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The World Bank

Report No: ICR2810

IMPLEMENTATION COMPLETION AND RESULTS REPORT

IN THE AMOUNT OF SDR US$18.8 MILLION
(US$30 MILLION EQUIVALENT)

TO THE

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

FOR THE

HORN OF AFRICA EMERGENCY HEALTH AND NUTRITION PROJECT

September 20, 2013

Health, Nutrition, and Population Unit; Eastern and Southern Africa (AFTHE)
Human Development Department
Country Department AFCRI

CURRENCY EQUIVALENTS
(Exchange Rate Effective: July 31, 2011)

Currency Unit = Kenyan Shilling (KES)
90.21 KES = US$1
Currency Unit = Ethiopian Birr (ETB)
16.82 ETB = US$1
US$1.596 = SDR1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AFTHE	Africa Region Health, Nutrition and Population Unit, Eastern and Southern Africa
AFTDE	World Bank Africa Region Development Effectiveness Department
ARI	Acute Respiratory Infections
AWD	Acute Watery Diarrhea
CAS	Country Assistance Strategy
CDC	United States Center for Disease Control and Prevention
CRW	Crisis Response Window
FPA	Fiduciary Principles Accord
GAM	Global Acute Malnutrition
HIS	UNHCR Health Information System
ICT	Information and Communications Technology
IDA	International Development Association
IFR	Interim Unaudited Financial Report
INT	Integrity Vice Presidency
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MOH	Ministry of Health
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OP/BP	Operational Policy/Bank Policy
OPCS	Operations Policy and Country Services
P&L	Pregnant and Lactating
POI	Project Outcome Indicators
PDO	Project Development Outcome
SAM	Severe Acute Malnutrition
SFP	Supplemental Feeding Program

UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene

Vice President:	Makhtar Diop
Country Director:	Colin Bruce
Sector Manager:	Olusoji O. Adeyi
Project Team Leader:	Sheila Dutta
ICR Team Leader:	Carolyn Shelton

Horn of Africa Emergency Health and Nutrition Project

CONTENTS

A. Basic Information			
Country:	Africa	Project Name:	Horn of Africa Emergency Health and Nutrition Project
Project ID:	P127949	L/C/TF Number(s):	IDA-H7350
ICR Date:	08/30/2013	ICR Type:	Core ICR
Lending Instrument:	ERL	Borrower:	UNHCR
Original Total Commitment:	XDR 18.80M	Disbursed Amount:	XDR 18.80M
Revised Amount:	XDR 18.80M		
Environmental Category: B			
Implementing Agencies: United Nations High Commissioner for Refugees (UNHCR)			
Cofinanciers and Other External Partners:			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	08/02/2011	Effectiveness:	08/16/2011	09/19/2011
Appraisal:	08/12/2011	Restructuring(s):		
Approval:	09/15/2011	Mid-term Review:	01/21/2013	
		Closing:	03/29/2013	03/29/2013

C. Ratings Summary	
C.1 Performance Rating by ICR	
Outcomes:	Satisfactory
Risk to Development Outcome:	High
Bank Performance:	Satisfactory
Borrower Performance:	Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)			
Bank	**Ratings**	**Borrower**	**Ratings**
Quality at Entry:	Satisfactory	Government:	Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Satisfactory
Overall Bank Performance:	Satisfactory	**Overall Borrower Performance:**	Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	No	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Satisfactory		

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Health	56	56
Sanitation	22	22
Water supply	22	22
Theme Code (as % of total Bank financing)		
Child health	45	50
Nutrition and food security	22	25
Other communicable diseases	33	25

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Makhtar Diop	Obiageli Katryn Ezekwesili
Country Director:	Colin Bruce	Yusupha B. Crookes
Sector Manager:	Olusoji O. Adeyi	Eva Jarawan
Project Team Leader:	Sheila Dutta	Sheila Dutta
ICR Team Leader:	Carolyn J. Shelton	
ICR Primary Author:	Carolyn J. Shelton	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)

The project's development objective (PDO) was to support the emergency response in targeted refugee camps, in Kenya and Ethiopia, by expanding implementation of a health and nutrition package of services, in a manner consistent with the sub-region's medium-term human development goals.

Revised Project Development Objectives (as approved by original approving authority)

The PDO was not revised during the implementation period.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Children under five years treated for severe/acute malnutrition (number)			
Value quantitative or Qualitative)	0	5,275		85,967
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 2 :	Pregnant and lactating women who received food or micronutrient supplements (number)			
Value quantitative or Qualitative)	0	23,475		173,541
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 3 :	Children under five years who received treatment for acute respiratory infections (number)			
Value quantitative or Qualitative)	0	68,263		209,466
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 4 :	Children under five years who received treatment for watery diarrhea (number).			
Value quantitative or Qualitative)	0	23,662		88,939
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 5 :	Direct project beneficiaries (number), of which female (percent)			
Value quantitative or Qualitative)	0	440,272		1,666,824
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. %	Fifty percent of direct project beneficiaries were female.			

achievement)	

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Targeted children 6-59 months old and pregnant/lactating women screened			
Value (quantitative or Qualitative)	0	123,475		406,895
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 2 :	Children 6-59 months old with severe/acute malnutrition referred for treatment/food supplements			
Value (quantitative or Qualitative)	0	5,275		85,967
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 3 :	Pregnant and lactating women received food supplements			
Value (quantitative or Qualitative)	0	23,475		174,403
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 4 :	Targeted children 9-59 months old vaccinated against measles			
Value (quantitative or Qualitative)	0	70,000		77,238
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 5 :	Targeted children 6-59 months old receiving one dose of vitamin A supplements			
Value (quantitative or Qualitative)	0	70,000		297,751
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. %				

achievement)				
Indicator 6 :	Latrines built or renovated for improved sanitation services			
Value (quantitative or Qualitative)	0	5,000		27,239
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 7 :	Percent of six monthly financial reports submitted on time			
Value (quantitative or Qualitative)	0	85%		100%
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				
Indicator 8 :	Share of six monthly M&E reports submitted on time			
Value (quantitative or Qualitative)	0	85%		100%
Date achieved	09/19/2011	03/29/2013		03/29/2013
Comments (incl. % achievement)				

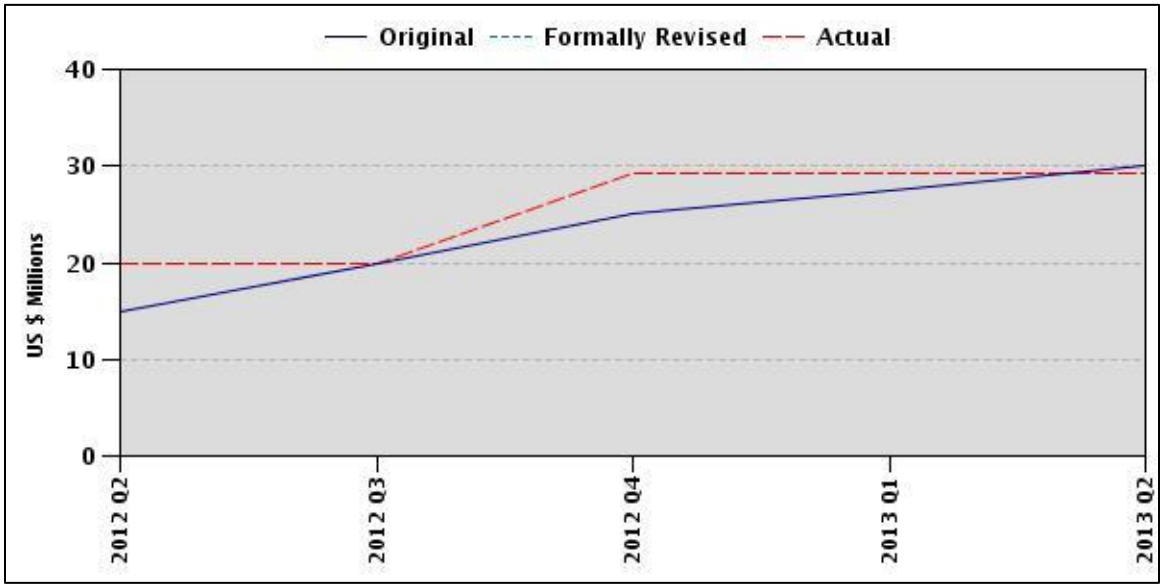
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	12/28/2011	Satisfactory	Satisfactory	20.00
2	06/27/2012	Satisfactory	Satisfactory	29.21
3	03/13/2013	Satisfactory	Satisfactory	29.21

H. Restructuring (if any)

Not Applicable

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. **Regional context of the emergency:** The Horn of Africa has experienced droughts – particularly in the last ten years - and each time, they have reversed progress in reducing poverty, disrupted food production systems, and jeopardized the hard-won improvements in human development. In 2011, the sub region experienced its worst drought in sixty years which yielded a severe food crisis. A sharp rise in food prices in parallel with the drought dramatically exacerbated the situation. Over 12 million people were severely affected and in urgent need of humanitarian aid across Kenya, Ethiopia, Somalia and Djibouti (Table 1). The crisis escalated dramatically between March and July 2011 as the estimated number of affected people in the Horn of Africa increased by nearly 40 percent during that period.

Table 1 Overview of Most Affected Countries

	Local Population	Somali Refugees	Other Refugees	Total	Comments
Djibouti	146,600	17,600	1,510	165,710	Northwest and southwest pastoral lands
Ethiopia	4,567,256	157,923	80,500	4,805,679	Somali, Oromia, Afar, Tigray, Amhara, Southern Nations, Nationalities and Peoples Region
Kenya	3,200,000	476,808	77,777	3,754,585	Upper eastern, north eastern, lower eastern and south regions: Garissa, Wajir, Moyale, Marsabit, Turkana
Somalia	3,700,000			3,700,000	Mainly southern Somalia; some areas in central Somalia also affected
Total	11,613,856	652,331	159,787	12,425,974	

Source: OCHA East Africa Drought: Humanitarian Snapshot – Regions Affected (June 28, 2011); Population Affected Update (August 9, 2011).

2. Although famine was declared in Somalia, large parts of Ethiopia and Kenya also experienced severe food insecurity and increasing inflows of Somali refugees. By mid-2011, an estimated 25 percent of Somalia's 7.5 million population had been displaced, either within Somalia or to neighboring countries, primarily Kenya and Ethiopia. Due to the persistence of food insecurity in southern Somalia sparked by the drought as well as conflict in parts of the country, people were unable to receive assistance in the most heavily affected areas of Somalia. As a result, Somalis were forced to travel long distances under difficult conditions which in turn had negative effects on their health condition while also depleting their resources and livelihoods.

