Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 15-Jan-2020 | Report No: PIDC27896

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Somalia	P172031		Improving Healthcare Services in Somalia (“Damal Caafimad” Project) (P172031)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Jun 29, 2020	Aug 27, 2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Federal Ministry of Finance	Federal Ministry of Health	

Proposed Development Objective(s)

To improve coverage of essential health and nutrition services for underserved populations in project areas and to develop capacity of Ministry of Health to manage health and nutrition services

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	75.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	75.00
IDA Grant	75.00

Non-World Bank Group Financing

Trust Funds	25.00
Global Financing Facility	25.00

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

Somalia is transitioning out of protracted conflict, into increased stability through institutional and political progress, which began with the establishment of a provisional constitution in 2011 and a Federal Government in 2012. The federal system established under the 2011 provisional constitution carved out four new states for a total of six under the Federal Government of Somalia (FGS). In the transition to greater political stability, the Government has improved financial transparency and institutional structures. Concurrently, an active armed insurgency, open constitutional questions, weak service delivery capacity, fiscal capacity constraints, and continual humanitarian crises remain.

Somalia is diverse geographically and in terms of population locations and income generation activities. The country's northern sections are arid and semi-arid and drought-prone while the Southern State have more rainfall and agricultural options. Somalia's population of roughly 14.0 million is 42% urban, 23% rural, 26% nomadic, and 9% internally displaced. Livestock and agriculture are key economic activities for non-urban populations, which are extremely sensitive to the country's periodic droughts and associated famines.

Population growth is high with an annual population growth rate of almost three percent and doubling every 24 years. Substantial population growth has resulted in a young population: 91% of the current population is under the age of 40, three-quarters is under 30, and 58% are under 20 years old. Youth unemployment is high and educational attainment limited, with only 16% of the population completing primary school and 7% completing secondary school. Gender disparities in Somalia are among the worst in the world, characterized by limited access to formal education, high rates of sexual and gender-based violence (SGBV) as well as nearly universal prevalence of female genital mutilation (FGM), and barriers to formal economic participation.

Somalia is among the poorest countries in the world with a per capita Gross Domestic Product (GDP) of US$ 500 in 2017 and an estimated 77% of the Somali population living in poverty (below US$1.9 per day, 2017). The low GDP is compounded by insufficient growth of 2.5% per year from 2013 to 2017, which is outpaced by population growth of 2.9% annually during the same period. The economy is highly dependent on foreign remittances, which are estimated to make up 21.5% of the country's GDP (2017), with less access to remittances among rural and poor populations.

In the absence of functioning public institutions, Somalia's private sector has thrived. A range of services including air transport, telecommunications, social services, urban water, and electricity are privatized, with a small number of entrenched, connected companies dominating the sectors. At the same time, regulation is weak to non-existent, with little cost regulation or clarity in processes to enter the market. Combined with weak supporting infrastructure including limited credit facilities, entry into the formal sector is difficult.

Sectoral and Institutional Context

Somalia's progress on human capital (HC) remains limited. Somalia suffers from high levels of mortality especially among children, stunting, high fertility, low school enrollment, and limited public and private sector social protection mechanisms. The country's high poverty rates further compound low HC as poverty limits opportunities for people to access basic services, exacerbating poor education and health outcomes, affecting HC accumulation that is critical for economic growth. Due to lack of data, Somalia's Human Capital Index (HCI) has not been calculated. Considering poor health nutrition population and education outcomes, the country's HCI raking would be low. As seen below, health outcomes in Somalia improved from 2006 to 2016 (see table 1). However, these remain among the worst in the world (see table 1), with an average life expectancy of fifty-six years.

Table 1: Somalia's Key Health Indicators 2006 and 2016

Indicator	2006	2016
Maternal Mortality ratio (per 100,000 live births)	911	732
Neonatal Mortality Rate (per 1,000 live births)	45.2	38.8
Infant Mortality Rate (per 1,000 live births)	104.9	86.2
Under five mortality Rate (per 1,000 live births)	173.7	132.5
Total Fertility Rate	7.2	6.4
Adolescent Fertility Rate (births per 1,000 women)	N/A	102.6 (*2015)
Stunting	N/A	25.3%** (**2009, WB)

Health data in Somalia are very limited and indicate weak service delivery, with facilities concentrated in urban areas. The most recent, reliable data in Somalia are from a 2011 multi-indicator cluster survey (MICS) conducted only in Puntland and Somaliland. The 2011 Somaliland and Puntland MICS indicates, respectively 11% and 9% DPT3 coverage, 32% and 24% prenatal care by skilled personnel, and 44% and 38% skilled deliveries. Coverage is expected to be much lower in the four emerging states which composed the former South-central zone where health systems are less developed. Seventy-nine percent of private and 62% of public facilities are in urban areas (SARA, 2016).

