and 2014. As 80 percent of refugees live outside camps, communicable disease outbreaks have spilled over to their host communities, jeopardizing the entire health system. Additionally, a quarter of Syrian refugees also suffer from chronic conditions, requiring costly and frequently long term treatments.

6. In terms of citizen satisfaction, the influx of refugees has led to increased waiting times and a shortage of health workers. The use of health services increased shortly after the refugee crisis. By July 2014, public facilities registered 60,000 additional outpatient services delivered to Syrian refugees. Medicine stock-outs have since become more common, Jordanians have had to wait in long queues, and the higher demand for health services at MOH facilities has resulted in Jordanian patients being referred to facilities outside MOH. Between 2011 and 2012, the cost of referrals to non MOH hospitals increased by 50 percent, reaching $124 million. To cope with the increased demand, MOH built new health facilities, particularly at the primary health care level. However, these facilities are not yet fully equipped, and a human resource shortage (primarily specialized doctors) remains a challenge. The number of doctors before and after the start of crisis declined from 28 to 23 and number of beds per citizen decreased from 18 to 15 per 10,000 people. In addition, the increased demand for services has hastened the wear and tear of machinery, resulting in an increased need for reagents and spare parts. The refugee crisis has also set back other major goals of the health system. This includes the goal of attaining universal health insurance by 2020, which is now further away due to the growth of the uninsured population, a large part of which are refugees.

7. MOH is in charge the stewardship over the entire sector but is also a major provider of primary and secondary level services in the public sector. These services are critical in prevention and early detection of infectious as well as non-communicable diseases. MOH also manages some secondary and tertiary levels of care. Following international good practices, MOH has developed a large nationwide network of primary health care facilities including some comprehensive PHC facilities with basic specialties (including mental health). Tertiary level of care services and specialized outpatient services are delivered in MOH hospitals and in other public sector facilities such as those managed by the University, Royal Medical Service. Jordan also provides a social insurance for people in the formal sector which provides services using contracts with public and private facilities. Individuals who face catastrophic out of pocket health expenditures also can resort to the Royal Court for subsidization of specific health care services on a case by case basis. As some waiting lists have increased with the influx of refugees, GOJ used the existing contracts with public and private hospitals to provide inpatient and outpatient care alternatives for insured patients with urgent and expensive health care needs.

8. In terms of financial protection, prior to the refugee crisis, Jordan had reduced regressive health care out of pocket payments by half – from 42 percent to 24 percent of total health spending (2003-2013). However, demand increases have limited the Government's ability to provide equitable financial protection for all. From 2012-2014, GOJ allowed registered Syrian refugees to pay the same rate as insured Jordanians at MOH facilities--this led to steep increase in demand for health services by Syrian refugees. While access to health services helped meet the needs of such vulnerable population in their first years of the crisis, it was fiscally unsustainable, and since November 2014 the MOH requires Syrian refugees to pay approximately 20 percent of the cost of care for select services, while still providing free services for certain interventions such as antenatal care, vaccinations, and treatment of communicable diseases.

9. Registered Syrian refugees now pay the same price for health care as uninsured poor Jordanians. While 80 percent of the cost of care is still paid for by GOJ, even a 20 percent copay has proven too high for many Syrians, resulting in a decrease in usage by more than 60 percent over the last two years (see Fig 1). One month after the introduction of copayments, 65 percent of refugees stated that cost was the biggest barrier to accessing health care, with one in five households facing catastrophic spending due to health care costs. Two years after the policy change, over half of Syrian refugees with chronic conditions stated that they could not access medicines and other services, and half of pregnant women reported that they could not afford the fees or transportation for antenatal care. As a result, there was a precipitous drop in health service use and a subsequent decline in health outcomes. This trend has persisted with a recent study of refugees living in communities in Irbid directorate in northern Jordan indicating that, on average, a third of adults and a quarter of children who require medical care still do not access it largely due to unaffordability. However, the services that remain free, such as vaccinations and antenatal care, continue to have a very high uptake.