3. Somali refugees – particularly women and children – arrived at the camps in Kenya and Ethiopia in poor states of health, dehydrated and severely undernourished, especially the children. For example, according to the nutritional screening conducted at the reception and transit sites in Ethiopia's Dollo Ado camp, one in three children under five was suffering from severe acute malnutrition (SAM). In Dadaab, approximately one quarter of children arriving from southern Somalia were malnourished with reported

child deaths inside Somalia and among new arrivals. As of end July 2011, the daily arrival rate to camps in Kenya and Ethiopia hovered at 2,000. The population of Kenya's Dadaab camp swelled to over 400,000 by July 2011 - granting it the distinction of being the largest refugee settlement in the world. By end August 2011, Ethiopia's Dollo Ado camp reported a camp population of over 120,000 – of which nearly 21,000 had arrived in July alone.[1] Given the pre-existing food security emergencies in both countries, refugee populations overcrowded and overwhelmed the existing response capacity in Kenya and Ethiopia at project appraisal.

Africa Region's Drought Response Plan in the Horn of Africa

4. With the onset of the drought, the Bank actively monitored the situation and engaged with affected clients. In July 2011, the Bank participated in an Emergency Ministerial-Level Meeting on the Horn of Africa. There was consensus that while relief and recovery were the first order of priority, medium- to long-term support would be key to promoting economic recovery. The Bank's Africa Drought Response Management team developed the Africa Region's *Drought Response Plan* for the Horn of Africa, which combined rapid response measures with economic recovery and longer term drought resilience.[2] A package of US$1.88 billion was identified which included restructuring, additional financing, trust fund contributions and proposed support from the Crisis Response Window (CRW). This operation was a part of the Bank's first six month rapid response phase, and was presented to the Board in parallel with the CRW Strategy, as the first operation to be funded under the CRW/International Development Agency (IDA) allocation for the Horn of Africa. In addition to the provision of health and nutrition services to refugee populations through this operation, the immediate response focused on boosting safety net programs, cash transfer and cash for work programs, followed by support to livelihood recovery, reinvigorating crops and livestock production, strengthening health facilities, and disaster preparedness.

5. With respect to the global response, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) coordinated a joint donor emergency response in the Horn of Africa with the development of a report and response plan, "Humanitarian Requirements for the Horn of Africa Drought," as of July 2011. The joint multi-agency report drew on the latest updates of each country's humanitarian requirements, outlined the needs and key elements of an immediate donor response with detailed projections and addressed donor mobilization through existing coordination mechanisms. This joint assessment provided critical background for project appraisal. According to the report, the following drought-related priorities and financing gaps for Ethiopia and Kenya as a whole were:

(a) Nutrition: About half of the 480,000 children under five with severe acute malnutrition did not have access to interventions for treatment. Many were

[1] UNHCR, Refugees in the Horn of Africa: Somali Displacement Crisis, Information Sharing Portal.

[2] The three-phased Drought Response Plan [Rapid Response (first 6 months), Economic Recovery (6 months to 2 years), and Drought Resilience (2-5 years)] was outlined in the Africa Region's briefing for the Board on July 28, 2011.

expected to perish if immediate measures were not taken, while new arrivals were overwhelming camp capacities to deliver emergency nutrition services.

(b) Health: The overcrowding camps posed a severe risk of further health outbreaks given limited service delivery and insufficient funding. This disease profile was expected to further exacerbate malnutrition among vulnerable populations and increase the risk of child mortality.

(c) Water, sanitation, and hygiene: An estimated 50 percent of communities in drought affected areas could no longer afford clean water, due to deteriorating household incomes. In the driest areas, water was trucked to the refugees and sanitation and hygiene conditions were severely affected.

6. As of July 2011, health and nutrition needs in Ethiopia[3] for the remainder of 2011 were estimated at US$31.4 million – available funding at that time covered 47 percent of these costs. Water and sanitation, and hygiene costs were estimated at US$20.2 million over this same period, of which only 14 percent had been financed. In Kenya[4], 2011 health needs were estimated at US$16.7 million (of which 14 percent had been financed), nutrition needs at US$65.3 million (of which 15 percent had been financed), and water, sanitation, and hygiene needs at US$17.4 million (of which 34 percent had been financed). These needs were superimposed on existing high levels of food insecurity and poor health and nutrition indicators among local populations in Kenya and Ethiopia – yielding an additional urgency to prevent further attrition of critical human development measures.

7. This operation aimed to contribute to the overall international response through financing for health and nutrition interventions to vulnerable populations in targeted refugee camps in Kenya and Ethiopia, for which UNHCR took overall lead responsibility. In 2011, refugee camps and their surrounding areas in Kenya and Ethiopia were the destination of 98 percent of Somali refugees. Since the Bank, and most key international development partners, had limited ability to operate in Somalia directly, the focus on the major refugee camps in Kenya and Ethiopia receiving Somali refugees was the best available solution.

Rationale for Bank involvement

8. In light of the severity of the drought emergency and efforts to reprogram the IDA allocation and accelerate disbursements, the Africa Region requested a US$250 million allocation from the dedicated CRW[5] for the Horn of Africa to complement existing IDA resources. Bank management noted that the exceptional nature of the drought emergency in terms of scale, scope and severity warranted eligibility for a CRW allocation to complement IDA emergency financing as a last resort and to support a robust World Bank Group crisis response. This operation set two significant precedents: (i) it was the first to receive financing through the dedicated CRW in IDA16; and (ii) it was the first CRW grant to an international institution such as UNHCR. Furthermore, this was the

[3] Revised Humanitarian Requirements Document for Ethiopia 2011. 28 July 2011.
[4] 2011+ Kenya Emergency Humanitarian Response Plan. 28 July 2011.
[5] Approved under IDA-16

first and only IDA/CRW operation for which the Fiduciary Principles Accord (FPA)[6] would be applicable on an exceptional basis.

Project focus on balancing humanitarian needs and development objectives

The Bank's role in the crisis response was its ability to link short-term a humanitarian crisis response with development objectives, and also help mitigate the negative impact of the crisis on the two refugee recipient countries (Kenya, Ethiopia). As a result, this operation contributed to the broader humanitarian effort led by specialized UN agencies, as reflected in the project development objective (PDO) which emphasized the Bank's contribution to the humanitarian effort. This approach took into account the evidence from humanitarian efforts which show that short term actions to address urgent health and nutrition needs – particularly among infants and children – have significant medium to longer-term effects on cognitive development, growth, nutritional status and thus human capital.[7]

9. This approach was also consistent with the 2011 WDR *Conflict, Security and Development* which makes the point that managed and contained communicable diseases in high density environments such as refugee camps mitigate negative spillover effects and create indirect benefits for countries hosting refugees, who also face their own development challenges. This operation was also designed to reduce the economic shock of the drought and the resulting population displacement by providing health and nutrition services to vulnerable populations in the targeted refugee areas. The project's emphasis on targeting poor and vulnerable populations in refugee camps in Kenya and Ethiopia was aligned with the Bank's mandate to manage vulnerability and assist member countries to manage crises.

OP/BP 8.00: Rapid response to crises and emergencies

10. Under OP/BP 8.00, Rapid Response to Crises and Emergencies, emergency support may be provided in response to a request for urgent assistance or, in response to an event that has caused, or is likely to cause, a major adverse economic and social impact. Consistent with OP 8.00, and in light of the magnitude of the crisis in the Horn of Africa, the project's activities were designed to contribute to the scaling-up of essential health and nutrition services in targeted refugee areas, with emphasis on the needs of vulnerable populations. As required by OP 8.00, and given the exceptional circumstances, the Governments of Kenya and Ethiopia submitted formal requests for emergency assistance from the World Bank, whereby the United National High Commissioner for Refugees (UNHCR) would serve as the direct recipient of IDA funds and act as implementing agency for the Horn of Africa Emergency Health and Nutrition Project.

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[6] On October 7, 2008, the World Bank's Board of Executive Directors endorsed the "World Bank and UN Fiduciary Principles Accord for Crisis and Emergency Situations" (SecM2008-0404). As a result, the United Nations Fiduciary Principles Accord (FPA) was entered into among certain UN agencies and the World Bank, including UNHCR.

[7] The Lancet, Maternal and Child Nutrition Series of June 6, 2013.

11. **Policy exceptions and Board Waiver:** The project was granted a Board Waiver, endorsed by the Acting Managing Director of the World Bank on August 10, 2011 in advance of the project's Board date, which allowed for the application of the Fiduciary Principles Accord (FPA).[8] The FPA was applied on an exceptional basis and enabled UNHCR to serve as the grant recipient and implementing agency for the project, using the FPA as the framework. UNHCR was the only agency able to respond with requisite speed to the health and nutrition crisis in targeted camps in the Horn of Africa – particularly given its extended track record of service delivery, and established operations including well defined supply chains and partnerships with ministries in Kenya and Ethiopia responsible for refugees. The exceptional application of the FPA was viewed as the only viable option to allow the Bank to respond in a timely fashion. Bank Management agreed that this unprecedented approach would be justified given the magnitude of the challenge and the need for a swift response.

1.2 Original Project Development Objectives (PDO) and Key Indicators

12. The project's development objective (PDO) was to support the emergency response in targeted refugee camps, in Kenya and Ethiopia, by expanding implementation of a health and nutrition package of services, in a manner consistent with the sub-region's medium-term human development goals.

13. The PDO is measured by the following five key indicators:

(i) Children under five years receiving treatment for severe/acute malnutrition (number)
(ii) Pregnant and lactating women who received food or micronutrient supplements (number)
(iii) Children under five years who received treatment for acute respiratory infections (ARI) (number)
(iv) Children under five years who received treatment for watery diarrhea (number)
(v) Direct project beneficiaries (number) of which are female (percent)

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

14. The PDO was not revised during the 18 month project implementation period.

1.4 Main Beneficiaries

[8] The FPA's application is limited to country-specific multi- and single-donor trust funds established to support emergency recovery programs in weak-capacity environments. Under the FPA, all funds transferred by the Bank to a UN agency would be received, administered, managed, expended, reported on, and audited, in accordance with the policies and procedures of the UN agency in a manner consistent with the standards set out in the FPA. The FPA did however include specific provisions to ensure that Bank standards, for example, with respect to governance and anti-corruption as well as procurement, were explicitly upheld. For example, UNHCR was not able to enter into contract with organizations on the Bank's list de-barred firms.

