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Report No: PAD3129

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT FROM THE IDA18 SUB-WINDOW FOR REFUGEES AND HOST COMMUNITIES

IN THE AMOUNT OF SDR 3.6 MILLION
(US$5 MILLION EQUIVALENT)

AND A

PROPOSED ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 0.8 MILLION
(US$1 MILLION EQUIVALENT)

TO THE

REPUBLIC OF DJIBOUTI

FOR THE

IMPROVING HEALTH SECTOR PERFORMANCE PROJECT

APRIL 5, 2019

Health, Nutrition & Population Global Practice
Middle East And North Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2019)

Currency Unit =	Djiboutian Franc (DJF)
DJF 178 =	US$1
US$ 1.39798 =	SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Ferid Belhaj
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ABBREVIATIONS AND ACRONYMS

ADDS	Djiboutian Agency for Social Development *(Agence Djiboutienne pour le Développement Social)*
AF	Additional Financing
ARV	Antiretroviral therapy
CDs	Communicable Diseases
CERC	Contingent Emergency Response Component
COGES	Health Management Committee (*Comité de Gestion de Santé*)
CRI	Corporate Results Indicator
CRRF	Comprehensive Refugee Response Framework
DA	Designated Account
DHIS2	District Health Information Software 2
DOTS	Directly Observed Treatment Short-course
EMP	Environmental Management Plan
ESIA	Environmental and Social Impact Assessment
FDI	Foreign Direct Investment
FM	Financial Management
GRS	Grievance Redress Service
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HOA	Horn of Africa
HRITF	Health Results Innovation Trust Fund
IDA	International Development Association
IFR	Interim Un-audited Financial Report
MEFIP	Ministry of Economy and Finance, in charge of Industry and Planning
MOH	Ministry of Health
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ONARS	Office for the Assistance of Refugees and Displaced Persons (Office National d'Assistance aux Réfugiés et Sinistrés)
PAPFAM	Pan Arab Project for Family Health
PAPSS	Djibouti Improving Health Sector Performance Project (Projet d'Amélioration de la Performance du Secteur de la Santé)
PDO	Project Development Objective
PFS	Project Financial Statements
PIU	Project Implementation Unit
POM	Project Operational Manual
PPSD	Project Procurement Strategy for Development
RBF	Results-based Financing
RMS	Results Measurement System
SOE	Statement of Expenditure
TT2	Two doses of tetanus toxoid
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees

UNICEF	United Nations Children's Fund
WBG	World Bank Group
WCBA	Women of Child Bearing Age
WFP	World Food Programme
WHO	World Health Organization

Djibouti
Improving Health Sector Performance Project Second Additional Financing

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BASIC INFORMATION – PARENT (DJ Improving Health Sector Performance - P131194)

Country	Product Line	Team Leader(s)		
Djibouti	IBRD/IDA	Elizabeth Mziray		
Project ID	**Financing Instrument**	**Resp CC**	**Req CC**	**Practice Area (Lead)**
P131194	Investment Project Financing	GHN05 (9320)	MNC03 (1491)	Health, Nutrition & Population

Implementing Agency: Ministry of Health

Is this a regionally tagged project?	

Bank/IFC Collaboration

No

Approval Date	Closing Date		Original Environmental Assessment Category	Current EA Category
02-Apr-2013	30-Apr-2019		Partial Assessment (B)	Partial Assessment (B)

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach [MPA]	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Disbursement-Linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	

Development Objective(s)

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

Ratings (from Parent ISR)

	Implementation					Latest ISR
	18-Dec-2016	11-Jul-2017	06-Mar-2018	13-Sep-2018	03-Jan-2019	02-Apr-2019
Progress towards achievement of PDO	S	MS	MS	MS	MS	MS
Overall Implementation Progress (IP)	MS	MS	MS	MS	MS	MS
Overall Safeguards Rating	MU	MS	MS	MS	MS	MS
Overall Risk	S	S	S	S	S	S

BASIC INFORMATION – ADDITIONAL FINANCING (Improving Health Sector Performance Project Second Additional Financing - P168250)

Project ID	Project Name	Additional Financing Type	Urgent Need or Capacity Constraints
P168250	Improving Health Sector Performance Project Second Additional Financing	Restructuring, Scale Up	No
Financing instrument	**Product line**	**Approval Date**	
Investment Project Financing	IBRD/IDA	26-Apr-2019	
Projected Date of Full Disbursement	**Bank/IFC Collaboration**		
30-Apr-2021	No		
Is this a regionally tagged project?			