10. The reasons for this decline in utilization vary. Given that the copay is still small, it is unclear why there has been such a sharp decline in service utilization. While cost is one clear explanation, other possible reasons could include the MOI service cards being introduced around the same time, which are now required for Syrians be able to access health services at MOH facilities. Only two in three Syrians in the community hold MOI cards, so this requirement has resulted in a much smaller number of potential users of MOH services. Other reasons suggested include the entry of NGOs into the health sector in Jordan in 2014, who provide free services targeted to Syrians, as well as a potential overuse of MOH services by Syrians when free care was provided from 2012-2014 with "provider shopping" taking place. Despite the decrease in utilization, MOH facilities still provide about 1.5 million health services (outpatient and inpatient) to registered Syrians annually, thus filling a critical gap in service provision.

11. Similar to registered Syrian refugees, about 2.1 million uninsured Jordanians also have to pay a copayment for select inpatient and outpatient services at Ministry of Health facilities. In Jordan, MOH is both the payer and provider for a large number of public health services. The MOH network includes over 477 primary health centers and 31 hospitals. While about 70 percent of Jordanians are insured, 30 per cent are uninsured and have co-payments for health services equal to what Syrian refugees are now paying. The last thorough assessment of the uninsured Jordanian population took place in 1999 and revealed that the majority of the uninsured were either unemployed or out of the labor force. More recent estimates suggest that the uninsured incur the highest out of pocket payments, which is the most regressive form of health financing. Among the uninsured there is a subgroup who are considered "poor" (according to the Ministry of Social Development criteria) or "unable to pay" (as determined at secondary care facilities) and are the target beneficiaries of this project. While the exact size of this group is unknown, it is not an insignificant share of the uninsured population.

12. Pre-existing inefficiencies have been exacerbated by the Syrian refugee crisis, and must be addressed to create a sustainable health system. The health system in Jordan, like many other health systems globally, is plagued by several issues related to technical and allocative efficiency including a highly fragmented insurance pool with several payers and purchasers including the Royal Medical Service, Ministry of Health, and private sector providers. In addition, there is very little data available on critical components of the health system including a costing of the basic package of services delivered at primary and secondary health care facilities or usage of services by gender and income group. There are also several inefficiencies around the procurement of pharmaceuticals which if addressed could reduce the cost of care.

13. Emergency concessional support is vital to move from a humanitarian to a development response. Since 83 percent of Syrian refugees live outside of camps, public health services are the backbone of Jordan's response to the refugee crisis. The World Bank provided technical assistance and delivered an emergency operation in 2013 to maintain health services and household needs for the Jordanians affected by the refugee crisis. Yet public resources are strained and the fiscal space is limited. Public spending on health is 7 percent of GDP—far higher than most developing countries. At the same time, Jordan's debt to GDP ratio increased from 67 to 94 percent over the last five years, which has forced spending cuts at the MOH. The combination of increased demand and fiscal pressures may thus undermine the public system's sustainability, as well as its ability to provide services at free or low costs. This can have implications for the containment of communicable diseases, which will affect both Syrian refugees and Jordanian host communities. Funding shortfalls for the Syrian refugee response have exacerbated these challenges. As a result, the Government of Jordan has requested emergency funding from international financial institutions.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

14. The Project development objective (PDO) is to support the Government of Jordan in maintaining the delivery of primary and secondary health services to poor uninsured Jordanians and Syrian refugees at Ministry of Health facilities.

Key Results

15. **Indicators to track the PDO include:**
    a. Maintaining number of health services delivered at MOH primary health care facilities to:
        i. Uninsured poor Jordanians
        ii. Registered Syrian refugees
    b. Maintaining number of health services delivered at MOH secondary health care facilities to:
        i. Uninsured poor Jordanians
        ii. Registered Syrian refugees
    c. Completion and dissemination of a health sector roadmap to improve the efficiency of services delivered.