15. The project beneficiaries were the populations served in the Ethiopia (Dollo Ado) and Kenya (Dadaab) refugee camps for all interventions outlined in the PDO. The project preferentially benefitted children under five years of age and pregnant or lactating women. From September 2011 – March 2013, this emergency response operation contributed to the expansion of health, nutrition and sanitation services to over 1.5 million beneficiaries in Kenya's Dadaab and Ethiopia's Dollo Ado refugee camps. A reported 51% of the combined camp populations were women during the project implementation period. Other project beneficiaries included communities surrounding the camps and broader camp populations accessing clean water and sanitation services.

1.5 Original Components

16. **Component 1 (US$27.9 million equivalent): Treatment and prevention of malnutrition and provision of basic health services, including the screening of beneficiaries and direct costs associated with service delivery.** This component would expand the coverage of UNHCR's core package of health, nutrition, and population related services being provided in Dadaab and Dollo Ado.

    (i) **Component 1a: Treatment and prevention of malnutrition among vulnerable populations, particularly children and women.** This component addressed the prevention and treatment of acute malnutrition among children, in addition to focusing on the nutritional needs of pregnant and lactating (P&L) women.

    (ii) **Component 1b: Screening and provision of basic health services.** This component focused on maternal and child health services, in addition to the prevention and treatment of common sources of morbidity and mortality, including respiratory tract infections, diarrheal disease, and malaria.

    (iii) **Component 1c: Strengthening of sanitation facilities and safe water supply as key contributors to improved health status.** This component enabled the provision of improved water and sanitation facilities in the targeted areas.

    (iv) **Component 1d: Strengthening project monitoring and evaluation (M&E).** This sub-component supported M&E activities (including the innovative use of ICT technology to facilitate data collection, monitoring, and management).

17. **Component 2: Project Management (US$ 2.1 million equivalent).** Project management consisted of indirect costs required to support project delivery.

1.6 Revised Components

18. The original components were not revised.

1.7 Other significant changes

19. No changes were made to the design, scope and scale, implementation arrangements or funding allocations during the 18 months of project implementation.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

20. **Preparation:** The project was prepared by a multi-disciplinary Bank team in close collaboration with UNHCR. The Bank's task team prepared the project within a five week period and extensively consulted with internal units Bank-wide to ensure that all areas of preparation (e.g. safeguards, procurement, financial management, and governance) would be approved by management in a timely manner. Preparation efforts also included field-based support from country-based staff in Addis and Nairobi, particularly in enabling dialogue meetings with key government officials. Senior management across the Bank were actively engaged during preparation such that the decision review was overseen by the Rapid Response Committee (RRC) which included representation from three Chief Counsels, and senior staff from OPCS, INT, as well as the Africa Region (RRC Decision Note, August 2011). The project design was closely coordinated under the Bank's three phase strategy to address the Horn of Africa crisis unfolding in 2011. The task team prepared the project drawing on the available resources and evolving data during the design phase. A background analysis, conducted in close collaboration with UNOCHA and UNHCR, informed the design which was endorsed by counterparts in Ethiopia and Kenya.

21. **Design:** The project's design focused on best practices in emergency refugee responses appropriate for the drought context. The design included appropriate objectives and indicators, a clearly outlined results chain and results framework. Lessons from previous operations in the Horn of Africa, as well as from global disaster risk management and emergency recovery/reconstruction experience were taken into account when relevant and appropriate. This operation also built on collaboration experience with UNHCR in the Horn of Africa and the Great Lakes Region, among others. In view of the significant capacity limitations, establishing a new project management unit and executing entities would not have been practical when the use of an existing implementing agency was critical to an efficient emergency response. The project used UNHCR as its implementing agency, given both its overall mandate in the management of refugee crises and on-going leadership role in the targeted refugee areas in Kenya and Ethiopia. UNHCR also is a signatory of the FPA, thereby enabling the streamlining of project processing. Given the high risk implementation environment, the use of UNHCR as the implementing agency could be considered a risk mitigation strategy.

22. The project was designed to enable retroactive financing of up to US$3 million which gave UNHCR the ability to initiate urgent procurement and other related transactions during the period immediately preceding the Board date. This allowed UNHCR the ability to scale up support almost immediately which was especially critical at the peak of the crisis.

23. Given the magnitude and urgency of the crisis in the Horn of Africa, the Bank demonstrated its ability to be agile and flexible in deploying available CRW resources

and trigger the FPA Accord under exceptional yet entirely applicable and justifiable circumstances. The speedy implementation start-up, agreement on key implementation issues (e.g. endorsement of operations manual/environmental safeguards) in advance, effectiveness declared two days after Board approval, candid risk assessment, review at high levels (ROC, OPCS, VPU and INT), strong stakeholder involvement including affected Governments of Ethiopia and Kenya, NGOs and other development partners demonstrated high quality preparation. The manner in which the operation was prepared showed the Bank's ability to draw on its technical and operational resources to prepare a well-informed operation which adequately responded to the urgent health and nutrition needs in the Horn of Africa.

24. **Risk Assessment and Mitigation:** The overall risk rating was high, reflecting a candid and realistic assessment of project risks elaborated in the ORAF including: (i) careful management of project stakeholder relations to ensure that local/community leaders endorsed the project's refugee focus given the food shortages, malnutrition and other impacts of the droughts in the camps' surrounding areas; (ii) planned interventions may be diverted away from targeted beneficiaries or possibility of leakage and spoilage of program resources; and (iii) a large financing gap in light of projections that the number of refugees would increase, further risking the sustainability of the supported interventions. The mitigation measures were appropriate, including: (i) the Bank's mobilization of further support from its existing portfolio in Kenya and Ethiopia to address needs in the drought-affected areas as part of the Africa Region's Drought Response Plan; and (ii) the selection of UNHCR as an implementing agency with clear accountability and decision-making structures and an extended track record of service delivery in refugee camps in Kenya and Ethiopia by trusted NGOs.

25. Despite the identified risks and mitigation measures including those covered under the FPA, the Bank team also clearly stated the potential for higher than usual implementation and reputational risks. With the approval of the Board waiver to apply the FPA, alternatives of inaction or a much delayed response would have been more costly from a socio-economic development perspective for Ethiopia and Kenya (and beyond) and would pose much higher reputational risks for the Bank. The Board's approval of this operation demonstrated the Bank's flexibility to which it is able to apply instruments intended for emergency crises situations such as the CRW and the FPA. The approval also signaled that the Bank was willing to take an exceptional and entirely justifiable risk to benefit the greater target population in the Horn of Africa.

2.2 Implementation

26. The Horn of Africa Emergency Health and Nutrition Project delivered on the expectation of a rapid response, with 70 percent of the grant disbursing within 3 months of Board approval, and 100 percent of the grant disbursing within 8 months of Board approval (nearly one year ahead of schedule). The project quickly became effective four days after the September 15, 2011 Board approval. Overall, the project was implemented smoothly in spite of security disruptions. Both Project Development Outcome and Implementation Progress were rated Satisfactory throughout, as well as fiduciary,

safeguards, M&E and project management. The project was not restructured or in risk status at any point. A mid-term review was not conducted as the project only had an 18 month implementation period. Activities supported by UNHCR essentially "hit the ground running" which affirmed the Bank's exceptional decision to designate a UN agency as the Recipient of the CRW/IDA funds as well as the sole implementing agency for the project.

27. This operation was an integral part of the Africa Region's first phase of its Drought Response Plan and contributed to achieving some of the short-term targets of the Bank's US$1.8 billion Response Plan. It complemented other projects under the first phase in Ethiopia and Kenya which disbursed at a slower pace. The other projects were the Ethiopia Productive Safety Net Project (PSNP) and the Kenya Health Sector Support Project.

28. Despite a challenging geopolitical implementation context, steady results were reported over the 18 month implementation period (September 2011- March 2013), as documented in the project's six monthly Technical and Financial Reports. With respect to the five PDO indicators, all end-project targets were surpassed in the first 12 months of the project's 18-month implementation period, which was in part because the number of refugees covered turned out to be much higher than originally anticipated. Achievements included key targets met for: children treated for severe acute malnutrition and acute respiratory infections, and pregnant/lactating women receiving food or micronutrient supplements. Similarly, end-project targets for all 8 interim project indicators were met before project closing.

29. Targets were surpassed which indicates a degree of conservative target setting. While these targets were set at the design stage based on the available knowledge whilst the crisis was unfolding, with the benefit of hindsight they could have been revised during the course of implementation to more accurately reflect the magnitude of the rapidly increasing health and nutrition needs of the refugees. For example, for the treatment of children with SAM, due to the scale of the crisis, the proximity of the treatment centers to the refugee population and the effectiveness of the community outreach and communication program elements meant that not only could the centers absorb more malnourished children than originally expected, but coverage and retention of malnourished children in the program was also high. In addition, unprecedented levels of malnutrition were observed amongst the new arrivals in Dollo Ado that far surpassed the levels used in the calculations for the targets set (e.g. over 45% in the surveys in Kobe and Hilaweyn in November 2011).

30. Reported results reflect implementation of UNHCR's package of health, nutrition and sanitation services in the targeted refugee camps. Considering the daily changes in refugee camp populations and the evolving health and nutrition needs among refugee populations during different phases of the crisis, it would not have been feasible or helpful to the emergency response to earmark the use of IDA's contribution. The exceptional circumstances of this operation led the project team not to use the traditional incremental coverage of health and nutrition services financed by the project. Therefore,

the targets indicated in the Results Framework were the targets of UNHCR's overall program through which the package of nutrition and health and sanitation services was implemented. With the benefit of hindsight this approach was generally reasonable as it allowed UNHCR and its specialized agencies to focus on the delivery of services rather than tracking contributions of each agency.

31. Key results achieved between September 2011- March 2013, as detailed in the Results Framework, include the following (aggregate data for Kenya and Ethiopia refugee camps):

- over 1,500,000 direct project beneficiaries (of which 50 percent are female).
- over 290,000 children (6-59 months) received a dose of Vitamin A supplements.
- over 85,000 children treated for severe acute malnutrition.
- over 170,000 pregnant and lactating women received food or micronutrient supplements.
- over 200,000 children under five years treated for acute respiratory infections.
- over 77,000 children (6-59 months) immunized against measles.
- over 27,000 latrines constructed or renovated for improved sanitation services.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

32. Overall, the project design included clear and pragmatic M&E arrangements. The emergency project paper presented a strong results framework, utilized a results chain to delineate links between project inputs and targeted outcomes and elaborated a plan for data collection and monitoring arrangements. The M&E data collection was based on UNHCR's existing health information system which provided timely data validated by their field presence.

