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

Appraisal Stage | Date Prepared/Updated: 21-May-2019 | Report No: PIDISDSA24717
## BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Project Name</th>
<th>Parent Project ID (if any)</th>
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<tbody>
<tr>
<td>Comoros</td>
<td>P166013</td>
<td>Comoros Comprehensive Approach to Health System Strengthening (COMPASS)</td>
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<td>MINISTRY OF FINANCE AND BUDGET</td>
<td>MINISTRY OF HEALTH, SOLIDARITY, SOCIAL PROTECTION AND GENDER PROMOTION</td>
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### Proposed Development Objective(s)

(i) To improve utilization of quality PHC and (ii) strengthen capacity of institutions which are critical to quality PHC

### Components

- Improve PHC infrastructure, workforce and service delivery platforms
- Strengthening institutions and governance which are critical to quality PHC and response to disease outbreaks
- Citizen Engagement and Empowerment, Project Management, Monitoring and Evaluation,
- Contingent Emergency Response Component

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

<p>| | |</p>
<table>
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<tr>
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### DETAILS
B. Introduction and Context

Country Context

A. Country Context

1. The Union of Comoros is a small volcanic archipelago off the coasts of Mozambique and Madagascar. Home to the second most diverse coral reefs in the world after Indonesia, Comoros has about 1,800 square kilometers of land and a maritime Exclusive Economic Zone (EEZ) 70 times the size of its land area. It consists of three islands (Ngazidja, Ndzuani and Mwali). About half of its 800,000 population live on Ngazidja, the largest island, where the capital city Moroni is located. While the country is prone to natural disasters (tsunami, cyclones, seismic and volcanic activities), its capacity to respond to emergencies remain weak.

2. Comoros’ development has been shaped by three defining characteristics. First, similar to other small and remote islands, the country faces the challenges of diseconomies of scale, highly concentrated markets, lack of competition and high costs of living. Second, as a country affected by fragility, conflict, and violence (FCV)\(^1\), Comoros is fragmented by political fragility and weak institutions as the central state, the three islands and local communities offer competing governance structures that often impede productive collaboration. Third, remittances deepen a consumption driven growth trajectory.

3. The country has made uneven progress in poverty reduction. The June 2018 revision of the national account system resulted in an increase of the GNI per capita (Atlas method) from US$760 to US$1280 in 2017. Comoros will therefore formally achieve the lower middle-income status in July 2019. Around 38 percent of Comorians are living under the international poverty line of US$3.2 a day per capita. Close to 40 percent of households receive remittances which help raise them out of poverty. Those without access to remittances

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\(^1\) Comoros is on the World Bank’s 2019 Harmonized List of Fragile Situations
are 11 percentage points more likely to be poor².

4. **Human development in Comoros remains low.** The Human Capital Index (HCI) 2017 value for Comoros is 0.41³ This means a child born in Comoros today will be 41% as productive when s/he grows up as s/he could be if s/he enjoyed complete education and full health. Not only is this value lower than the average for lower-middle-income countries, it also places Comoros at the lower end of the global distribution (122nd ranking out of 157 countries).

5. **Comoros’ fiscal balance has been largely under control in recent years but highly dependent on grants⁴.** Between 2011 and 2017, total revenues (at 17.2% of GDP) outweighed total expenditures (15.6%), generating a positive fiscal balance of 1.6%. However, without large and continuous support from external donors during this period (on average 7.9% of GDP), the fiscal balance would have been negative. Comoros’s very limited access to financial markets might have been another factor which helps keep its fiscal balance under control. Comoros’ risk of debt distress is moderate as per the 2018 WB-IMF joint debt sustainability assessment. The large share of the wage bill in the budget (more than 60% of domestically generated revenues over the last decade) leaves very little room for other spending.

**Sectoral and Institutional Context**

6. **Health outcomes in Comoros have improved since 2000, generally surpassing Sub-Saharan Africa (SSA) averages but lagging those of lower-middle-income countries (Table 1).** However, the country performs worse than SSA averages in three child health indicators: infant mortality rate, neonatal mortality rate and severe wasting. The gaps between Comoros’s health outcomes and lower-middle-incomes averages are significant. Such gaps are even bigger if the country is compared to its aspirational peers; namely Mauritius, Cape Verde, Samoa and Fiji.

<table>
<thead>
<tr>
<th>Outcome Indicators</th>
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<td>Infant mortality rate (per 1,000 live births)</td>
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<td>Neonatal mortality rate (per 1,000 live births)</td>
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<td>509</td>
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² Systematic Country Diagnosis: Towards a more united and prosperous Union of Comoros, World Bank, 2018  
⁴ Systematic Country Diagnosis: Towards a more united and prosperous Union of Comoros, World Bank, 2018
### Communicable diseases and child health conditions (including malnutrition) still dominate Comoros’s burden of diseases.