D. Project Description

16. The Project is a Results Based Financing (RBF) project to support the delivery of primary and secondary health care services at MOH facilities, and provide technical assistance and capacity building to improve the efficiency of

the health sector. The project will pay for the delivery of outputs, here health services, at MOH facilities to target beneficiaries. For this, a unit cost has been established, and the government will be reimbursed according to the quantity of outputs (health service packages) delivered to the target population. These unit costs include the cost of non medical recurrent expenditures (HR costs and utilities; about 77 per cent of total costs), but exclude costs for pharmaceuticals, medical equipment, and consumables (about 23 per cent of total costs).

17. The project addresses the immediate humanitarian challenge and also provides longer term development support. In effect it will help GOJ maintain its current support of primary and secondary health services to the project beneficiaries. Therefore, the Project will comprise of the following two components which is expected to be financed in parallel with the Islamic Development Bank (IsDB) and offered at concessional rates through the Global Concessional Financing Facility (GCFF).

18. **Component 1. Results based financing to deliver health care services at primary and secondary care facilities of MOH to the target population** (US$148 million: US$100 million by IsDB, and US$48 million by IBRD). This component is designed as a Results Based Financing (RBF) model in which MOH facilities are paid for the specified health services delivered to the target population. The builds on the World Bank's Health Nutrition Population (HNP) Global Practice experience with RBF over the past ten years globally in several countries in Latin America, Africa, and Asia.

19. This component will pay for services utilized by the target population (Syrian refugees and poor uninsured Jordanians) at MOH facilities nationwide. The services covered are based on the country's identified package of primary and secondary health care inpatient and outpatient services. The disbursements are based on a verification of two things by an independent verification entity (IVE)—(i) the number of health services provided to the project beneficiaries; (ii) the cost to GOJ to deliver these services. The Terms of Reference (ToR) of this independent verification entity will be based on similar ToRs used in RBF projects and adapted to the specific circumstances of this project and country.

20. The project will fund part of the cost for delivering health care services to the beneficiaries, which will be up to US$13 per beneficiary for primary care and US$80 per beneficiary for secondary care. The costs mainly cover MOH's expenditures for key recurrent non medical expenditures such as human resources and operating costs of health facilities such as rental and utilities (water, electricity, fuel). The Project does not finance the cost of medical items such as vaccines, medicines, equipment or consumables that will continue to be financed by GOJ and other donors (UNICEF, USAID).

21. The operational definition of a service delivered is either a visit to an outpatient facility (first or second levels of care) for medical, emergency, or diagnostic services (i.e. lab tests, x-rays, etc.) or a hospital discharge. A "primary health care service" is defined as an episode of primary health care such as one antenatal care visit. A "secondary health care service" can be considered to be an episode of ambulatory or inpatient care such as the delivery of a baby. This component includes two subcomponents:

a. **Subcomponent 1.1. Results-based financing for the delivery of primary health care services to target populations**. This subcomponent will pay at the national level for services provided at primary health care centers (PHC) by MOH to the target populations. This subcomponent includes PHC services such as, but not limited to, (a) maternal and child health care services (b) malnutrition prevention and treatment; (c) Integrated Management of Childhood Illness (IMCI); and (d) prevention, early detection and management of non-communicable diseases. The current utilization rates of primary health services among the target population

represent around 10 percent of the total utilization rate of these services at MOH. Based on 2015 utilization rates, the Project estimates that if will pay for approximately 289,000 services delivered to Syrians and 1.75 million services delivered to poor uninsured Jordanians at PHC facilities over the two-year period.

b. **Subcomponent 1.2. Results-based financing for the delivery of secondary health care services to target populations**. This subcomponent will pay at the national level for both outpatient and inpatient health care services received by the target beneficiaries at the 33 MOH hospitals in Jordan. The current utilization rates of secondary health services among the target population represent around 30 percent of the total utilization of these services at MOH hospitals. Based on 2015 utilization rates, the Project estimates that if will pay for approximately 215,000 services delivered to Syrians and 1.32 million services delivered to poor uninsured Jordanians at secondary care facilities over the two-year period.