33. The selection of indicators in the Results Framework was guided by the content of the package of services provided by UNHCR in the camps. Indicators were selected from those that were already collected by UNHCR in both refugee camps to ensure minimal additional data collection burden and disruption to service delivery. The quality of the indicators was also assessed according to accepted criteria such as clarity, relevance, adequacy, feasibility and economy of implementation.

34. Given the relatively short implementation period (18 months), a conscious choice was made to utilize service delivery indicators in the Results Framework. Given the lag between many health outcome improvements and services delivered, this was a pragmatic approach for the project's context.

35. Throughout implementation, UNHCR submitted comprehensive technical progress reports which reported on the project's results framework and included available data on camp population and statistics and various survey results. Complete data was reported in the ISRs for all PDO and interim indicators for each 6-month period of project implementation. The project explicitly utilized the timely M&E data generated to assist in planning and guiding the numerous operational assessments conducted by

UNHCR. This enabled the project to be more responsive to the evolving needs of highly vulnerable sub-groups within the refugee camps (particularly with respect to the service delivery needs of new arrivals from Somalia). UNHCR provided progress reports every six months as agreed which included detailed information on activity implementation progress, challenges and resolution of bottlenecks as well as data collected and analyzed per camp. The reports also included detailed annexes which contained for example camp population statistics, results from joint nutrition and health surveys, WASH camp assessments, and a knowledge, attitudes and practice survey.

2.4 Safeguard and Fiduciary Compliance *(focusing on issues and their resolution)*

Environmental and social safeguards

36. Given the application of the FPA for this operation, World Bank safeguard policies did not apply. UNHCR's 2005 Environmental Guidelines were adopted for this operation according to UNHCR's standard project implementation mechanisms. The UNHCR Guidelines were assessed as largely consistent with the Bank's respective policies. The project was classified as a Category B operation and OP 4.01 was triggered for the purpose of Bank records and to signal that had this been a standard Bank operation, not using the FPA instrument, these elements would be appropriate and relevant safeguard tools would have been prepared. An ISDS was also completed.

Fiduciary compliance and expenditure (*Trend of disbursements in data sheet)*

37. Fiduciary issues were handled by the implementing agency, UNHCR. As agreed under the FPA, the financial management and disbursement procedures of UNHCR applied. As agreed during project negotiations, UNHCR maintained a separate ledger account (Grant Control Account) to record the financial transactions of this project. All six month financial reports (IFR) were submitted on-schedule and cleared by AFTFM. The Bank's final FM review indicated that the Statement of Sources and Uses of Funds presented a fair and reasonable accountability of IDA resources channeled to the project since the project effectiveness. The project was consistently rated Satisfactory for Financial Management throughout implementation.

Procurement

38. Since this project was implemented under the FPA, the procurement procedures and policies of the UNHCR were applied. The objective of UNHCR's procurement policy is to provide the beneficiaries or end users with appropriate quality products or services at the specified time and place and at the lowest total cost. Whether carried out locally or internationally, all contractual arrangements are subject to the financial rules and procurement procedures established by UNHCR in line with the Financial Regulations and Rules of the United Nations and the Financial Rules for Voluntary Funds Administered by the High Commissioner.

2.5 Post-completion Operation/Next Phase *(transition arrangement to post-completion operation of investments financed by present operation, Operation & Maintenance arrangements, sustaining reforms & institutional capacity, & next phase/follow-up operation, if applicable)*

Sustainability

39. The issue of sustainability falls beyond the scope of this 18-month emergency operation. Given the human and social costs of a protracted response to the crisis in the Horn of Africa, the counterfactual of no response was simply not acceptable.

40. While challenges in sustaining critical services within Dadaab and Dollo Ado persist with new arrivals to the camps and anticipated extended-term needs of the Somali refugee population, other development partners are better equipped to address these in the medium-term. Moreover, the project contributed to putting in place capacity which remains at project completion. . The small scale water and sanitation infrastructure and health facilities improvements under the project will continue to serve the camps' populations and local communities going forward using financing for UNHCR's other partners. The drinking water treatment and pumping infrastructure built with support from this project reduced the cost of providing safe drinking water to the camp populations by trucking it in.

41. The project also had positive spillover effects to communities surrounding the camps. For example, the community surrounding Dollo Ado has access to improved health facilities and water infrastructure in the camp, as well as upgraded health facilities in the town of Dollo Ado and new entrepreneurial opportunities as the result of the increase of refugees and aid workers who provide new customers for goods and services. The host communities will also benefit from the water infrastructure established for the camps. Locals were also trained on operations and maintenance of such facilities and equipment – thereby enhancing its sustainability.

42. In line with the Bank's broader mandate to eradicate poverty and promote development, at project completion senior management decided not to process Additional Financing for the Horn of Africa Emergency Health and Nutrition Project (noted in the June 2012 ISR) but to explore possibilities for further support to refugee camps and their surrounding communities through country-specific operations (which would not require an IDA policy exception).

43. To mitigate the sustainability risk, a longer term livelihoods development perspective will be incorporated in the Regional Pastoral Livelihoods Recovery and Resilience Project for delivery in FY14 which will target cross-border pastoral communities in both Ethiopia and Kenya. This proposed operation is part of the original long term response portion of the Bank's Horn of Africa Drought Response Plan. UNHCR has also received support from the IKEA Foundation for longer term livelihood development activities in Kenya and Ethiopia.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

Rating: High

44. The objectives of the Horn of Africa Emergency Health and Nutrition Project were (and remain) highly relevant to the existing geopolitical context, country development objectives, global priorities and the Bank's regional and country assistance strategies. Technical considerations continue to be in sync with the current international emergency health response as well as the Bank's strategic drought response to the subregion.

Relevance of PDO: The PDO remains relevant to the subregion's emergency challenges and health and nutrition service needs. The Bank's rationale for involvement grounded in balancing humanitarian needs with medium-term objectives remain consistent with national and local development priorities for the Horn of Africa, current Bank assistance strategies and prevailing overall corporate goals. Persistence of food insecurity in southern Somalia, combined with conflict in parts of that country, continue to provoke refugee outflows into Ethiopia and Kenya. Kenya's Dadaab camp is both the largest refugee camp in the world and the third largest city in Kenya (based on population). After Dadaab, Dollo Ado in Ethiopia accommodates nearly 200,000 Somali refugees. Maintaining coverage of essential health and nutrition services in these refugee camps remains a critical challenge which continues to be addressed by UNHCR and its specialized agencies.

45. ***Relevance of Design:*** The operation provided swift, expanded coverage of critical health, nutrition and water and sanitation needs to refugees in a challenging context - maximizing benefits and minimizing administrative burden through a highly effective collaboration with UNHCR. The project relied on existing UNHCR systems and its network of highly specialized institutions partners already on the ground. This should serve as an example for future crises where a rapid response is needed.

3.2 Achievement of Project Development Objectives *(brief discussion of causal linkages between outputs and outcomes, with details on outputs in Annex 2)*

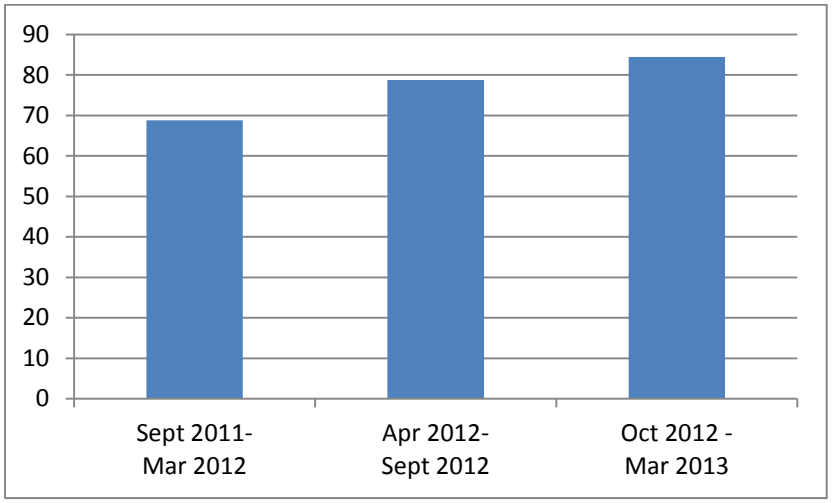
Rating: Substantial

46. This section assesses outcomes against project targets and objectives and highlights project outputs and inputs that contributed to those outcomes. Directly attributing the outcomes achieved to the Bank's support in this joint response would have been difficult and time consuming, diverting attention to the main task at hand of serving vulnerable groups.. However, the Bank's contribution to the larger international response effort was critical in that it was able to deploy available resources quickly to meet urgent health and nutrition needs, and played a role in bridging the gap between the humanitarian response and the broader development agenda. Furthermore, the Bank acted responsibly as an international partner, filled a short-term financing gap by utilizing its emergency CRW funds which in turn, helped Kenya and Ethiopia mitigate the overall impact stemming from the influx of refugees

47. **Attainment of PDO:** The Horn of Africa Emergency Health and Nutrition Project achieved its development objective. The project was implemented well within the time frame and the implementation of planned activities was done in a timely manner and undoubtedly contributed to the achievement of expected outputs. All 5 PDO indicators surpassed their end-project targets before project closing. On the basis of the solid evidence presented below, project efficacy is rated as Substantial.

i. *PDO Indicator 1: Children under five years treated for severe acute malnutrition (number).* More than 85,000 children were treated for SAM in both camps of Ethiopia and Kenya during the project period – surpassing the target of 5,275. In Dollo Ado, the SAM recovery rate among children aged 6-59 months increased from 68.8% reported in March 2012 to 84.4% (Standard > 75%) by the March 2013 project closure (Figure 1). Recovery rates for moderate acute malnutrition (MAM)[9] also steadily improved in Dollo Ado, from 85.6% reported in September 2012 to 92.7% by March 2013, demonstrating the effectiveness of these interventions. The mortality rate from SAM was also kept low at 0.3% (standard <10%), indicating effective health and nutrition interventions.