Health service utilization is low, particularly in the public sector, estimated at 0.23 outpatient visits per person per year and 0.81 hospital discharges per one hundred people per year (SARA, 2016). Clan structures are believed to have major impacts on service utilization, dictating which facilities people visit. Traditional medicine and health seeking within families and outside of formal medicine are believed to be common.

The poorly regulated private sector is an important service delivery provider. At least 60% of health services are estimated to be delivered by the private sector. Analysis indicates that public perceptions of private facility quality is higher than of public facilities. It is estimated that the private sector provides around 80% of the country's medicines by importation and distribution through private retail outlets and pharmacies.. Because of lack of regulation in Somalia's health sector, there are no quality standards for services or pharmaceuticals, limiting the full potential of the private sector.

Out-of-pocket payments (OOP) as a percentage of total health expenditure in Somalia is high, estimated at 45% of total health sector financing. Average annual household OOP on health is estimated at US$110 (2017) and varies substantially between the richest quintile (US$200 per household) and the poorest (US$11 per household), indicating that households are accessing healthcare services based on ability to pay instead of healthcare needs, underlining health inequities. Remittances are an important source of healthcare financing driving OOP, but there is little data on the extent of their contribution to OOP. There are almost no formal risk-protection mechanisms in the country: health

insurance is limited to private plans for international companies and NGOs and is estimated to compose 1% of health expenditures.

Staffing and equipment gaps are persistent as are pharmaceutical stock outs, particularly in public facilities. Somalia's private health worker's density, at 4.9 per 10,000 and the public health worker density at 4.3 per 10,000 both are significantly worse than WHO's cut-off for "critical" Human Resource shortage at 2.28 health workers per 1000 population. Availability of qualified medical staff is predictably concentrated in urban areas with recruitment and retention challenges in rural areas. There are also believed to be a large number of unqualified individuals providing health services, particularly in private facilities. Shortage of medicines and other health commodities at public facilities are common. Supply chain management for health is challenged by the volatile security environment, poor infrastructure, human resource shortages and low capacity, limited access to supervision and monitoring, and a lack of integrated sector-wide information management systems. Thirty percent of Somalia's pharmaceuticals are from the UN managed supply chain which stocks public facilities and 70% are from private importers.

Service delivery challenges are underpinned by very limited financing for health in Somalia. Per capita public expenditure on health is approximately US$ 33 per person per year, far below Sub Saharan Africa's average of US$98. Government expenditure on health as a percentage of total government expenditure is 6.9%, far below the Abuja target of 15%. Low health expenditure is underpinned by the Government's low fiscal capacity. Donor financing is an important source of health expenditure, composing 45% of total health expenditure and much of this is off-treasury.

Capacity of Somalia's Federal and State Ministries of Health to manage health services is very weak across Somalia. Other than the nascent Ministries of Health in Somaliland and Puntland, the rest of the country is just beginning to set up governance structures. Key health staff in most of the Ministry of Health units are either secondees from non-governmental organizations (NGOs) and other development partners or volunteers. Certain skills that are essential for planning such as health economics are lacking from the planning departments of the Ministries of Health. The government also lacks contract management capabilities to effectively enter into and manage service delivery contracts.

The current service delivery landscape is fragmented with very limited coordination among donor funded projects. Conversations with stakeholders in Somalia reveals significant benefits of a previous multi-donor coordinated Somalia's Joint Health and Nutrition Program (JHNP) which closed in 2016. The program had notable achievements in supporting efforts between different levels of government and partners which led to adoption of similar policies and strategies. Furthermore, the JHNP allowed the pooling of donor financing to jointly support Somalia's Essential Package of Health Services (EPHS)[1].