22. **Component 2: Independent verification and institutional capacity building to improve efficiency of health services delivered** (US$2 million; US$0 by IsDB; US$ 2milion by IBRD). This component will have two subcomponents.

a. **Subcomponent 2.1. Independent auditing and verification of expenditures incurred and utilization of services by project beneficiaries**. This component will finance (i) the external financial audit of expenditures incurred by MOH for the services utilized by the target population, (ii) an independent verification of the services utilized by the target population at MOH facilities. This will verify that services are effectively delivered to the project beneficiaries, against which funds will be disbursed. If possible, one firm will be used for both functions to simplify procurement and prevent delays.

b. **Subcomponent 2.2. Capacity building to monitor and improve efficiency**. This component will strengthen the existing institutional capacity of the public health entities to analyze and plan sectoral reforms while building consensus on key priorities for the health sector to improve the efficiency in the medium to long term. While MOH and the High Council of Health are evaluating health system efficiency, these institutions need support and young professionals also need to be trained to start building institutional capacity to move forward with strengthening universal health coverage policies within the framework of a tightening fiscal space. Critical inputs are local and international consultants to define the package of health care services and compute their associated costs, as well as the review of public expenditures in the sector to identify areas of improving resource allocation policies and coordination among public (MOH and other public facilities) and private providers.

23. The output of this sub component will be the development and dissemination of a roadmap identifying current inefficiencies in the health system and providing policy suggestions, based on global best practice, to increase efficiency and fiscal space. This component will finance capacity building, analytical work, and knowledge sharing with translation into Arabic of training tools on various topics such as, but not limited to, (i) health financing and health economics with an emphasis on costing of services and cost-benefit analysis; (ii) fiscal space analysis including means to improve revenue collection and increase technical and allocative efficiency; (ii) improving digital health information systems to improve efficient use of resources including expansion of digital tools for evidence-based policy-making that is able to generate useful data pools for big data analysis on clinical, costing, and cost benefit analysis for evidence-based policy-making.

24. The Project covers the costs incurred by MOH for the delivery of primary and secondary health services (outpatient and inpatient) to the target populations. The calculations are based on actual MOH expenditures for

2015. The line items used in the calculations are “Provision of Primary Health Services” (line 4610-601; US$152.9 million) and “Provision of Secondary Health Services” (4615-601; $272.8 million). These line items, which accrue to $424 million, reflect expenditures in HR costs and overhead (rental, utilities, and maintenance) for the entire population in Jordan (insured Jordanians, uninsured Jordanians, registered Syrian refugees, foreigners). They exclude costs for pharmaceuticals, medical equipment, and consumables (US$126.2 million).

E. Implementation

25. Under the proposed Jordan Emergency Health Project (JEHP), the Ministry of Planning and International Cooperation (MOPIC) will be the implementing agency, as well as the managing entity of the fund with focal points appointed in the MOH. Based on the Project design, both MOPIC and MOH will set up mechanisms through their existing public system structures to ensure the delivery of the Project’s proposed output and the timely monitoring and reporting of the various activities during the Project duration.

26. MOPIC has demonstrated capacity to manage World Bank supported projects in the past which is crucial for an Emergency Project. Through previous project experiences with the Bank, such as the Emergency Services and Social Resilience Project, MOPIC has accrued expertise on Bank operational policies and procedures. The World Bank and UN agencies’ division under the department of International cooperation at MOPIC will be responsible for project management. Dedicated focal points will be assigned for the day to day communication with the Bank project team to support the various planned activities during the Project timeline. In addition, a steering committee, including the same team at MOPIC, will comprise of focal points from the concerned department at MOH to oversee the overall progress of the Project implementation and facilitate the administrative process among the various stakeholders. On the implementation front, MOH focal points will ensure the timely implementation and reporting on the Project progress and support the activities of Component 2.