Figure 1: Recovery Rate for Severe Acute Malnutrition among children aged 6-59 months in Dollo Ado



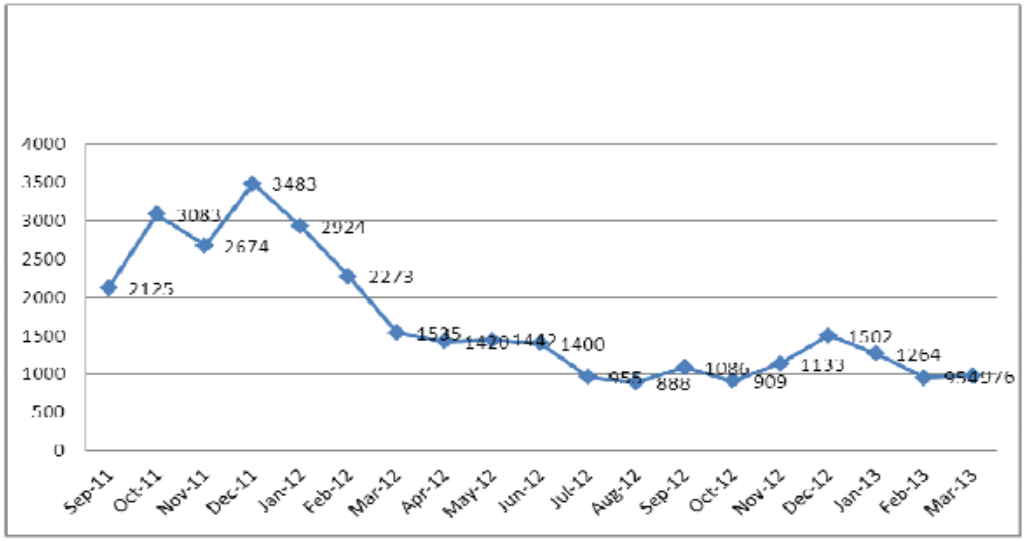
Source: UNHCR Narrative Report October 2012 – March 2013; UNHCR HIS

[9] MAM is a less severe form of acute malnutrition and usually represents the major part of the total acute malnutrition levels, with SAM representing only a small proportion (often < 10%). At appraisal, the evidence gathered through nutrition surveys and screenings from this crisis show a highly unusual pattern of the ratio of MAM to SAM, whereby 2 out of 3 acutely malnourished children were suffering from MAM. This suggested a shift in the severity of the acute malnutrition and made the appropriate treatment of MAM all the more urgent in order to prevent children from sliding further into the state of SAM.

48. In Ethiopia, the Outpatient Therapeutic Program (OTP) [10] and Stabilization Centers (SC) carried out the management of SAM. During the final reporting period (October 2012 – March 2013), 1,632 children aged 6-59 months and 435 children aged 5-10 years were newly admitted for management of SAM in the OTP and SC. This was a decrease compared to 3,403 in September 2011 (when the project was approved), highlighting effective efforts to contain malnutrition and the smaller number of children in need of support by project completion. Overall coverage of blanket supplementary feeding program (BSFP) was high by project closure. By March 2013, over 32,000 children in Dollo Ado were enrolled, resulting in 89.2% coverage (standard > 90%).

49. Similarly in Kenya's Dadaab, the number of new admissions for treatment of SAM among children under five years old peaked at the height of the drought crisis in the latter part of 2011, and gradually declined until March 2013. The increased number of admissions in therapeutic feeding centers in November and December 2012 as shown in Figure 2 below is attributed to the acute watery diarrhea and accelerated active case finding.

Figure 2: Number of new admissions for treatment of SAM among children 6-59 months, September 2011- March 2013 in Kenya



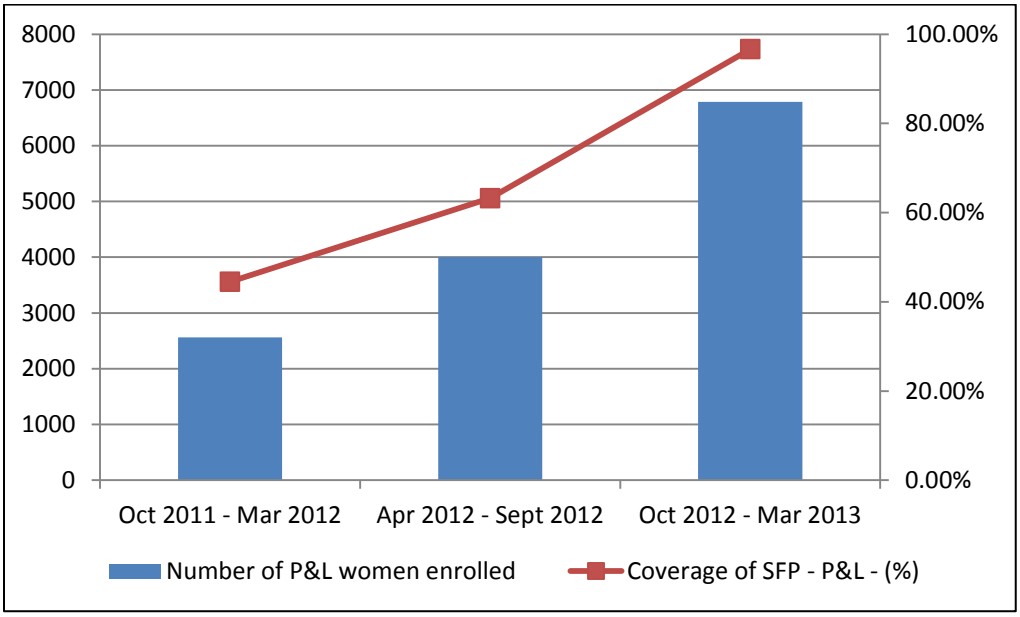
Source: UNHCR Narrative Report October 2012 – March 2013; UNHCR HIS

(ii) *PDO Indicator II: Pregnant and lactating women who received food or micronutrient supplements (number).* Over 173,000 pregnant and lactating women received food or micronutrient supplements in both camps of Ethiopia and Kenya during the project period – surpassing the initial modest target of 23,475. Supplementary feeding for P&L women provided additional nutritional needs that arise in pregnancy and lactation. It is used to ensure that P&L women access adequate nutrients to prevent

[10] . The OTP supports the rehabilitation of SAM in children aged 6 months to 10 years old presenting without medical complications, while the SC supports the treatment and partial rehabilitation of SAM in children with medical complications.

maternal and neonatal malnutrition. Nutritious food in the form of corn, soya, sugar, and oil are provided through this program. In Dollo Ado for example, coverage under the supplementary feeding program (SFP) progressively improved from 44% to 97% throughout the project reporting periods (Figure 3).

Figure 3. Supplementary feeding program coverage for pregnant and lactating Women in Dollo Ado



Source: UNHCR Narrative Report October 2012 – March 2013; UNHCR HIS

(iii) *PDO Indicator III: Children under five years who received treatment for acute respiratory infections (number).* Over 200,000 children under five years received treatment for acute respiratory infections (ARI) during the project period – tripling the target of 68,263. While the overall service delivery target was met, ARI continues to be a major public health concern.

(iv) *PDO Indicator IV: Children under five years who received treatment for watery diarrhea (number).* More than 88,000 children received treatment for acute watery diarrhea (AWD) during project implementation surpassing the target of 23,662. In Dolloa Ado, the incidence per 1,000/month of AWD among children under five years declined from 23.5% in March 2012, 21.1% in September 2012 and to 18% by March 2013.

(v) *PDO Indicator V: Number of direct project beneficiaries, and percent of which female.* The IDA core indicator tracked the number of targeted direct project beneficiaries in the camps and the percent of which were female. By end project closure, cumulatively approximately 1.6 million people directly benefitted from the project's interventions - of which 50% were female.

50. The provision of bednets formed part of UNHCR's basic package of health and sanitation services as outlined in the project paper. While tracking bednets was not part of

the results framework given this project's focus on nutrition and sanitation related services – UNHCR reported over 32,000 treated nets were distributed in Dollo Ado, and over 161,000 at Dadaab (of which 88,000 were supported by IDA). This was an important contribution in protecting mothers and children from malaria.

Efficiency *(net present value/economic rate of return, cost effectiveness, e.g. unit rate norms, least cost, and comparisons; financial rate of return)*

Rating: Substantial

51. Project efficiency examines whether costs involved in achieving project objectives were reasonable in comparison with both benefits and recognized norms (i.e., value for money), in addition to efficiency in implementation.

52. This operation contributed to the rapid scale up response to meeting health and nutrition needs of a population in crisis. In the two largest refugee camps in the world where project interventions were implemented – increased service delivery and coverage of high impact interventions were possible. The project supported the rapid expansion and strengthening of UNCHR's ongoing health program in the Dadaab and Dollo Ado refugee camps, and consequently built on existing infrastructure and systems (versus establishing new/parallel implementation arrangements) and worked through strong, efficient specialized UNHCR partner institutions.

53. UNHCR has been coordinating service delivery in the Dadaab refugee camp for over 20 years and in Dollo Ado for nearly 15 years. For example, UNHCR has well established supply chains and was able to leverage economies of scale in procurement which would not have been possible through a separate stand-alone project. Medical supplies and other related commodities financed by the project were procured directly through UNHCR's established global supply chains and benefited from bulk procurement pricing. In addition to the lower costs associated with such bulk procurement, this arrangement also enabled critical standards regarding both quality and reliable/rapid delivery to be met. The implementation efficiency of this project benefited from this extended service delivery experience in Dadaab and Dollo Ado, which also enabled the mitigation of risks resulting from the challenging geopolitical environment (e.g. UNHCR has substantial experience in planning for, and rapidly responding to, service delivery challenges caused by annual/seasonal flooding in Dollo Ado; similarly, UNHCR has long-term expertise in addressing periodic security challenges around Dadaab's camp perimeter (in collaboration with national authorities). Such extended experience in planning/managing camp operations in Dadaab and Dollo Ado enabled consistently strong service delivery, and rapid scale-up, as can be evidenced in each of the six monthly technical reports).

54. In terms of ensuring quality and consistency, all health, nutrition, water, and sanitation services in Dadaab and Dollo Ado were delivered following UNHCR's operations manuals which enabled standardization in service delivery across countries/camps and detailed project monitoring (including epidemic surveillance),

despite a challenging emergency context. This standardized approach ensured that the technical design of the package of health, nutrition, and sanitation services being delivered met internationally endorsed standards.

55. UNHCR's practice of working through qualified local, national, and international NGOs, also served to enhance service delivery efficiencies by contracting organizations with specialized skills. The project consequently further strengthened UNHCR's practice of harnessing civil society potential to increase access, enhance quality, and improve efficiency in the delivery of health, nutrition, water, and sanitation services in the Dadaab and Dollo Ado refugee camps.