The EPHS in Somalia does not reach the full population. The EPHS was developed in 2009 with support of UNICEF/ European Commission, learning from similar work in other FCV countries. EPHS implementation started in 2013 through the JHNP and the Health Consortium for Somali People along with partial alignment from the Global Fund and Gavi, Alliance for Vaccine and Immunizations (Gavi). However, following the closure of JHNP after the end of DFID financing, EPHS implementation has become an uncoordinated patchwork, with substantial missing geographic areas and package components. According to 2017 World Health Organization (WHO) figures, approximately 47/89 districts are covered by EPHS, translating into an estimate of approximately 5.7 million people (41%) with coverage of the EPHS. Although efforts are underway to expand the EPHS including through humanitarian agencies, the current EPHS is not fully implemented anywhere in the country due to financing and logistics gaps. There is no evidence of any efforts to provide the EPHS through the private sector.

[1] The EPHS six core programs are: Maternal, reproductive and neonatal health; Child health; Communicable disease surveillance and control, including WASH promotion; First aid and care of critically ill and injured; Treatment of common illness; and HIV, STIs and TB. The four additional programs are: Management of chronic disease and other diseases, care of the elderly and palliative care; Mental health and mental disability; Dental health; and Eye health. Compared to the 2003 BPHS prepared in Afghanistan, the Somalia EPHS was much broader and subsequently required more resources to implement.

Socio-cultural factors play a significant role in the health status of women in Somalia. Responsibility for decisions related to health-seeking behavior, such as when to travel to a clinic for treatment, mostly resides with men and contributes to care seeking delays. Early marriage is a significant factor in high maternal mortality rates, leading to early first pregnancies and high fertility rates. Female Genital Mutilation/Cutting (FGM/C) in particular is a deeply entrenched, near universal, cultural practice in Somalia, with 98% of women between the ages of 15-49 having undergone either Type II or Type III FGM/C, although recent survey data indicates a reduction in reported incidence in urban areas (Joint UN-World Bank study 2016). FGM/C, is a likely factor contributing obstructed labor, fistulas, and infection, which dramatically impact maternal health in Somalia. This is in addition to the fact that it violates the rights of women and girls. Further, there are substantial socio-cultural barriers to reporting GBV and there is a lack of trained, quality GBV response services.

Relationship to CPF

The Somalia Country Partnership Framework (CPF) for fiscal years 2019 to 2022 focuses on building institutions. Core results include improvements in the quality and equity of basic services as well as improved fiscal space and equity in use of public resources. The project will contribute to Focus Area 1: Strengthening Institutions to Deliver Services, primarily the specific objectives of "Strengthening public finance accountability and institutional development" (Objective 1.1) and "Improve delivery systems for more inclusive social services" (Objective 1.3).

C. Proposed Development Objective(s)

To improve coverage of essential health and nutrition services for underserved populations in project areas and to develop capacity of Ministry of Health to manage health and nutrition services

Key Results (From PCN)

Progress in the area of service delivery under the project will be measured by the following indicators (disaggregated by selected areas):

- Percentage of pregnant women who attend 1st ANC visit
- Percentage of births attended by skilled health personnel
- Percentage of children under one year of age receiving Penta-3 vaccination
- Number of women using modern contraceptives (Couple Years of Protection)
- Percentage of children between 6-23 months old receiving micronutrient supplements (place holder)

Potential PDO indicators measuring progress in the area of building stewardship capacity in MoH under the project will include:

- Development contract management capacity within the MOH
- Satisfactory implementation and monitoring of service delivery contracts at FMS level

The PDO indicators and the project's Results Framework will be agreed during project preparation with the Government.

D. Concept Description

After a prolonged absence in the health sector, the World Bank has re-engaged to respond to health sector challenges using a twin approach that includes an ASA and a health operation through the existing Recurrent Cost and Reform Financing (RCRF) project (P154875). The proposed project, which is the first Bank health operation in Somalia, will build on the ongoing ASA as well as activities under RCRF, which supports re-establishment of the Government's Female Health Worker (FHW) program. The proposed project will be financed through an IDA grant of US$75 million, co-financed by the Global Financing Facility (GFF) Trust Fund through an additional US$25 million over five years. The proposed project will be developed in strong partnership with the FGS and the Federal Member States

(FMS) to rapidly expand the coverage of a prioritized package of essential primary and secondary healthcare services. The selection of target geographical areas will incorporate experience from RCRF and findings from ongoing work, health service delivery needs, political considerations, available information on health outcomes, and equity. In anticipation of Somalia gaining full access to IDA following the anticipated March 2020 HIPC decision point, the proposed project is planned to be delivered in early FY21.