27. MOH department of primary health care will submit regular utilization data to MOPIC. This data will serve to identify the number of primary health care services delivered to the Project’s target population (uninsured poor Jordanians and registered Syrian refugees) at MOH facilities. Similarly, the department of secondary health care will submit the actual utilization data on the number of secondary health services provided at the 33 MOH hospitals. This utilization data will be verified by an independent verification process to ensure that the target beneficiaries received the services.

28. MOH department of budget and department of expenditure will provide regular internally audited reports of actual expenditure on Project related expenses. This will be audited by an independent verification entity who will ensure that the expenses claimed are eligible to be paid by the Project.

29. MOH reports on the actual utilization and expenditure data will be independently verified and audited by an independent financial and technical verification entity hired by MOPIC according to the Bank’s procurement procedures. Accordingly, the costs incurred by MOH to provide the services to the target population will be reimbursed to the Project designated account based on the costing exercise estimates. For the Bank to disburse, GOJ will use agreed invoicing procedures that consist of (i) presenting the results of an independent financial auditor on the relevant line items of actual budget expenditures; and (ii) presenting a formal report on the total number of outpatient and inpatient services provided to the target populations by an independent verification entity (IVE). The IVE will verify the documentation based on a representative sample of services which will be reviewed using the clinical files of the sampled facilities. Once the field verification is conducted, the IVE will furnish MOPIC with a report describing the total utilization of services by beneficiaries at MOH facilities. MOPIC will in turn

send the disbursement request with the documentation produced by MOH and the IVE. The Bank will review the documentation and, if complete and satisfactory, then proceed to disburse the amount.

30. The proposed Project is expected to be financed through a parallel financing arrangement between the World Bank and the Islamic Development Bank using the GCFF. The Project's Financial Management will follow the World Bank procedures. The Project is financed in parallel by the World Bank (US$ 50 million) and by the IsDB (US$ 100 million). Three separate US Dollar Designated Accounts (DAs) will be opened at the Central Bank of Jordan (CBJ) to receive the loan proceeds from each agency. The World Bank will have two Das—one for each component—and IsDB will have one DA for component 1 which they are also funding. These DAs will be managed by MOPIC.

31. Retroactive financing will be used for 40 percent of the project amount for the delivery of health services up to one year prior to the signing of the loan agreement. The Project will finance services which have been already delivered by MOH 12 months prior to the signing of the loan agreement to ensure an adequate response to the health sector needs. Based on the preliminary estimates (to be confirmed during negotiations), the proposed amount for the retroactive financing will by approximately US$ 20 million.

32. Given the scope of services and proposed activities under the Project, procurement will be limited and mostly concerned with Component 2 (US$ 2 million). This component is fully funded by WBG and these procurement activities will follow the World Bank procurement policies and procedures.

33. The closing date and implementation schedule. Given the critical need of the health sector in Jordan, the planned activities under the proposed emergency operation will be implemented over a period of two years (July 31, 2017 to July 31, 2019-see the disbursement schedule). It is estimated that 65 percent of the total project amount will be disbursed over the first year of implementation. According to the Project disbursement profile, around 98 percent of the World Bank financing (US$50 million) will be disbursed with the 1st year of implementation, while the remaining funds (US$100 million from IsDB) will be disbursed over two years.

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

There are two main groups that will benefit from this Project: registered Syrian refugees and poor uninsured Jordanians using primary and secondary care services at MOH facilities. These beneficiaries are dispersed throughout Jordan. Therefore, there is no specific target location.

G. Environmental and Social Safeguards Specialists on the Team

Tracy Hart,Mariana T. Felicio

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	No	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

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:

According to the OP 4.01 on Environmental Assessment, this Project is classified as Environmental Category "C". The sole activities to be financed are the delivery of health services activities supported by this Project are expected to have minimal to no direct environmental impacts. The Project will not fund any medical consumables (e.g. vaccination kits, vials, syringes), nor fund the purchase of any equipment, goods, or works. If the procurement plan is revised to include any of the above, then the Project is subject to environmental assessment (EA) reclassification, which would then necessitate a project restructuring.