56. Project costs for reaching the indicated objectives were likely lower in comparison to alternative institutional arrangements proposed (e.g., the establishment of a new, parallel Project Management Unit managed by a governmental/inter-governmental agency with less direct experience in coordinating refugee programs). Furthermore, approximately 7 percent of the total project amount of US$30 million was set aside for project management and administration costs – which represents good value for money. As outlined above, the project promoted the efficient use of limited resources in addressing the needs of increasing Somali refugee populations in the Horn of Africa. The overall design of the project also served to enhance inter-agency partnerships, ownership, and engagement of stakeholders at the national, regional, and international levels.

3.4 Justification of Overall Outcome Rating *(combining relevance, achievement of PDOs and efficiency)*

57. Implementation of the Horn of Africa Emergency Health and Nutrition Project contributed to the rapid expansion of health and nutrition services provided in the targeted refugee camps of Kenya and Ethiopia. All PDO indicators and IO indicators were achieved and all targets were surpassed. In view of high relevance, substantial efficacy (attainment of PDO/Implementation progress), substantial efficiency, the overall project outcome rating is rated **Satisfactory.**

3.5 Overarching Themes, Other Outcomes and Impacts *(if any, where not previously covered or to amplify discussion above)*

(a) Poverty Impacts, Gender Aspects, and Social Development:

58. **Impact on Poverty:** The project had positive spillover effects on communities surrounding the camps. The community surrounding Dollo Ado has access to improved health facilities and water and sanitation infrastructure in the camp, as well as upgraded health facilities in the town of Dollo Ado and economic opportunities with the increase of refugees and humanitarian aid workers.

59. **Impact on Gender:** Approximately 50% of this project's 1.6 million beneficiaries were female. Over 170,000 P&L women received food or micronutrient supplements and over 400,000 children under 5 years old and P&L women were screened for nutrition through a blanket SFP. The SFP provided additional nutritional needs that

arise in pregnancy and lactation, and ensured that P&L women access adequate nutrients to prevent maternal and neonatal malnutrition. In Ethiopia, coverage progressively improved throughout the project reporting periods and currently stands at 96.6% (Standard > 90%).

(b) Institutional Change/Strengthening *(particularly with reference to impacts on longer-term capacity and institutional development)*

60. This operation bolstered the expansion of the provision of a health and nutrition package of services in the targeted refugee camps of Ethiopia and Kenya. This expansion improved UNHCR's ability to respond more effectively to rapidly growing needs. Water and sanitation systems were improved in the camps through installation of pumps instead of, at the height of the crises, trucking water in to serve over 2 million people. UNHCR and its implementing partners strengthened the disease surveillance capacity across the camps. Improvements were made in responses to epidemic-prone diseases, prevention of outbreaks (through scaling-up vaccination programs particularly for measles, polio and the Expanded Programs on Immunization-EPI), distribution of long-lasting insecticide-treated bed nets, vitamin A supplementation, and in water, sanitation and hygiene as well as health education and promotion.

(c) Other Unintended Outcomes and Impacts (positive or negative)

4. Assessment of Risk to Development Outcome

Rating: High

61. Challenges in sustaining critical services within Dadaab and Dollo Ado persist with continued new arrivals to the camps and anticipated extended-term needs of the Somali refugee population. While the Bank plans on continuing to support the governments of Kenya and Ethiopia with broader development needs and UNHCR and its specialized agencies will continue to focus on the needs of refugees, the risk to development outcome is high, given the volatile environment in the Horn of Africa.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

Bank Performance in Ensuring Quality at Entry

Rating: Satisfactory

62. The strong multi-disciplinary Bank team should be commended for the speed and quality in which this operation was prepared in close collaboration with UNHCR. The task team successfully and rapidly prepared the project drawing on the available resources and evolving data available during the design phase. The task team prepared the project under exceptional circumstances which required close collaboration internally from both regional and OPCS units responsible for operational policies (and IDA policy

exceptions), financial management, procurement and safeguards. In addition, the team ensured extensive involvement from INT, CFP and AFTOS to further enhance quality at entry. Well planned monitoring and evaluation arrangements in agreement with UNHCR took advantage of existing information systems, and ensured the availability of reported results. This enabled project activities to essentially "hit the ground running," and affirmed the Bank's decision to designate a UN agency as the sole implementing agency for the project. As part of the OP/BP 8.00 including the request for the Board waiver and the eventual Board approval of the FPA application, the Bank took measures to assess quality at entry by an OPCS review conducted at the VP level.

Bank's Quality of Supervision

Rating: Satisfactory

63. The Horn of Africa Emergency Health and Nutrition Project was implemented in a challenging and rapidly changing environment which required the need for flexibility, and rapid scale up. Implementation progress was relatively smooth and accelerated throughout its 18 month implementation period which included clear and concise reporting on project achievements. The Bank team closely coordination with UNHCR staff in Kenya and Ethiopia as well as the Geneva headquarters to address potential challenges and ensure smooth implementation.

64. Despite significant security constraints (particularly in Dadaab, where missions were cancelled three times due to security challenges), the Bank team did an excellent job in terms of comprehensive reporting and staying in touch with key counterparts.. It should be noted that supervision of operations under the FPA are viewed with a somewhat different lens than a standard IDA investment since the project was essentially "outsourced" to UNHCR. In July 2012, a World Bank mission, accompanied by UNHCR representatives from Geneva and Addis Ababa visited Ethiopia's Dollo Ado refugee camps. As a result of the security situation, this was the only Bank mission conducted over the 18 month implementation period. Key members of the UNHCR team working on Kenya's Dadaab also joined the Bank's mission to Ethiopia's Dollo Ado to share inter-country experiences.

65. Despite the noted security challenges, core project activities were effectively implemented and not substantially affected. Refugees continued to receive essential health, nutrition, water and sanitation services as supported by the project.

Justification of Rating for Overall Bank Performance

Rating: Satisfactory

5.2 Borrower Performance

(a) Government Performance

Rating: Satisfactory

66. The Governments of Ethiopia and Kenya showed their commitment to addressing the crisis affecting their countries and both endorsed the decision to outsource implementation to UNHCR. Government commitment was high as there was no interference on their part or additional requirements, restrictions or limitations put in place that would hinder UNHCR's implementation of the project.

(b) Implementing Agency or Lead Agencies Performance

Rating: Satisfactory

67. Given the complexities and challenges of oversight and implementation in two separate populations separated by country borders – UNHCR was well suited for the task as originally expected. They worked to achieve impressive results in a challenging environment and reported on a timely basis in great detail. No major problems of misprocurement of mismanagement of funds were reported. Technical and financial reports were submitted on time and were complete with both quantitative and qualitative data collected by UNHCR and reported against this operation's results framework. Subcontracted NGOs with a long standing track record working with refugees carried out activities on a timely basis under huge demands with positive results.

(c) Justification of Rating for Overall Borrower Performance

Rating: Satisfactory

6. Lessons Learned

68. The following lessons may be drawn from the implementation of the Horn of Africa Emergency Health and Nutrition Project:

i. *Ensuring a quick disbursing mechanism and working through specialized partner agencies for an effective emergency response.* The project's rapid results and efficient manner in which project funds were disbursed indicate that UNHCR was indeed the appropriate institution to implement this emergency refugee health operation in the Horn of Africa. The Bank's senior management decision to invoke the FPA and grant a waiver to enable UNHCR to serve as the project's implementation agency was timely and demonstrated the Bank's flexibility and pragmatism.

ii. *Need for speed and flexibility when responding to an emergency context.* The speed, flexibility, and responsiveness with which the project was prepared, reflected the urgency and severity of the 2011 crisis in the Horn of Africa. While this operation was considered high-risk (given the context in the subregion and the inherent service delivery challenges in refugee camps with rapidly increasing populations), the development impact risks from not responding quickly were considered much higher.

iii. *Inclusion of retroactive financing in an emergency operation*: The inclusion of retroactive financing in the project design encouraged and enabled rapid implementation start-up in the emergency response context.

iv. *Standard IDA lending instruments have limitations in addressing service delivery needs of refugee populations.* Utilizing standard IDA lending instruments in support of refugee populations generally does not provide appealing options to governments. This is particularly the case for IDA credit-eligible countries, where governments would be required to borrow in support of foreign refugees. For IDA *grant*-eligible countries, utilizing IDA funds for such an endeavor may have an impact on national IDA ceilings. In addition, countries would need to take fiduciary and implementation responsibility for programs benefiting refugees, which may overstretch service delivery capacities and have political ramifications nationally. This operation's Board waiver enabled substantial policy exceptions to standard IDA lending terms. In the absence of the flexibility granted by the Board waiver, it would not have been possible to replicate the rapid preparation, efficient implementation, and results achieved.

v. *Importance of addressing the needs of refugee camp populations and surrounding communities in an integrated manner.* The refugee camps targeted in the project serve and continue to serve as centers for provision of health, nutrition and sanitation services. This project supported such interventions for the target population but the surrounding communities also benefitted – which gave needed access and may have indirectly raised the bar in terms of access and quality of services available for groups in remote areas. This avoided distortions in the quality and level of services available and supported the national governments as they faced enormous challenges in addressing the rapidly evolving and increasing needs of refugees occupying their territories.

vi. *Regional operations have an added benefit of addressing hard to reach communities.* The communities surrounding both Dollo Ado and Daadab may have been much harder to reach through country level operations.

7. Comments on Issues Raised by Grantee/Implementing Agencies/Donors

(a) Grantee/Implementing Agencies:

(b) Comments from Co-financiers/Donors

Not Applicable

(c) Other partners and stakeholders

Not Applicable

Annex 1. Project Costs and Financing

(a) **Project Cost by Component (in USD Million equivalent)**

Components	Appraisal Estimate (USD million)	Actual/Latest Estimate (USD million)	Percentage of Appraisal
Component 1: Treatment and prevention of malnutrition and provision of basic health services, including the screening of beneficiaries and direct costs associated with service delivery.	27.9	27.2	98%
Component 2: Project management	2.1	2.0	95%
Total Baseline Cost			
Physical Contingencies			
Price Contingencies			
Total Project Costs	30.0	29.2	97%
Project Preparation Costs			
Total Financing Required	30.0	29.2	97%[11]

(b) **Financing**

Source of Funds	Type of Co-financing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
IDA Crisis Response Window		30.0	29.2	97%

[11] In SDR terms, 100 percent of the grant was disbursed.

Annex 2. Outputs by Component

1. This annex presents a detailed description of the project components, its main outcome indicators and the outputs by Component.

2. **Component 1: Treatment and prevention of malnutrition and provision of basic health services.** This component addressed the treatment and prevention of malnutrition through the strengthening of the provision of an existing package of basic health, nutrition services, including screening of beneficiaries and direct costs associated with service delivery. The component would expand the basic package (such as blanket feeding provided by the World Food Program), to enhance program efficiencies, improve health and nutrition outcomes, and reduce vulnerabilities to infection and mortality.