No	

Financing & Implementation Modalities

[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Disbursement-Linked Indicators (DLIs)	[✓] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	
[✓] Contingent Emergency Response Component (CERC)	

Disbursement Summary (from Parent ISR)

Source of Funds	Net Commitments	Total Disbursed	Remaining Balance	Disbursed
IBRD				%
IDA	7.00	6.54	0.01	100 %
Grants	7.00	6.61	0.39	94 %

PROJECT FINANCING DATA – ADDITIONAL FINANCING (Improving Health Sector Performance Project Second Additional Financing - P168250)

FINANCING DATA (US$, Millions)

SUMMARY (Total Financing)

	Current Financing	Proposed Additional Financing	Total Proposed Financing
Total Project Cost	14.00	6.00	20.00
Total Financing	14.00	6.00	20.00
of which IBRD/IDA	7.00	6.00	13.00
Financing Gap	0.00	0.00	0.00

DETAILS - Additional Financing

World Bank Group Financing

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

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
National PBA	1.00	0.00	0.00	1.00
Refugee	0.00	5.00	0.00	5.00
Total	**1.00**	**5.00**	**0.00**	**6.00**

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any other Policy waiver(s)?

[ ] Yes [✓] No

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Elizabeth Mziray	Team Leader (ADM Responsible)	Public Health	GHN05
Melance Ndikumasabo	Procurement Specialist (ADM Responsible)	Procurement	GGOPM
Rock Jabbour	Financial Management Specialist (ADM Responsible)	Financial Management	GGOMN
Antoine V. Lema	Social Specialist (ADM Responsible)	Social Safeguards	GSU05
Mohamed Adnene Bezzaouia	Environmental Specialist (ADM Responsible)	Environmental Safeguards	GENME
Andrianirina Michel Eric Ranjeva	Team Member	Disbursement	WFACS
Asma Aden Chideh	Team Member	Administrative Support	MNCDJ
Damien B. C. M. de Walque	Team Member	Health Economics	DECHD
Eloise Sophie Fluet	Social Specialist	Social Safeguards	GSU05
Jenny Helena Dangre	Counsel	Legal Support	LEGAM
Mariam William Guirguis	Team Member	Administrative Support	GHN05
Miyuki T. Parris	Team Member	Operations	GHN05
Nagad Khaireh Allaleh	Team Member	Administrative Support	MNCDJ

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Oscar Alberto Bernal Acevedo	Team Member	Public Health	GHNDR
Saba Nabeel M Gheshan	Counsel	Legal Support	LEGAM
Sheila Johanna Carrette	Team Member	Public Health	GHN05

Extended Team

Name	Title	Organization	Location

I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Introduction

1. **This Project Paper seeks the approval of the Executive Directors to provide the second additional financing (AF) to the Republic of Djibouti's "Improving Health Sector Performance Project (*Projet d'Amélioration de la Performance du Secteur de la Santé*; PAPSS)" (P131194) in the amount of US$6 million (a US$1 million IDA credit from the national allocation and a US$5 million grant from the IDA18 Sub-Window for Refugees and Host Communities).** The parent project is a five-year results-based financing (RBF) project funded by a US$7 million IDA credit, approved by the World Bank Group's (WBG) Executive Directors on April 2, 2013 and became effective on July 11, 2013. In May 2015, the first additional financing (AF1) in the form of a grant of US$7 million from the Health Results and Innovation Trust Fund (HRITF) was approved. The proposed second AF (AF2) will support the Government of Djibouti's efforts to mitigate the negative health impacts of the protracted refugee crisis and ensure that refugees and host communities have access to quality and equitable health services.