Somalia recently became a GFF Country and is in the initial stages of developing an Investment Case (IC) to improve health outcomes by improving health service coverage and quality, developing Government stewardship capacity, and mapping resources available in the health sector. The proposed project will be aligned with Somalia's IC with the proposed project and is expected to implement a portion of the IC. The Government is in the process of developing a Country Platform, which will have participation across states and include civil society, UN agencies, the private sector, and non-Governmental organizations (NGOs). In light of increased fragmentation of donor support to Somalia's health sector after JHNP's closure, there is substantial momentum among partners to capitalize on the opportunity presented by WB and GFF to re-establish an effective health sector coordination mechanism. Through strengthened partner coordination utilizing the GFF process, the proposed project will complement service delivery efforts currently supported by other development partners including DFID, Gavi, the Global Fund, SIDA, and NGOs. In doing so the task team will coordinate with development partners to reduce fragmentation and enhance development effectiveness by aligning resources around the Government's priorities. In addition, recognizing substantial inflow of humanitarian aid in the health sector, the team will also seek areas of collaboration between project activities and activities supported through humanitarian aid to avoid duplication and confusion on the ground.

In Somalia, delivering health services through the Government is a necessary first step to develop state legitimacy, improve service responsiveness to population needs, and move towards sustainable systems. Somalia's current CPF and the concept note for the latest WBG FCV Strategy (under development) both emphasize the importance of strengthening institutions to re-establish state legitimacy towards preventing and exiting fragility. Somalia has a long history of a fragmented delivering of emergency services through NGOs and UN agencies. While these approaches have delivered critical services to populations in need, there are substantial gaps in service delivery coverage and quality. Furthermore, repeated emergencies and immediate needs for service delivery by NGOs and UN agencies have resulted in the absence of large investments in critical government capacities and the system building necessary for long-term stability. Following the WBG FCV Strategy concept note and learning from experiences of other partners in Somalia's health sector, the proposed project design focuses on building the government capacity and institutions to ensure a visible Government role in managing service delivery for the population. Further, the current WB Somalia portfolio emphasizes the use of country systems (even if in a nascent form) as it has multiple advantages; while the use of country systems carries some implementation risks, it will help Somalia emerge rapidly from the post conflict situation and improve government-citizen relationships.

The project intends to improve coverage of a quality assured prioritized Essential Package of Health (and nutrition) Services (EPHS). Utilizing resource mapping being conducted by the GFF, the WB task team will engage with the Ministry of Health and key partners to support development of a prioritized EPHS for project areas that is costed and aligned with available resources as well as prioritized to Somalia's health needs. The EPHS delivery modalities will be carefully selected to avoid duplication with other partners' activities and promote equity and improved access to health services by under-served groups. Considering extremely poor health outcomes, the service delivery component will target the underserved/vulnerable population group, i.e., mothers, children, and reproductive age women in specific geographic areas.

The proposed project will incorporate lessons learned from WB operations in Somalia and other FCV contexts, such

as notable rapid improvements in Afghanistan's health outcomes through contracting service delivery to non-governmental organizations. Preliminary lessons learned from the ICR (under development) of the recently closed South Sudan Health Rapid Results Project (P127187) suggests avoiding rushed project preparation, simplicity of project design, strong data verification mechanisms, and incorporating robust supervisory systems, given critical government capacity constraints and a difficult, complex FCV environment. The aforementioned South Sudan Health Project also indicates the importance of persistently and patiently developing institutional capacity. Moreover, there is abundant Somalia portfolio-wide operations experience, most notably, the foundational RCRF health component. The recently approved "Water for Agro-pastoral Productivity and Resilience Project" (Biyoole; P167826) provides lessons learned on engagement with Somaliland and will be a prototype for the proposed health project on legally including Somaliland in a mutually satisfactory manner.

There are two main components to be supported under the project, along with the project management component and a possible Contingent Emergency Response Component (CERC; to be decided): (1) Expanding the coverage of prioritized EPHS in selected areas, and (2) Developing government stewardship capacities to enhance service delivery.

(1) Expanding the coverage of prioritized EPHS in selected areas

During project preparation, the task team will undertake EPHS prioritization to select and cost a package of minimum essential health and nutrition services to be supported under the project. It is expected that two to four regions in each of two to three states and Somaliland will be covered in the project, depending on the cost of the prioritized EPHS and the level of co-financing from other partners. Based on political complexities in Somalia and learning from experiences of other Bank projects, the task team will support development of objective geographic selection criteria to be agreed with the Government. Due to accessibility and health worker safety concerns, project coverage is not expected to extend to areas with substantial security challenges at this time. Project coverage is expected to include a mix of areas which currently have better health service coverage, those with some gaps, and those with no coverage.