3. **Component 1a: Treatment and prevention of malnutrition among vulnerable populations, particularly children and women.** This subcomponent focused on the treatment of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) as well as the prevention of acute malnutrition especially amongst the most vulnerable. Treatment for SAM was provided in existing health facilities or temporary nutrition facilities in the camps. A community based management (CMAM) approach was used for the treatment of SAM, whereby patients with SAM or severe complications were managed in inpatient stabilization units, requiring qualified personnel and sufficient supplies of therapeutic milks and essential medicines. Other uncomplicated SAM cases or stabilized cases were managed on an outpatient basis in the community which required qualified personnel, Ready-to-Use Therapeutic Foods (RUTF), essential medicines and equipment. Treatment of MAM was on an outpatient basis from clinic/health facilities based inside the camp, managed directly by NGO and government partners of UNHCR.

4. The scale of the emergency required additional nutrition support for the most vulnerable groups within the refugee population. Blanket feeding programs provided additional energy, macro (carbohydrate and protein) and micronutrients (vitamins and minerals) to children 6 months to 5 years old and pregnant and lactating women. Strong links between the existing Infant and Young Child Nutrition (IYCN) elements of the program as well as reproductive health care services were also promoted. Services were provided by NGO and governmental partners and products provided by WFP. UNHCR is responsible for the procurement of equipment and the operational costs for the preventative programs.

5. The treatment programs for SAM and MAM and the preventative programs also included nutrition education and counseling for caregivers, with a focus on improving nutrition in the window of opportunity period from pregnancy to 24 months old.

PDO Indicator 1: Children under five years treated for severe acute malnutrition (number). More than 85,000 children were treated for SAM in both camps of Ethiopia and Kenya during the project period – grossly surpassing the target of 5,275. In Dollo Ado, the SAM recovery rate among children aged 6-59 months increased from 68.8%

reported in March 2012 to 84.4% (Standard > 75%) by the March 2013 project closure (Figure 1). Recovery rates for moderate acute malnutrition (MAM)[12] also steadily improved in Dollo Ado, from 85.6% reported in September 2012 to 92.7% by March 2013. The mortality rate from SAM was also kept low at 0.3% (standard <10%), indicating effective health and nutrition interventions. By March 2013, over 32,000 children in Dollo Ado were enrolled in the Blanket Supplementary Feeding Program (BSFP), resulting in 89.2% coverage (standard > 90%).

6. In Ethiopia, the Outpatient Therapeutic Program (OTP)[13] and Stabilization Centers (SC) carried out the management of SAM. During the final reporting period (October 2012 – March 2013), 1,632 children aged 6-59 months and 435 children aged 5-10 years were newly admitted for management of SAM in the OTP and SC. This was a decrease compared to 3,403 in September 2011 (when the project was approved). Similarly in Kenya's Dadaab, the number of new admissions for treatment of SAM among children under five years old peaked at the height of the drought crisis in the latter part of 2011, and gradually declined until March 2013.

7. *PDO Indicator II: Pregnant and lactating women who received food or micronutrient supplements (number).* Over 173,000 pregnant and lactating women received food or micronutrient supplements in both camps of Ethiopia and Kenya during the project period – surpassing the target of 23,475. Supplementary feeding for P&L women provided additional nutritional needs that arise in pregnancy and lactation. It is used to ensure that P&L women access adequate nutrients to prevent maternal and neonatal malnutrition. Nutritious food in the form of corn, soya, sugar, and oil are provided through this program. In Dollo Ado for example, coverage under the supplementary feeding program (SFP) progressively improved from 44% to 97% throughout the project reporting periods.

8. *PDO Indicator III: Children under five years who received treatment for acute respiratory infections (number).* Over 200,000 children under five years received treatment for acute respiratory infections (ARI) during the project period – tripling the target of 68,263. While the overall service delivery target was met, ARI continues to be a major public health concern.

9. *PDO Indicator IV: Children under five years who received treatment for watery diarrhea (number).* More than 88,000 children received treatment for acute watery diarrhea (AWD) during project implementation - surpassing the target of 23,662. In Dollo

[12] MAM is a less severe form of acute malnutrition and usually represents the major part of the total acute malnutrition levels, with SAM representing only a small proportion (often < 10%). At appraisal, the evidence gathered through nutrition surveys and screenings from this crisis show a highly unusual pattern of the ratio of MAM to SAM, whereby 2 out of 3 acutely malnourished children were suffering from MAM. This suggested a shift in the severity of the acute malnutrition and made the appropriate treatment of MAM all the more urgent in order to prevent children from sliding further into the state of SAM.

[13] . The OTP supports the rehabilitation of SAM in children aged 6 months to 10 years old presenting without medical complications, while the SC supports the treatment and partial rehabilitation of SAM in children with medical complications.

Ado, the incidence per 1,000/month of AWD among children under five years declined from 23.5% in March 2012, 21.1% in September 2012 and to 18% by March 2013. Following September 2012, a cholera case was reported in Dadaab and local transmission within the camps confirmed the declaration of an outbreak. By February 2013, 38 cholera cases were listed in Dadaab. WASH and health partners worked to initiate cholera preparedness and response mechanisms with weekly outbreak coordination meetings to monitor response activities. Health staff from camp agencies, CDC, UNICEF, UNHCR, and MOH-Kenya were also trained in clinical management of AWD.

10. **Component 1b: Screening and provision of basic health services.** This component focused on maternal and child health services, in addition to the prevention and treatment of common sources of morbidity and mortality, including respiratory tract infections, diarrheal disease, and malaria. Primary health care service provided in the targeted camps in Kenya and Ethiopia, built on UNHCR's existing health service delivery infrastructure. Services included preventative activities such as routine and mass vaccinations, growth monitoring of the youngest children, reproductive health and child health services, as well as curative services for a wide range of morbidities. Common morbidities observed were respiratory tract infections, diarrheal diseases and malaria. Bank support included the procurement and delivery of a strengthened basic health care package that includes immunization, treatment, and prevention of common diseases, such as diarrhea, acute respiratory infections, and parasitic infections.

11. **Component 1c: Strengthening of sanitation facilities and safe water supply as key contributors to improved health status.** This component recognized the importance of ensuring safe water supply as an essential component of nutrition and health programs and key to improving the health and nutrition status of the population are at severe risk. The challenge of providing 15 liters/person/day of clean water for drinking, cooking and hygiene was further compounded by the severe drought situation.

12. Activities to improve the quantity and quality of water available to refugees included: upgrading, extension and maintenance of exiting water networks; provision of higher capacity pumps and sufficient fuel to run them for long periods; construction of increased numbers of tap stands; increased capacity for water tanking, storage and treatment facilities; hydrological survey, installation of pumps and generators, reservoir tanks, distribution systems and distribution of jerry cans for water transport and storage. Over 27,000 latrines were constructed or renovated for improved sanitation services – triple the original target.

13. Overcrowded conditions in the camps made the provision of adequate sanitary conditions a first line defense against preventable illness. This included ensuring provision of adequate latrine facilities, an effective solid water management system, provision of soap and widespread hygiene measures and promotional activities. Pit latrines and disposal pits were constructed and in view of the increasing numbers, facilities at the Transit Center and reception centers would be rehabilitated. Along with the regular distribution of soap, hygiene promotion activities were organized.

14. **Component 1d: Strengthening project monitoring and evaluation (M&E).** This sub-component supported M&E activities (including the innovative use of ICT technology to facilitate data collection, monitoring, and management). The UNHCR Health Information System (HIS) was used by Health Workers to record activities daily including outcomes (number of admissions, number of children seen, defaulters, number of discharged cured) which were compiled monthly for statistical reporting. Death and recovery rates of children in each camp were monitored using the HIS as well as morbidity and mortality were also monitored using HIS as well as the associated standardized tools available from the primary health care facilities and community. Various nutrition surveys (referenced in Annex 5) were conducted to monitor the improvement of the nutrition situation.

15. The project design noted that UNHCR had begun to develop expertise in the use of improved appropriate technology to facilitate data collection and management. This also included adaptation of standard nutrition survey tools especially designed for refugee situations for use on Android phones. The March 2013 Kenya Dadaab nutritional survey report noted the use of such technology. Data collection questionnaires were prepared on paper in English before being coded as electronic questionnaires in Open Data Kit Collect (ODK Collect) and uploaded onto Android smart phones for testing. The questionnaires were revised with the input of Supervisors and Team Leaders and then piloted by teams in two to three households before the survey. Data validation ranges and skip patterns were coded in the questionnaires to help reduce data entry errors. Following piloting and several rounds of revision, the electronic questionnaires were finalized. These were administered in Somali via translators if required – many team members spoke Somali and associated dialects.

Achievements of Intermediate Results Indicators

IO#	Indicator and Result
IO#1	over 77,000 children (6-59 months) immunized against measles (target was 70,000).
IO#2	over 290,000 children (6-59 months) received a dose of Vitamin A supplements (target was 70,000).
IO#3	over 400,000 targeted children 6-59 months old and pregnant/lactating women screened (target was 123,475).
IO#4	over 85,000 children 6-59 months old with severe/acute malnutrition referred for treatment/food supplements (target was 5,275).
IO#5	over 170,000 pregnant and lactating women received food supplements (target was 23,475).
IO#6	over 27,000 latrines constructed or renovated for improved sanitation services (target was 8,500).
IO#7	100% of six monthly financial reports submitted on time (target was 85%).
IO#8	100% of six monthly M&E reports submitted on time (target was 85%).

16. **Component 2: Project Management and M&E:** Project management by UNHCR was satisfactory throughout, as evidenced by detailed quarterly program monitoring and monthly registration data from Dadaab and Dollo Ado and the submission of timely (and complete) six monthly technical and financial progress reports. Despite the security limitations in Dadaab, UNHCR still included both quantitative and qualitative data for Dadaab in its progress reports. Bank support to project management consisted of indirect costs required to support project delivery which included fixed and variable elements. An example of fixed indirect costs relate to costs of UNHCR's HQ support on supply and logistics to field offices. Variable indirect costs related to local costs of recruitment, procurement actions and contracting, budget preparation and control and some elements of reporting contingent on a specific project.