2. **The parent project was conceived to cover existing public health facilities at the primary level in Djibouti-Ville and through a phased approach to cover all public health facilities at the primary and secondary levels in the five regions – Obock, Tadjourah, Dikhil, Arta, and Ali-Sabieh**. Currently, all existing public health facilities at primary and secondary levels and three tertiary hospitals in Djibouti are contracted through a public purchaser approach and remunerated based on indicators related to delivery of health services. The project aims to increase the volume and quality of health and nutrition services, with a focus on maternal, neonatal and child health and nutrition interventions to address malnutrition. With support from the project there has been an increase in the availability and utilization of these services.

3. **The large influx of refugees and protracted humanitarian crisis have strained an already fragile health system and have further stretched the limited capacity of the health system to provide basic health and nutrition services.** As of end-2016, the Republic of Djibouti hosted 17,683 registered refugees[1] fleeing conflict and political instability in the surrounding countries. Obock, the region with the highest stunting and wasting rates in the country, is currently hosting the largest refugee population from Yemen. The capacity of health centers throughout Djibouti is under severe strain. In certain communities in Djibouti-Ville, displaced populations including refugees constitute a large share of health service users.[2] In Balbala they represent more than 40 percent of all consultations in health structures. The limited coverage of health services and the absence of essential nutrition and water and sanitation facilities have increased the risk of disease outbreaks. In recent years Djibouti has experienced repeated outbreaks of acute watery diarrhea (e.g. cholera), measles, chicken pox and multi-drug resistant tuberculosis.[3]

4. **Over the past four decades, the Government of Djibouti has maintained an open-door policy for refugees and has committed to providing adequate protection to refugees**. The National Refugee Law was adopted by the Djibouti Parliament in 2016 and promulgated in 2017. The law provides a strong legal framework for the

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[1] Of the more than 150,000 displaced individuals in Djibouti, only an estimated 17,683 refugees are registered with UNHCR as refugees or asylum seekers

[2] Development policy letter for refugees, displaced persons and host communities of the Republic of Djibouti ; August 9, 2017 (Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017)

[3] Ibid.

protection of refugee rights enabling them to enjoy fundamental rights, including access to basic services (health, education, water and sanitation), social protection and economic inclusion through employment and naturalization.[4] Djibouti is one of the countries rolling out the Comprehensive Refugee Response Framework (CRRF).[5] In December 2017, the Government announced that it would utilize a "whole of society" approach with all refugee camps in the country considered as villages.[6] The new refugee law will facilitate the integration of refugees and host communities and is implemented through two decrees that include the right to movement and access to legal employment and social services such as healthcare and education.[7]

5. **The Government of Djibouti has committed to a strategy to support refugees that has three pillars[8] designed to move towards a long-term solution for refugees.[9]** Under pillar one, "*institutional and legislative strengthening*" the government will implement a series of progressive reforms to facilitate the implementation of the National Refugee Law. These reforms will allow for better integration of refugees into labor markets, facilitate the registration of more refugees, and help them gain access to civil documentation. The reforms will also strengthen the capacity of the National Office for Assistance to Refugees and Displaced Persons (*Office National d'Assistance aux Réfugiés et Sinistrés* - ONARS) and the National Eligibility Committee to implement the National Refugee Law. The Government of Djibouti also plans to adopt an emergency institutional framework, which will allow for rapid response to and better management of future influxes of refugees. Lastly, the Government aims to pool resources and improve coordination among humanitarian and development actors to promote the integration of refugees and host communities.