They account for 9 out of the top 10 causes of premature deaths (Figure 1). Especially, Comoros has a high prevalence of diarrheal diseases and acute respiratory infection among children under five. Undernutrition among under five children remains high with 17% underweight and 32% stunted. Undernutrition is concentrated among the worse-off households while other child health outcomes are relatively similar across different socioeconomic categories. Key underlying determinants of undernutrition are early child bearing (with birth by age 18 at 17%), low female secondary education enrolment (47%) and low sanitation coverage (34%).

### At the same time, Comoros has been facing a significant surge in non-communicable diseases (NCDs).

NCDs now account for 41% of deaths in the country, compared with 28% in Sub-Saharan Africa. Between 2005 and 2016, ischemic heart disease has gained 6 places in the ranking of top causes of premature death and 30.3% increase in terms of disease burden (Figure 1). Overweight is very high among women at 32.7%.

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9. **Comoros has yet to make a full fertility transition and is still a long way from reaping the demographic dividend.** Over the last 15 years, population growth averages 2.4 percent per year, which is below SSA average but higher than that of lower-middle-income countries. With around 4.4 children per woman, Comoros falls in the group of countries where the fertility transition has been initiated but fertility rates remain high, particularly among adolescents at 65.3 per 1,000 women ages 15 to 19. Contraceptive prevalence rate is low and declining between 2000 (25.7 percent) and 2017 (19.4 percent). Over the next 15 years, the total population is projected to increase by 50 percent and the size of the labor force to double, resulting in employment creation and poverty reduction challenges as well as additional pressures on limited land and natural resources.

10. **Comoros’s health system consists of three levels of facilities.** They are central (a national referral hospital), intermediate (one regional hospital in each of the three islands) and district (17 district health centers and 73 health posts). District facilities and the nascent community health platform constitute Primary Health Care (PHC) (please see para 15 for details on the community health platform).

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8 As per Guengant 2017, there are five groups of SSA countries: (i) fertility transition complete (or close to completion) with TFR is less than 3, (ii) fertility transitions underway with TFR is in the 3-4 range; (iii) fertility transitions initiated with TFR in the 4-5 range; (iv) slow and irregular transitions with TFR in the 5-6 range and (v) very slow and/or incipient fertility transitions with TFRs over 6

9 Systematic Country Diagnostic. Towards a more united and prosperous Union of Comoros; World Bank Group; 2017
11. Overall, health service access and utilization have improved. On average, 63% of the population live within 5 km of a health facility. However, geographical access varies among the islands with 45% in Ngazidja, 69% in Mwali and 74% in Ndzuwani. To help ease this constraint, the government has been providing the poorest households with patient transport subsidies, especially for referrals among islands. At 82%, skilled birth attendance is significantly higher than both SSA average (55.3%) and lower-middle-income countries’ average (71.4%). Similarly, with DPT immunization rate of 91% among children age 12-23 months, Comoros outperforms SSA (73.6%) and lower-middle-income countries (82%) (Table 1).

12. However, PHC is still facing major challenges. While a PHC approach is the most efficient, fair and cost-effective way to organize a health system, significant deficiencies in Comoros’s PHC remain. Less than half (48.9 percent) of pregnant women receive full antenatal care (ANC) which is defined as 4 ANC visits or more. Only 38.1 percent of children under 5 with suspected pneumonia are taken to an appropriate health facility or provider. Although data on quality of PHC are extremely limited, available information indicates major quality deficits, especially in the process of care and patient outcomes. For example, only 33% of ANC clients are counseled on complications, 27% of women who delivered in a facility receive a timely check-up postpartum, 23% of children with pneumonia receive antibiotics and 37.5% of children with diarrhea receiving appropriate treatment. Blood pressure under control is only achieved in 27% of hypertensive cases.

13. To better understand the system constraints, a rapid mixed methods assessment of PHC system quality in Comoros was jointly conducted by the MOH and the World Bank in January 2019. The assessment examined all the elements of the foundation of quality PHC (population, governance, platforms, workforce and tools) as per the framework by the Lancet Global Health Commission on High Quality Health System (see Figure 2 for more details of the framework), using the Primary Healthcare Performance Initiative’s data collection approach.