Annex 3. Economic and Financial Analysis

The Bank does not conduct appraisal of specific activities under the Fiduciary Principles Accord (FPA). Furthermore, given the evolving context of the emergency, a formal economic and financial analysis was not feasible. Instead, a detailed contextual country analysis was conducted for Ethiopia and Kenya by UNOCHA. This was done in the place of the standard Economic and Financial Analysis. The assessments supported: (i) the rationale for the approach in the delivery of health and nutrition services in the targeted camps; (ii) the activities under the UNHCR program are appropriate to respond efficiently to the needs on the ground; and (iii) the UNHCR's implementation structure is conducive to cost-efficient provision of services, given the challenging operating environment. Moreover, this emergency response project was designed to reduce the down-side economic shock of the extraordinary drought conditions and the resulting population displacement, by providing health and nutrition services to vulnerable populations in the targeted refugee areas to reduce the impact of morbidity and mortality. The social and human development cost of a protracted response to the crisis in the Horn of Africa would have been incalculable.

Annex 4. Grant Preparation and Implementation Support/Supervision Processes

Preparation

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending/Grant Preparation			
Sheila Dutta	Senior Health Specialist	AFTHE	Task Team Leader
Carla Bertoncino	Senior Economist	AFTED	
Gayle Martin	Senior Health Economist	AFTHE	
Anthony Molle	Counsel	LEGAF	
Casey Torgusson	Operations Analyst	AFRCI	
Frode Davanger	Senior Operations Officer	AFRCI	
Zhanar Abdildina	Senior Operations Officer	AFTDE	
Aisha Khan,	Operations Analyst	AFTDE	
Bolormaa Amgabazaar	Senior Operations Officer	AFTDE	
Cary Ann Cadman	Senior Forestry Specialist	AFTOS	
Victoria Gyllerup	Senior Operations Officer	AFTDE	
Menno Mulder-Sibanda	Senior Nutrition Specialist	AFTHE	
Zia Hyder	Senior Nutrition Specialist	AFTHE	
Meera Shekar	Lead Nutrition Specialist	AFTHE	
Jose Janeiro	Senior Finance Officer	CTRFC	
Rajiv Sondhi	Senior Finance Officer	CTRFC	
Fily Sissoko	Lead Financial Management Specialist	AFTFM	
Henry Amuguni	Financial Management Specialist	AFTFM	
Qamrul Hasan	Senior Procurement Specialist	AFTPC	
Supervision/ICR			
Sheila Dutta	Senior Health Specialist	AFTHE	Task Team Leader
Miriam Schneidman	Lead Health Specialist	AFTHE	
Carolyn Shelton	Operations Officer	AFTHE	
Henry Amuguni	Financial Management Specialist	AFTFM	
Menno Mulder-Sibanda	Senior Nutrition Specialist	AFTHE	
Casey Torgusson	Operations Analyst	AFRCI	

Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending	**9.65**	**40,298.40**
Total:	9.65	40,298.40
Supervision/ICR	47.55	221,447.88
Total:	57.20	261,746.28

Annex 5. Beneficiary Survey Results

No end of project beneficiary survey was carried out. However, UNHCR and other development partners conducted health and nutrition surveys as well as a knowledge, attitude and practice report conducted in Ethiopia. The following lists the various survey and studies carried out by UNHCR over the 18 months of implementation:

1. UNHCR guidance on Laboratory Services in UNHCR-Supported Primary Health Care Facilities, Principles and Guidance, UNHCR, 2011.

2. Long Lasting Insecticide Treated Net Distribution Strategy and Training Manual with Monitoring Tools (March 2012 Progress Report)

3. Training Curriculum for Refugee Health workers in Clinical Management of Sexual Violence (March 2012 Progress Report)

Dollo Ado, Ethiopia:

1. Annual nutrition surveys Ethiopia, December 2011
2. IMC conducted an assessment on causes of malnutrition in Kobe and Melkadida camps following the high GAM prevalence rates in Kobe (March 2012 progress report).
3. Knowledge, Attitude and Practices Haleweyn Refugee Camp, Somali Region, Ethiopia, Oxfam June 2012
4. Joint Nutrition and Health Survey, Dollo Ado Refugee Camps Kobe and Hilaweyn, by UNHCR, ARRA, WFP, UNICEF, ACF, IMC, GOAL, September 2012
5. Baseline Assessment of Water Supply, Sanitation and Hygiene (WASH) Status in Boqolmayo Refugee Camp, Somalia Region, Ethiopia, International Medical Corps, June 2012
6. Baseline Assessment of Water Supply, Sanitation and Hygiene (WASH) Status in Kobe and Melkadida Refugee Camp, Somalia Region, Ethiopia, International Medical Corps, June 2012
7. WASH Strategy for Refugee Camps in Dollo Ado, Ethiopia 2011 – 2014, UNHCR
8. Nutritional Survey for Dollo Ado, Ethiopia – March 2013

Dadaab, Kenya:

1. Nutrition Survey Kenya, August/September 2011
2. Report on the findings of a mass MUAC screening carried out in Ifo1, Ifo 2, Dagahaley, Hagadera and Kambioos camps from 26-30 March, 2012
3. Outbreak Preparedness and Response Guidelines –Dadaab (March 2012 progress report)
4. Anaemia Strategy, Dadaab (March 2012 Progress Report)
5. Laboratory Assessment Checklist, Dadaab (March 2012 Progress Report)
6. Nutritional Survey for Dadaab, Kenya – March 2013

Annex 6. Stakeholder Workshop Report and Results

Given the duration of this operation and the nature of the Bank supported activities implemented through a pooled joint emergency crisis response, it was not possible to conduct a stakeholder workshop. A number of assessments conducted by UNHCR throughout implementation that were done to improve service delivery along the way, including nutrition and health surveys, as well as water, sanitation and hygiene assessments as noted in Annex 5.

Annex 7. Summary of Grantee's ICR

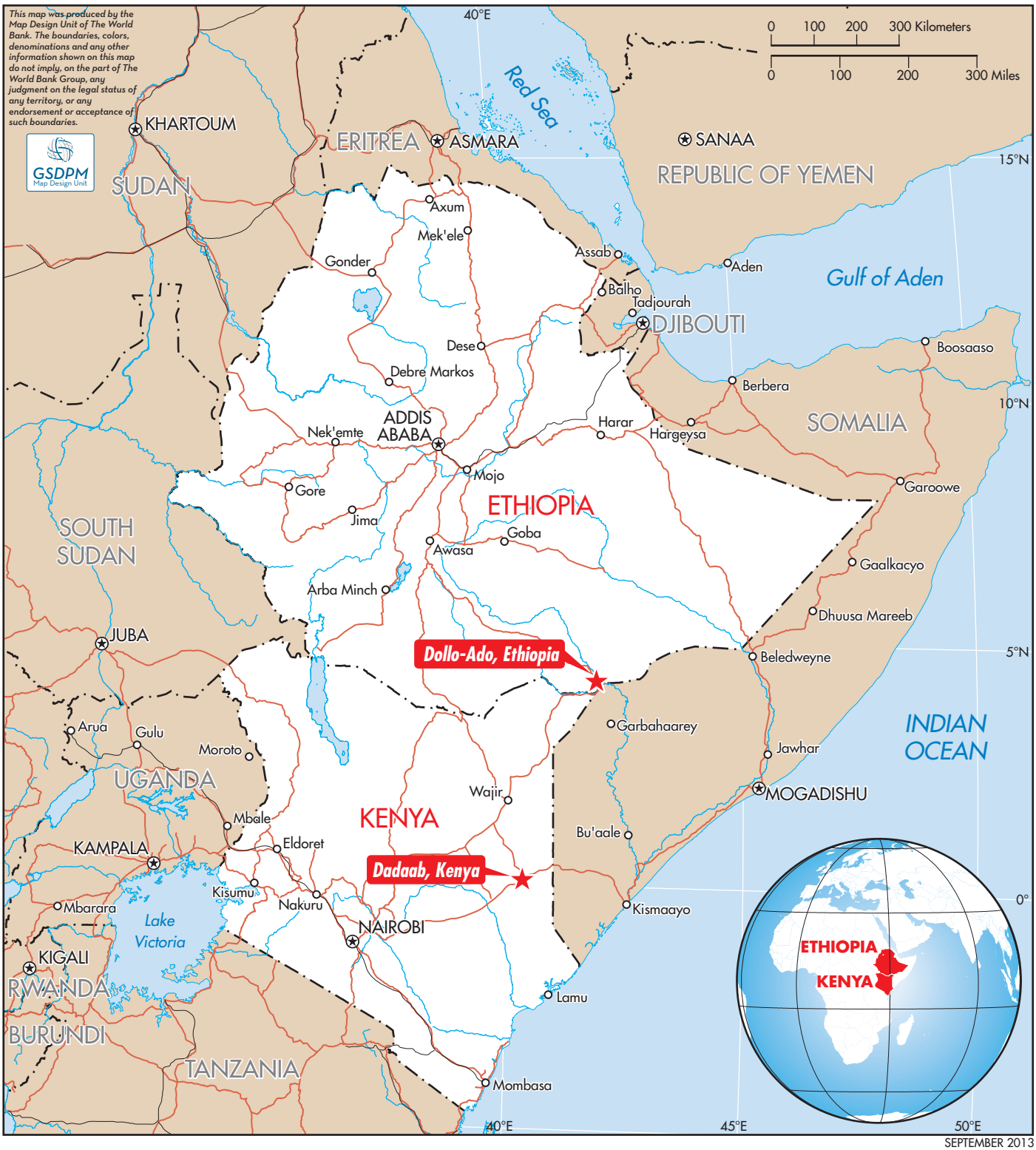
Annex 8. Comments of Co-financiers and Other Partners/Stakeholders

Not Applicable

Annex 9. List of Supporting Documents

- United Nations. Humanitarian requirements for the Horn of Africa Drought. July 2011
- UNHCR Letter to World Bank President (September 2011)
- UNHCR Technical and Financial Report and Annexes (September 2011 – March 2012)
- UNHCR Technical and Financial Report and Annexes (April – September 2012)
- UNHCR Technical and Financial Report and Annexes (October 2012 – March 2013)
- World Bank. Official Memo from AFRVP to OPCVP: Board Waiver request to enable UNHCR to serve as the implementing agency under the FPA (August 10, 2011)
- World Bank. World Bank and United National fiduciary principles accord for crisis and emergency situations. Operations Policy and Country Services, September 19, 2008.
- World Bank. Decision Note: Rapid Response Committee Meeting Decision Meeting (August 11, 2011)
- World Bank. Horn of Africa Emergency Health and Nutrition Project. Emergency Project Paper (September 2, 2011)
- World Bank. Implementation Status Reports (1 – 3)
- World Bank. Technical Note - Mission to Dollo Ado, Ethiopia (July 2012)

HORN OF AFRICA



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