6. **The Government has committed to addressing the increasing health needs of refugees and host communities. Under pillar two, "improving access to basic services, particularly education and health" the Government intends to[10]** (i) improve the quality of basic health services in refugee affected health zones by enhancing existing health facilities and training additional health personnel; (ii) integrate health facilities in refugee camps, under the management of the United Nations High Commissioner for Refugees (UNHCR), into the National public health system; (iii) strengthen the national epidemiological and endemic surveillance and monitoring systems by equipping laboratories, training staff and establishing an early warning system; and (iv) include refugees into the national healthcare system and extending health insurance coverage to them. In January 2018, the Ministry of Health (MOH) officially signed an agreement with UNHCR to take over the provision of health services for refugees.[11]

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[4] WHO EMRO (2018) Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. *http://www.who.int/migrants/publications/EMRO-Practices.pdf*

[5] In 2016, the United Nations adopted the New York Declaration for Refugees and Migrants, which calls upon the UNHCR to develop and initiate the application of the CRRF. The objectives of this framework include: (i) to ease pressure on host countries, (ii) enhance self-reliance of refugees; (iii) expand access to third-country solutions; and (iv) support conditions in countries of origin for return in safety and dignity. Source: *http://www.globalcrrf.org*

[6] Reliefweb (2017). UN Refugee Chief praises Djibouti New Refugee Law. *https://reliefweb.int/report/djibouti/un-refugee-chief-praises-djibouti-new-refugee-laws*

[7] UNHCR (2018). Oral update on the CRRF. *https://www.unhcr.org/5aa2a8617*

[8] The three pillars are as follows: (i) "institutional and legislative strengthening"; (ii) "improving access to basic services, particularly education and health"; and (iii) "social protection and economic promotion".

[9] IDA18 Refugee Sub-Window Board consultation on Eligibility AFR, MNA, SAR; September 19, 2017

[10] Idem.

[11] UNHCR (2018). Djibouti factsheet. Source: *http://reporting.unhcr.org/sites/default/files/UNHCR Djibouti Fact Sheet - January 2018pdf*

7. **Pillar three, "social protection and economic promotion" will ensure that refugees and host populations have access to adequate social assistance**[12] by: (i) extending universal health coverage and the cash transfer mechanism to refugees; and (ii) promoting economic opportunities for Djiboutians and refugees by financing microprojects through lending, subsidies or guarantee mechanisms.

8. **The IDA18 Sub-Window for Refugees and Host Communities (RSW) was created in response to demands from refugee-hosting countries,** like Djibouti, as a mechanism for development assistance and concessional financing from the WBG. This will help advance policy and institutional reforms with a view to enhancing the management of refugee situations in host countries through: (i) mitigating the shock caused by an influx of refugees and creating social and economic development opportunities for refugees and host communities; (ii) facilitating sustainable solutions to protracted refugee situations, including through the sustainable socioeconomic inclusion of refugees in the host country and/or their return to their country of origin; and (iii) strengthening preparedness for increased or potential new refugee flows.[13]

9. **The Government of Djibouti meets all three criteria to access financing through the RSW** [14] including: (i) as of end-2016, the Djibouti refugee population constituted 1.88 percent of the country's population[15]; (ii) the WBG in consultation with UNHCR has determined that Djibouti adheres to a framework for the protection of refugees that is adequate for the purpose of the RSW[16]; and (iii) the Government of Djibouti has articulated a strategic approach to move towards long-term solutions that benefit refugees and host communities. On August 9, 2017, the Government of Djibouti requested financing under the RSW by sending a Letter of Development Policy.[17] Access to the RSW for Djibouti was approved by the Board of Executive Directors in September 2017.

B. Country context

10. **Djibouti is a small (23,200 square kilometers), lower-middle-income country with a per-capita income of US$1,927 in 2017 and a population of 956,985.**[18] While resources such as arable land and water are scarce, economic growth has accelerated over the recent years, reaching 6.5 percent annual growth rate in 2016, mostly due to an increase in Foreign Direct Investments (FDI), ports services and rents from foreign countries for their military bases.