14. As per the assessment’s findings, delivery of quality PHC in Comoros is hindered by major constraints in governance, capacity and institutions. At the population level, there is little citizen engagement and patient empowerment. People do not trust PHC and prefer to seek care in hospitals. In terms of governance, various important health policies, strategies, regulations, standards and norms are yet to be developed. Other than the performance-based financing (PBF) scheme put in place since 2016 with the support of AFD (see Paragraph 17 and Box below), there are not significant accountability mechanisms in PHC. A M&E culture for decision making and improvement is yet to take root, especially in quality of care. Capacity of key institutions for stewardship or service delivery in PHC is low. As a result, the country does not have a systematic approach to quality of care and key quality improvement interventions are either very patchy (e.g. licensing, training, supportive supervision, clinical mentorship/coaching, clinical audit) or still missing (e.g. accreditation, pay for quality, continuous quality improvement). There are no clear recruitment and promotion criteria for PHC workers to form a basis for a career development path. The growing private sector is still unregulated by the national government. In terms of tools, the majority of PHC facilities have unmet needs in equipment and infrastructure. Regarding the PHC workforce, 60% of staff in public facilities are volunteers, which is an anomaly not only in the region but also globally (Please see Annex 2 for details).

10 Kruk ME et al. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. Lancet 2018

15. **The community health platform is particularly underdeveloped.** The National Community Health Strategy was developed in 2014 with the plan to put in place at least two Community Health Workers (CHWs) per village. Such CHWs, to be trained and supervised by districts health centers and health posts, are responsible for the delivery of a package of community health interventions. However, the implementation of the National Community Health Strategy has been very small-scale and fragmented. The most significant effort in community health so far is the introduction of this platform in 69 poorest villages/communities on three islands in 2016 with the support of the World Bank-financed Comoros Social Safety Net project. Under the nutrition component of this project, 100 CHWs were trained and put in place for the delivery of a minimum package of nutrition-specific interventions for the “first thousand days” window of opportunity (from pregnancy to 2 years of age). It also promotes better nutrition and reproductive health for mothers. UNICEF Comoros is the implementing agency of this component with US$ 1 million grant from the project. Other than this initiative, Comoros’s community health platform is very nascent. There are some CHWs but they are only activated during specific health campaigns. Given the limited coverage of community health so far, it is critical to further expand this platform in Comoros.

16. **Although the country is prone to disease outbreaks (including cholera and arbovirus), its level of pandemic preparedness is low.** As per the 2017 Joint External Evaluation (JEE) of the implementation of the International Health Regulations (IHR), the country’s capacity in prevention, detection and response to public health events remains very limited. Out of 47 indicators used in the assessment, Comoros was rated 1 (no capacity) for 24 indicators and 2 (low capacity) for 18 indicators. Especially, the JEE noted the lack of (i) a multisectoral coordination mechanism for IHR implementation, (ii) a risk communication strategy, (iii) a national action plan to address antimicrobial resistance, (iv) a national action for infection prevention and control, (v) a Public Health Emergency Operations Center. The capacity of the National Public Health laboratory is also low as per the JEE.

17. **Comoros spends much less on health than SSA and lower-middle-income country averages.** Total health expenditure per capita is around US$57, which is much lower than both SSA average (US$98) and lower-middle-income countries’ average (US$92). Government spending on health accounts for 32.8% of total health expenditure, which is also lower than SSA average (42.6%) and lower-middle-income countries’ average (37.1%). Health accounts for 8.7% of total government spending. As the result of low public spending on health, the share of out-of-pocket (OOP) spending on health in total health expenditure at 43% is much higher than the WHO-recommended threshold of 20%. Coverage of private health insurance schemes (“Health Mutuelle”) is low at 3.3% of the population as of 2012. Every year, OOP for health drive 1.7% of the population into poverty, increasing the overall level of poverty by 5 percent. In other words, on average, 35 Comorians fall into poverty daily because of catastrophic health expenditures. Many already poor

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12 The Comoros Social Safety Net Project (P150754) is financed by a US$6 million IDA grant. Its Project Development Objective is to increase poor communities’ access to safety net and nutrition services. It became effective on July 2, 2015 and will close on June 30, 2019

13 Politique Nationale de Protection Sociale en Union des Comores, July 2012
households experience a deepening of poverty due to OOP.\textsuperscript{14} Around 67 percent of the population self-report problems in accessing health care due to treatment cost.\textsuperscript{15}

18. **Health is prominent in the Government’s 2016-2021 Multisectoral Investment Plan** (Plan d’Investissement Quinquennal or PIQ). The overall objective of the health-related action plan in this five-year PIQ is “to improve the health status of the Comorian population through an efficient and equitable health system”. The immediate goal is to improve accessibility and quality of essential health and nutrition services to the population. Activities to achieve this goal include: (i) improving supply side through the construction/rehabilitation of health facilities, provision of equipment and essential generic drugs; (ii) developing community health service focusing on MCH; (iii) continuing and scaling up the performance-based financing (PBF) scheme in MCH; (iv) creating a health solidarity/equity fund through the taxation of goods and services; and (v) conducting National Health Accounts and developing national health financing policy.