The Health Care Accreditation Council (HCAC), Jordan's only non-profit health accreditation, assesses how health care services address environmental and social risks inherent to health service delivery. HCAC is a member of the International Society for Quality in Health Care (ISQua) Federation. HCAC surveyors are required to use the measurable elements in the standards to determine whether the institution has met, partially met, or did not meet the standard requirement. The 15 standards clusters are as follows: (1) patient and family rights; (2) access and continuity of care; (3) patient care; (4) diagnostic series; (5) medication use; (6) infection prevention and control; (7) environmental health and safety; (8) support services; (9) quality improvement and patient safety; (10) medication records; (11) human resources management; (12) management and leadership; (13) medical staff; (14) nursing series; and (15) patient and employee education.

Standards within each cluster are classified as critical, core, and stretch. Critical standards are standards which, if not met, could cause injury or death to patients, staff or visitors and are required by law. The facility must meet 100

percent of the critical standards. Core standards relate to the systems and processes of the facility; 70 percent of the core standards must be met. Stretch standards are more difficult to meet, sometimes due to a lack of resources or to the significant change required in culture or thinking within the organization. The organization must meet 40 percent of the stretch standards. If a “seminal event” occurs which demonstrates a failure of any critical standards, the facility must report this event or risk loss of accreditation. Standards are reviewed and revised every two years. The HCAC accreditation awards are also valid for two years.

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

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

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.
HCAC Accredited MOH Primary Health Care (PHC) Centers in Jordan currently include 120 out of 240 facilities. HCAC, together with MOH and the Royal Court, have set National Quality and Safety Goals (NQSG) to increase the number of HCAC accredited centers. HCAC is relatively new; the process of standards setting started in 2007, with 20 and 42 PHC centers accredited in 2010 and 2013, respectively. MOH Quality Assurance Directorate regulates MOH-operated PHC centers so that they are meeting national standards. This provides a “safety net” for health care quality, whereas the HCAC system is pushing Jordanian medical facilities to achieve quality on par with international standards.

The primary constraint to more facilities becoming accredited is lack of necessary financial resources to host accreditation site visits and work on accreditation-related capacity building needed to close identified gaps. There is a goal to accredit 20 new PHC centers per year, and MOH is consistently hitting that target.

MOH has an Occupational Health and Safety department, which assists MOH-funded as-yet-unaccredited facilities to meet HCAC standards for infection prevention and control as well as environmental health and safety.

As part of the Jordan Response Plan, the Royal Court is providing funding, as well as coordinating with HCAC, to prepare additional MOH-run facilities for HCAC accreditation. USAID, which supported Jordan in establishing health care accreditation systems, is now focusing on quality care improvement in field-based health facilities working with Syrian refugees and other vulnerable groups.

The Project is not expected to pose social safeguard risks; however, there are non-safeguard social risks. The first risk is ineffective targeting of vulnerable Jordanians, such as elderly, disabled, single headed households, uninsured, and those who may be discouraged from seeking health care due to recent increases in out of pocket payments. Also, Syrian refugees, particularly those not registered, may also be difficult to identify. Access to care may be perceived as favoring the insured, deterring the target population from seeking public coverage. Peoples’ perceptions of key issues matter in mitigating risks to social cohesion. This includes perceptions of how humanitarian aid is delivered and to whom. Such public perception aspects and their potential impact on relationships between refugees and host communities place a premium on communication and outreach.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
In collaboration with other relevant local stakeholders (Health Directorates, UNHCR, MedAir, International Medical

Corp, Medecins du Monde, local NGOs, and health centers in locations with high presence of Syrian refugees), the team will support the MOH in rolling out outreach and communications activities, to disseminate information about the project, the rights of Jordanians and Syrian refugees including on access to health services. This would include: where and how to access health services; changes introduced with regards to copayments; and where and how to submit a grievance. Project documents will be disclosed via InfoShop and through the MOH.

B. Disclosure Requirements

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?
NA
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?
NA

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
NA
Have costs related to safeguard policy measures been included in the project cost?
NA
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
NA
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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Implementing Agencies

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