11. **Djibouti's recent economic growth has not translated to reduced poverty or shared prosperity, and the country lags behind on human development indicators.** In 2017, Djibouti ranked 172 of 189 countries on the Human Development Index and life expectancy remains relatively low (62.6 years) compared to countries in

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[12] IDA18 Refugee Sub-Window Board consultation on Eligibility AFR, MNA, SAR; September 19, 2017
[13] IDA18 Refugee Sub-Window Board consultation on Eligibility AFR, MNA, SAR; September 19, 2017
[14] To be eligible for the RSW , countries supported by IDA 18 need to : (i) host a least 25,000 or 0.1 percent of the country population (UNHCR-registered refugees), including persons in refugee-like situations; (ii) have an adequate framework for the protection of refugees; and (iii) have an action plan, strategy, or similar document that describes concrete steps, including possible policy reforms that the country will undertake towards long-term solutions that benefit refugees and host communities, consistent with the overall purpose of the window.
[15] UNHCR 2016. Global Trends: Forced Displacement in 2016.
[16] Adequacy is determined based on adherence of national policies and/or practices consistent with international refugee protection standards.
[17] Development policy letter for refugees, displaced persons and host communities of the Republic of Djibouti ; August 9, 2017 (Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017)
[18] WDI 2018

the region with a lower GDP (Ethiopia: US$767 in 2017, life expectancy: 65.9 years).[19] Almost half of the population (40.7 percent; 2013) lives in poverty,[20] 23 percent living in conditions of extreme poverty, particularly in rural areas (44 percent). Unemployment remains alarmingly high reaching 39 percent in 2015, particularly among young people.

Refugee crisis

12. **Djibouti hosts more than 150,000 displaced individuals including refugees, asylum seekers and migrants (15 percent of total population), fleeing conflict, political instability and environmental degradation in the surrounding countries.**[21] Djibouti has hosted large numbers of displaced populations from the Horn of Africa (HOA) since the late 1970s, many of which seek asylum or transit to the Gulf countries in search of better living conditions. More recently, displacements of individuals towards Djibouti has been exacerbated by the recurrent conflicts in Somalia, more recent conflict in Yemen and recurrent droughts, ethnic conflicts and rising poverty levels in Ethiopia and Eritrea. For example, since March 2015, there has been an influx of approximately 37,000 people, including 19,636 Yemenis (54 percent).[22]

13. **Of the more than 150,000 displaced individuals in Djibouti, only an estimated 17,683 refugees (about 11 percent)[23] have been registered as refugees and asylum seekers by the UNHCR**.[24] Displaced individuals resist getting registered for a number of social and economic reasons, including; (i) the lack of economic opportunities within refugee camps; (ii) the perception of being locked in the camps or being at risk of deportation at any moment; (iii) fear of stigmatization; and (iv) pride amongst displaced individuals from Somalia and Ethiopia with ethnic or tribal links to Djibouti. In December 2016, only 20 percent of 19,000 Yemenis who arrived in Djibouti accepted to be registered as refugees by UNHCR.[25] The proportion of unregistered refugees and asylum seekers from Somalia and Ethiopia is estimated to be much higher than those from Yemen.

14. **More than 80 percent of refugees registered by UNHCR reside in three refugee sites (Markazi, Ali-Addeh and Holl Holl)**[26] where they are dependent on humanitarian assistance. The three camps are situated in underserved border regions with strong development needs among refugees and host populations. Access to basic services, land, water, and other natural resources and economic activities are limited, thereby hampering self-reliance and prospects for integration. Refugees in camps survive on aid, and services such as education, health, and water are delivered through parallel systems funded by UNHCR and coordinated by the ONARS. There are often significant inequalities in access to services between refugees – who benefit from external resources – and host communities. The remaining refugees, asylum seekers and migrant population live amongst the host community in the peri-urban zone of Djibouti-Ville, mostly in the slums of Balbala, or in new towns and villages they create, most of which are in very poor condition.