19. **The Government has recently made a commitment to Universal Health Coverage (UHC).** The Parliament has ratified the law No.17-012/AU to establish a compulsory National Health Insurance System (NHIS or AMG) for UHC (summarized in Box 1) to be funded by (i) contribution from the formal sector and (ii) government subsidies for the non-formal sector, especially the poor. The law also identifies several measures to strengthen service delivery in preparation for the AMG. They include the introduction of an accreditation system, a referral mechanism and other interventions to strengthen quality. A technical committee was also established to guide the implementation of the new law.

\textsuperscript{14} Sub-National Analysis of Systematic Differences in Health Status and the Access to and Funding of Health Services: An Example from Comoros. World Bank 2016

\textsuperscript{15} PPCPI 2018
20. Since 2011, the French Development Agency (Agence Française pour le Développement – AFD) has been supporting a PBF scheme under the PASCO project (Projet d’Appui au Secteur de la Santé aux Comores). PASCO reimburses public facilities for the provision of (i) a package of MCH services, including family planning, at PHC level and (ii) C-section at the hospital level at significantly reduced user fees. The scheme has shown promising results. The service utilization rate has increased from 26% at baseline to 80% for facilities in the scheme. PASCO reimbursements account for 40 to 60% total non-salary income of facilities (in all facilities of 15 districts out of 17). However, the scheme is only limited to pay-for-quantity so far and has yet to incorporate pay for quality. It will close by the end of 2020.

B. Relevance to Higher Level Objectives

21. The proposed Project is fully in line with the GOC’s strategies and visions for health and nutrition. The project supports the GOC’s Accelerated Growth and Sustainable Development (SCADD) Strategies for the 2018-2021 period, especially (i) SCADD Core Strategy 2 “Accelerating the development of human capital and promoting social well-being and (ii) Strategic Objective 2.1 “Promote population health and nutrition and accelerate the demographic transition”. It also contributes toward the achievement of UHC stipulated in the new law No.17-012/A.
The proposed Project is aligned with various World Bank strategies and objectives. First, it is fully in line with the World Bank Group’s twin goals of reducing poverty and promoting shared prosperity. Second, it is meant to support Pillar 2 (shared growth and increased employment) of the World Bank Group’s Comoros Country Partnership Strategy (CPS) for FY14-19 (Report No. 82054-KM) and specifically objective 5 which seeks to improve effectiveness of social safety nets and active labor markets. Third, it will address some of the binding constraints identified in the World Bank’s 2018 Systematic Country Diagnosis for Comoros through its focus on improving health system governance, institutions and capacity. Fourth, it is part of the World Bank’s Human Capital Plan (HCP) for Africa. The objective of the plan is to enable Africa’s young people to grow up with optimal health and equipped with the right skills to compete in the digitizing global economy.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)
23. The project development objective is (i) to improve utilization of quality PHC and (ii) strengthen capacity of institutions which are critical to quality PHC.

Key Results
24. The following indicators will measure the achievement of the PDO:

(a) People who have received essential health, nutrition and population (HNP) services (number) (including the following three underlying indicators: number of children immunized; number of deliveries attended by skilled health personnel; number of women and children who have received basic nutrition services)\(^{16}\);

(b) PHC facilities with accreditation level 2 and above as per the facility accreditation program (number);

(c) PHC facilities participating in the PBF scheme supported by the project which reimburses for both quantity and quality of service (number);

(d) Functional community health sites (number)

(e) Annual District and National Health Assemblies (number)

D. Project Description

25. The project will support the strengthening of the foundational elements of a quality PHC system: infrastructure, workforce, service delivery platforms, governance, institutions for quality, and citizen engagement/empowerment, with the aim to bring quality PHC closer to the people. Support for such elements are organized by four components.

26. Component 1. Improving PHC infrastructure, workforce and service delivery platforms (US$ 22M). This component will support: (i) rehabilitation of district centers and health posts\(^ {17}\) and provision of PHC equipment and vehicles; (ii) pre-service and in-service training for selected health cadres as well as recruitment of PHC health workers, (iii) a PBF scheme in PHC, and (iv) scale-up of the community health and nutrition platform piloted under the Comoros Social Protection Project.

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\(^{16}\) These are also World Bank’s Corporate Results Indicators (CRI) for HNP

\(^{17}\) District health centers are headed by a medical doctor whereas the health posts are managed by midwives or nurses. Health posts are under the supervision of district health teams.
27. **Subcomponent 1.1: Supporting the rehabilitation of PHC facilities (district health centers and health posts) and the provision of PHC equipment and vehicles.** The project will support minor rehabilitations (including those related to improving health care waste management and facility resilience to climate change) and provision of equipment for selected existing health centers and health posts on the basis of a comprehensive needs assessment. No financing for new facility constructions is expected. Ambulances and vehicles will be procured to support (i) emergency referrals; and (ii) PHC supervision in health districts. The project will also contribute to the piloting of Emergency Medicine Service (EMS) units in two districts.