In implementation areas to be supported by the proposed project, the goal is to ensure that the prioritized EPHS is delivered consistently across the target areas, inclusive of a focus on community engagement and demand creation. Following the selection of geographic areas using an agreed upon criteria, a specific service delivery modality will be agreed between WB and the Government, depending on the government capacity and characteristics of the target geographical areas: (1) contracting out service delivery to non-state actors, such as UN, NGOs and private sector networks; and (2) strengthening existing government service delivery in government facilities where the government is currently delivering services (to be applied only if geographic areas with existing government service delivery are selected) to expand service delivery in targeted areas. As a component of contracting out of service delivery, contracting to existing private sector providers through private sector networks in select urban areas will be piloted. Customizing service modalities to the context of each selected area will facilitate Somalia's current constitutional direction of decentralized service provision at the FMS level, supporting the country's nascent federal system. This approach is also in line with other WB-financed projects in Somalia.

(2) Developing government stewardship and management capacity to enhance service delivery

Building on RCRF capacity development and assessments, this component is intended to support development of core government stewardship capacities at both the Federal and FMS levels to enhance quality service delivery. At the recent project design workshop, the government agreed to increase capacity through additional positions supported through the RCRF project human to fill gaps in agreed areas of capacity support. These positions are expected to be gradually integrated into the MoH's core function over time. Given historical off-budget donor supports and emphasis on

immediate service delivery, there is a wide range of core capacity and functions missing in the current Federal and FMS MoHs. The task team has mapped out potential areas for capacity building under the project, while taking into consideration the complementarity with other partners' work and the RCRF health component, as well as analytical work under the ongoing health ASA, and the proposed analytical work and TA under the GFF IC. In addition, the task team will work with the Governance GP to design the initial activities required at the MoH level contributing to the government-wide common PFM system.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

The ESRS will be used iteratively as a design and appraisal tool from the initial stages of project preparation: however, a final completed screening will be included as part of final project documentation. Pre-screening of the project documents (including the concept note and early drafts of the PAD) will help ensure that social and environmental sustainability issues are considered and integrated into project design, enhancing the quality of the project. Early screening will help to anticipate how the relevant World Bank's environmental and social standards are best addressed in the project design.

Screening of project activities (or sub-projects funded and implemented under this project) will be a desk-based exercise in which the project team, including ES Safeguards specialists, will draw on their experience and professional judgment and, where warranted, on expert advice. Screening project activities or sub-projects with potentially significant social and environmental risks and/or impacts requires more time and may need to involve relevant experts. While the screening process takes place during the project concept, design and preparation stages, implementation and monitoring of identified risk management and mitigation measures will be required of the PIUs throughout the life-cycle of the project.

The summary of environmental risks at concept stage is as follows:

- (i) provision, storage, handling, and disposal of essential drugs, supplies and equipment will result in the generation of significant amount of medical and other hazardous waste (that is generally expected to be non-toxic and non-hazardous) on a daily basis as a result of delivery of preventive and curative health services;
- (ii) possible exposure of health facility staff, waste handlers, patients and other facility users and the larger community to medical and other hazardous waste and associated ill health;
- (iii) rehabilitation of health facilities may result in generation of debris and other solid waste;
- (iv) inadequate incineration or the incineration of unsuitable materials may result in the release of pollutants into the air and in the generation of ash residue. In addition, incineration of heavy metals or materials with high metal content (in particular lead, mercury and cadmium) can lead to the spread of toxic metals in the environment; and
- (v) disposal of untreated health care wastes in landfills can lead to the contamination of drinking, surface, and ground waters if those landfills are not properly constructed, posing danger to human health and community wellbeing.

The summary of screening of social risks includes the provision that the project will not include acquisition of land/restriction of land use. Rehabilitation of health facilities may result in potential risks related to labor and working conditions, such as work-related discrimination, GBV and OHS. Considering the contextual risks of operating in a conflict

zone where effective and inclusive community consultations, stakeholder engagement and community participation and safety of staff is challenging, and the risk of project benefits not reaching the underserved populations including, nomads, other vulnerable and marginalized groups, internally displaced populations and developing effective grievance redress mechanism due to difficulty in accessing rural Somalia, the social risk rating is substantial. Ensuring health services are acceptable and accessible to women particularly when delivered by men and the potential risks of sexual exploitation and abuse or sexual harassment in delivery of uptake of health services is also a concern.

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APPROVAL

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