28. **Subcomponent 1.2: Improving PHC workforce.** This subcomponent will finance selected in-service and pre-service trainings in PHC as part of its support for the implementation of the National Human Resources for Health Strategy. A comprehensive five-year training plan will be developed and updated annually on a rolling basis. On that basis, the project will finance a subset of the training plan. Support for pre-service clinical training includes (i) around 15-20 scholarships for overseas training in selected specialties such as pediatrics, OB-GYN, surgery and anesthesia and (ii) assistance for the nursing school in Moroni to adopt a competency-based curriculum in nursing and establish the laboratory technician training program. Support for non-clinical pre-service training include, *inter alia*, training in public health, health economics, health management and planning to help create a pipeline of health leaders/experts for the country. For in-service training, the project will support the development and implementation of integrated curricula for continuous professional development (CPD) in which prioritize (i) training in quality of care and patient safety for PHC health workers; and (ii) training in health management and planning for managers at both national and district levels. On-the-job trainings will be linked to the PBF or pay for performance scheme for PHC facilities, with the use of training outcomes as parts of the performance indicators. Finally, the project will support the recruitment of PHC professionals for selected district health centers with the aim to reduce the reliance on volunteers. Such positions will be transitioned into the government payroll when the project ends.

29. **Subcomponent 1.3: Supporting the PBF scheme in PHC.** Building on the PBF experience with 58 health centers supported by PASCO so far, the project will expand the PBF scheme to the remaining 32 health centers. Although the project will adopt the key approaches of the PBF scheme under PASCO, it will also introduce new features, including (i) expansion of the PBF service package to include more services (e.g. selected NCD interventions such as opportunistic screening of hypertension and diabetes and their management at the PHC level) and (ii) addition of a pay-for-quality component to the PBF scheme (beyond the existing pay-for-quantity approach). For the latter, PHC facilities in the scheme will undergo a quarterly quality assessment, using a detailed Balanced Score Card. PBF payments to facilities will be a function of quality and quantity performances by facilities, with the aim to stimulate health workers’ performance. It also provides an entry point to introduce more facility managerial autonomy and more accountability for results. The project will closely coordinate with PASCO in terms of institutional arrangements (e.g. third-party payment, verification of results, and mainstreaming) to maximize synergy and avoid duplication. When PASCO ends (expected date: December 2020) the project will take over the support for PBF scheme in all PHC facilities (90 in total).

30. **Subcomponent 1.4: Scaling up the community health platform.** The project will support the implementation of the National Community Health Strategy through the recruitment, training, motivation, supervision and

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18 While these specialists are critical to (i) the PHC continuum and (ii) the training, supervision and mentorship for PHC health workers, such pre-service specialty trainings are not available in Comoros.
monitoring of CHWs to deliver a package of health, nutrition, family planning and early years development services at the community level. Built on the experience of the World Bank-financed Social Safety Net project, the service package provided by community health workers will be complemented by a peer-led education approach. In this approach, each community group will elect a lead mother (a.k.a “mother leader”) to provide peer support and organize regular community discussions on health, nutrition, family planning, early years development and other topics of their interest. Such activities aim to build knowledge and skills of caretakers as one of the major pathways to improving PHC outcomes. Mother leaders will also be linked to community health workers and PHC facilities to foster coordination among them. The project will scale up the community health platform from the 69 poorest communities/villages under the Social Safety Net project to at least 170 additional villages or 40% of total population owing to MOH capacity constraint.

31. Component 2: Strengthening institutions and governance which are critical to (i) quality PHC and (ii) response to disease outbreaks (US$5M).

This component will support the strengthening and operationalization of selected institutions and governance structures which are critical to (i) quality PHC and (ii) disease outbreak response, which include, *inter alia*: the Directorate of Public and Private Health Structures which takes the lead in setting quality standards, norms and regulations; the Department of Health Promotion (which is also responsible for coordination of communications in public health emergencies); the National Technical Platform of Health Infrastructure, Pharmaceutical and Procurement (OCOPHARMA); the Public Health Emergency Operations Center, and Health Professional Associations; quality units (or quality committees) at the facility levels.

32. It will support such entities to:
   (i) develop relevant sector policies, strategies, plans and regulations;
   (ii) develop/revise and implement quality standards, norms, protocols, guidelines, and procedures, including:
   a. a health facility accreditation program to accredit health facilities and
   b. an integrated supportive supervision scheme for PHC facilities with a focus on quality,
      using a standardized quality checklist which include skills assessment
   c. initiatives to improve quality of care such as clinical mentoring/coaching and team-based
      quality improvement approaches;
   (iii) strengthen their capacity to implement their most critical mandates related to quality PHC and response to disease outbreaks,
   (iv) strengthen their M&E, including purposeful quality of care monitoring at the PHC facility level for accountability and improvement;
   (v) conduct selected assessments, pilot innovations and carry out operational research.

   The support will be in the form of technical assistance, selected equipment and non-salary operating cost.

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33. **Component 3: Citizen Engagement and Empowerment, Project Management, Monitoring and Evaluation, (US$ 3M).** This component will finance (i) citizen engagement, patient empowerment and support, and (ii) project management and project M&E.

34. **Subcomponent 3.1: Citizen engagement, patient empowerment and other patient support.** This will include support for (i) strengthening of PHC facilities’ community management boards to help them better carry out their mandates; (ii) establishment and/or strengthening of the associations of people living with hypertension, diabetes, chronic respiratory diseases, cancer support groups; etc. (iii) implementation of a patient experience survey (at least every 2 years); (iv) Periodic Feedback beneficiary consultations to inform subsequent activities: (v) Annual District and National Health Assemblies to bring all key stakeholders and citizen representatives together once a year to discuss health issues and come up with resolutions; (v) subsidies for inter-island patient transfer, targeting the two poorest quintiles; and (vi) the implementation of a project grievance redress mechanism to strengthen project governance.

35. **Subcomponent 3.2: Project Management and Project M&E.** This sub-component will finance PMU staff salaries and other operating costs (fiduciary, safeguards) to enable the PMU carry out its mandates. (e.g. coordination, financial management, procurement, audits, project monitoring and evaluation). M&E support will include contributions to (i) the Service Availability and Readiness Assessment (SARA) study (baseline and end-of-project); (ii) the EDS/MICS survey; and (iii) annual joint reviews of the health sector (all of which will be co-financed by various DPs).

36. **Component 4: Contingent Emergency Response Component (CERC) (US$0M).** A CERC will be included under the Project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13 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.

37. **Project Cost and Financing:** The proposed total project cost is US$30 million over five years (Table 2).
Project Components

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<td>Sub-Component 1.1: Supporting rehabilitation of district health centers and health posts, provision of PHC equipment and vehicles</td>
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<td>Sub-Component 1.2. Improving PHC workforce</td>
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| Component 2: Strengthening institutions and governance which are critical to (i) quality PHC and (ii) response to disease outbreaks | 5.0 | 5.0 |

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<td>Sub-component 3.1: Citizen engagement and empowerment</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Sub-component 3.2: Project Management and Project M&amp;E</td>
<td>2.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

| Component 4: Contingency Emergency Response Component | 0.0 | 0.0 |

| Total Project Costs | 30.0 | 30.0 |

**E. Implementation**

Institutional and Implementation Arrangements

**Institutional Arrangements**

38. The Ministry of Health and Solidarity (MOH) is the Project’s implementation Agency. Led by the General Director for Health (DGS), the MOH is responsible for Project implementation, technical oversight, and overall coordination of all the Project stakeholders. The Director of the Regional Health Directorate will oversee the implementation of Project activities at the regional (island) level.
39. The MOH’s Project Management Unit (Unité de Gestion des Projets – UGP) will be responsible for the fiduciary matters as well as other day to day management of the project. UGP was established as a MOH unit in February 2019 to take charge of fiduciary matters and other day-to-day management of all health projects financed by development partners (including IDA), in close collaboration with different national and regional structures of the MOH. Different MOH departments and Government of Comoros agencies, who benefit from the project support, will develop annual workplans with detailed activities and proposed budgets for UGP’s validation. UGP will then consolidate annual workplans and submit to the World Bank for No Objection. To ensure UGP to be able to carry out its mandates, the Project will support (i) capacity building for UGP in procurement and financial management and (ii) selected key UGP positions at the central and regional levels.

40. The institutional arrangements for the PBF scheme will mirror those under PASCO. Similar to PASCO, UGP will play the role of the Strategic Purchasing Unit for the PBF scheme supported by the Project, while FENAMUSAC will play the role of the verification agency (including community-based verification). When PASCO closes in 2021, UGP will be the sole Strategic Purchasing Unit for PBF in the country (Figure 4). For sustainability, when the Project closes in 2024, the Strategic Purchasing Unit is expected to transition from UGP into either (i) the DGPE department of the Ministry of Health or (ii) the National Health Insurance Agency (AMG) if such an agency has become operational by then.
Figure 4. PBF Arrangements and Flow of Fund

Till 2020 – PBF Pay for Quantity

- AFD
- IDA/WBG

MOH – DGS Regulator/Purchaser

PASCO
Strategic Purchasing Unit

UGP
Strategic Purchasing

FENAMUSAC
Contractor/Verification

Island hospital

District Health Center

Health Post

From 2021 – PBF Pay for Quantity & Pay for Quality

- IDA/WBG

MOH — DGS Regulator/Purchaser

UGP
Strategic Purchasing

FENAMUSAC
Contractor/Verification

Island hospital

District Health Center

Health Post/CHW

BENEFICIARIES
Use of health services free of charge or subsidized
F. Sustainability

41. The scale-up of cost-effective PHC interventions under the project, using the PBF and community health platforms, will contribute to the Project’s technical sustainability. Such technical interventions are well-known but have not been implemented in Comoros in a systematic manner. With the use of PBF and community health platforms, coupled with capacity building, the project will help the country to improve the delivery of technical interventions in PHC in a more sustainable manner.

42. The Project’s strong focus on building institutions and governance is likely to have long-lasting impacts, with positive outlooks on institutional sustainability. The critical role of institutions in sustainable development is undisputable. The Project will not only strengthen/operationalize various institutions and governance structures which are critical to quality PHC, it will also create the entry points to potentially improve the way such institutions behave and interact with one another in a sustainable manner. However, it is worth pointing out that the track record in mainstreaming PBF schemes supported by World Bank projects into government systems after such projects end remains mixed. This is not just an issue related to institutional sustainability but also a challenge in financial sustainability. Having said that, the PBF scheme’s linkage to the planned NHIS can increase the likelihood of its sustainability.

43. The Project’s financial sustainability depends on various factors. One important determinant of the project’s financial sustainability is the country’s economic outlook, but this is outside the control of the project and the sector. Another factor is whether the project can increase PHC performance in Comoros (including quality and efficiency) and help the country get more health for the money. Successful Project implementation therefore will be critical to the project’s financial sustainability. With regard to the PBF scheme, the full country coverage of PBF will cost 6.5% of government’s annual expenditure on health. These estimates include a 2% annualized cost for the maintenance of equipment. Finally, political commitment to health is another important factor for the project’s financial sustainability. With the Parliament’s ratification of the law related to national health insurance as well as an accreditation system, a referral mechanism and other interventions to strengthen quality, the government indicates a strong political commitment to UHC.

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

The project will be implemented in selected geographic areas of Comoros across the islands of Ngazidja, Anjouan and Mohéli. Targeted sub regions (districts), such as the five poorest will be prioritized for more intensive support to ensure equity of access to quality health and nutrition services and to make optimal use of limited resources. Health facilities will be supported to improve project beneficiaries access to quality services by addressing supply side constraints, and strengthening referral and counter referral systems. It is proposed to renovate and rehabilitate existing health facilities.
### G. Environmental and Social Safeguards Specialists on the Team

Erik Reed, Environmental Specialist  
Andrianjaka Rado Razafimandimby, Social Specialist  
Mario Rizzolio, Social Specialist

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### SAFEGUARD POLICIES THAT MIGHT APPLY

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>Yes</td>
<td>This policy is triggered due to the fact that the project will finance minor rehabilitation of health infrastructure and the installation of incinerators. This minor rehabilitation and installation of incinerators will have adverse risks and impacts on the environment (both physical and natural), and also on social inked to the risk of Gender-Based Violence and HIV/AIDS spreading by construction site staff to women in communities close to rehabilitation / renovation works. As all project sites are not known during project preparation, an Environmental and Social Management Framework (ESMF) has been be prepared, amply consulted upon and publicly disclosed both in-country and on the World Bank website prior to appraisal.</td>
</tr>
<tr>
<td>Performance Standards for Private Sector Activities OP/BP 4.03</td>
<td>No</td>
<td>The policy is not applicable for this project.</td>
</tr>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td>No</td>
<td>The Policy is not triggered as the Project will not affect natural habitats.</td>
</tr>
<tr>
<td>Safeguard Policy Issue</td>
<td>Triggered</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td>Forests OP/BP 4.36</td>
<td>No</td>
<td>The Policy is not triggered as the Project will not have any adverse impact on forests, nor engage in afforestation.</td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td>No</td>
<td>The policy is not triggered as the project will not finance pesticides procurement nor support targeted pest management measures beyond what is covered in the NMWMP.</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td>No</td>
<td>This policy is not triggered as the project will involve rehabilitation but not the construction of new infrastructure and thus no excavation.</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td>No</td>
<td>The Policy is not triggered as there are no Indigenous People, as defined by the policy, in Comoros</td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td>No</td>
<td>The Policy is OP 4.12 is not triggered for this project as the project will finance minor rehabilitation of health infrastructure (including the installation of small incinerators at the sites of health centers). The planned activities will not require involuntary taking of land that could result in relocation or loss of shelter; loss of assets or access to assets; or loss of income or livelihoods.</td>
</tr>
<tr>
<td>Safety of Dams OP/BP 4.37</td>
<td>No</td>
<td>The Policy is not triggered as the Project activities will not affect dams nor depends on waters from such dams.</td>
</tr>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td>No</td>
<td>The Policy is not triggered as the Project will not occur in international waterways</td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td>No</td>
<td>The Policy is not triggered as Project activities will not occur in disputed areas.</td>
</tr>
</tbody>
</table>

**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 proposed project has been assessed as Category B (Partial Assessment), no potential large scale, significant and/or irreversible impacts have been identified in the project, and OP 4.01 (Environmental Assessment) has been triggered. Project activities aim to improve the quality of health and nutrition services at the community level and in primary care health centers at the commune level in target areas. All of this is expected to yield positive social and environmental benefits. Environmental impacts are expected in specific locations as a result of rehabilitation or renovation of existing health centers and installation of incinerators. In addition, the improvement of access and utilization of health services could increase medical and pharmaceutical waste production in the different types of health facilities, which could adversely affect the environment and local populations, and for which there is currently limited treatment. Incinerators will be purchased and placed at strategic locations within the different target districts.
as part of the implementation of the medical waste management plan which was developed. Negative social impacts expected could arise from improves access and utilization of health services as this could increase the medical and pharmaceutical waste production in health facilities, and adversely affect the health of local population affecting their capacity to work and generate revenue, affecting their livelihoods. Other social negative effects are linked to the risk of Gender-Based Violence and HIV/AIDS spreading by construction site staff to women in communities close to rehabilitation/renovation works. Despite the fact that some negative impacts are expected from this project, there are also significant positive impacts that may counteract the negative ones. The positive impacts include: improved health status for the beneficiaries of health centers, safe and healthy environments, improved livelihoods and economic stimulation as a result of a much healthier population, amongst others.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Long term environmental and social impacts are expected to be positive, including through more effective treatment of medical waste and expired medications.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
Different options for medical incinerators have been considered and the most effective, efficient and practical have been selected based on the country's sector wide engagement. Placement of incinerators will be guided by an expert during implementation.

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.
The Environmental Assessment OP/BP 4.01 is triggered due to generation of health care waste and environmental and social risks associate with the rehabilitation of existing health infrastructure. The EA category for this project is Category B, owing to the location specific and manageable nature of the potential environmental impacts at the selected health facilities. To this end, and Environmental and Social Management Framework (ESMF) and a national medical waste management plan (NMWMP) including a destruction guide for expired medications was finalized, submitted to the Bank and disclosed. Environmental and Social Screenings will be conducted for each rehabilitation work including public consultation, and environmental and social mitigation measures will be included in all works contracts as outlined in the ESMF. A new project implementing entity was established, with oversight from the Ministry of Health (MoH). The Direction des Etablissement Sanitaires Publiques Privés (DESPP) and its decentralized units at regional and district levels will be responsible for implementing the national Medical Waste Plan. An Environmental and Social Specialist is being recruited as part of the project implementing unit full time to ensure the proper implementation of the NMWMP and evaluation of small works. The Bank will ensure that the PIU staff has adequate capacity to manage environmental and social safeguards. The Bank will provide close supervision to ensure that the basic recommendations of the ESMF and NMWMP are fully embedded in the client's overall project implementation strategy.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
Key Stakeholders consulted during the preparation of the instruments included ministry authorities, technical partners, private distributors of medicines (destruction of medicines), local authorities and health center operators at different levels, as well as planning authorities on the three target islands. The instruments designed are primarily at policy level related to medical waste managements thus consultations focused on raising awareness of better health and nutrition are an integral part of the project activities. As specific rehabilitation sites are identified environmental and social screenings will be conducted and public consultations will be carried out. The Ministry of Health will develop a Stakeholder Engagement Plan (SEP) to improve and facilitate decision making and create an atmosphere of
understanding that actively involves relevant stakeholders in a timely manner, to ensure these groups are provided sufficient opportunity to voice their opinions and concerns that may influence Project decisions. The SEP will identify in detail the key stakeholders as well as the mechanisms of consultation for project implementation.

B. Disclosure Requirements

<table>
<thead>
<tr>
<th>Environmental Assessment/Audit/Management Plan/Other</th>
<th>Date of receipt by the Bank</th>
<th>Date of submission for disclosure</th>
<th>For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12-Nov-2018</td>
<td>12-Mar-2019</td>
<td></td>
</tr>
</tbody>
</table>

"In country" Disclosure

Comoros

12-Mar-2019

Comments

The disclosure was published in newspapers and hard copies made available on the three target islands as well as made available on the Ministry website.

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

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

No

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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