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[19] WDI 2018, United Nations Development Programme. 2017. Human Development Report 2017. New York: UNDP
[20] Poverty: defined as consumption less than US$2.98 per day (2011 purchasing power parity, PPP)
[21] IDA 18 Refugee Sub-Window Board consultation on Eligibility AFR, MNA, SAR, September 2017.
[22] Development policy letter for refugees, displaced persons and host communities of the Republic of Djibouti ; August 9, 2017 (Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017)
[23] UNHCR (June 2018) Registered refugees represent an estimated 3 percent of the total population in Djibouti. Source: *http://www.globalcrrf.org/crrf_country/dji/*
[24] Development policy letter for refugees, displaced persons and host communities of the Republic of Djibouti ; August 9, 2017 (Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017)
[25] Idem.
[26] IDA 18 Refugee Sub-window Board consultation on Eligibility AFR, MNA, SAR, September 2017

15. **The ethnic and tribal links between populations in the HOA have led to an integration of these societies within the host community**, leading to better economic and social integration of displaced populations and refugees in these communities. However, the continued influx of displaced individuals has had a number of negative impacts on hosting areas, including: increased competition—direct and indirect—for basic social services such as health, education, and drinking water; a degraded physical and natural environment due to high pressure on biomass to meet energy and construction needs; limited livelihood opportunities; decreasing water availability evidenced by deeper boreholes and increased costs for water transport; crowded health centers and classrooms; and increased distance, time, and/or cost for collecting wood for cooking and lighting. This has led to increasing frustrations amongst the local population, and social tensions have emerged between refugees and the local population that could worsen if left unaddressed.[27]

16. **The situation for displaced women and girls, who account for 49 percent of refugees in Djibouti, is particularly difficult.** Women and girls are disproportionately exposed to economic and social vulnerabilities and face multiple challenges associated with poorer health, lower education and labor market outcomes compared to refugee men. For example, men are roughly two-thirds more likely to be working than women and are paid 24 percent more; while refugee women are more likely to be employed in the informal economy.[28]

C. Sector context

17. **Despite improvements in Djibouti's health status in the last few years, the health indicators remain among the lowest, not only in the Middle East and North Africa region, but in the world.** For example, infant and maternal mortality ratios remain higher than those of economically comparable nations as well as those countries within Djibouti's geographic region.[29] Over 85% of deliveries are attended by skilled health personnel. However, only 23 percent of women receive four or more antenatal care visits, while only 54 percent of women receive any form of postnatal care.[30] From the last demographic and health survey conducted in 2012[31], the contraceptive prevalence rate was 19%, and was estimated at about 11% in 2015 (based on annual health statistics). Maternal mortality, although decreasing, is still estimated at 229 per 100,000 live births, markedly higher than the target of 185 set for 2015 for the Millennium Development Goals. The leading causes of death are attributed to communicable diseases and poor maternal, neonatal and nutritional conditions.[32] Maternal and infant malnutrition are the number one cause of death and disability in Djibouti, while wasting diarrheal disease due to poor access to quality water in rural areas and acute respiratory infections are the most common causes of morbidity and infant mortality.[33] Approximately 77% of HIV positive pregnant women receive complete treatment for the prevention of mother to child transmission of HIV[34]. These indicators are indicative

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[27] Development policy letter for refugees, displaced persons and host communities of the Republic of Djibouti ; August 9, 2017 (Lettre de politique de Développement de Réfugiés, personnes déplacées et communautés hôtes de la République de Djibouti ; Août 9, 2017)
[28] UNHCR. 2018. Livelihoods Strategic Plan UNHCR Djibouti 2018-2022. UNHCR Livelihoods Unit.
[29] World Bank Group, "World Development Indicators."
[30] Ministère De La Santé Djibouti, Direction De La Statistique Et Des Etudes Démographiques, and Pan Arab Project for Family Health, "DEUXIEME ENQUETE DJIBOUTIENNE SUR LA SANTE DE LA FAMILLE EDSF//PAPFAM 2 – 2012 : Rapport Final
[31] Ministère De La Santé Djibouti, Direction De La Statistique Et Des Etudes Démographiques, and Pan Arab Project for Family Health, "DEUXIEME ENQUETE DJIBOUTIENNE SUR LA SANTE DE LA FAMILLE EDSF//PAPFAM 2 – 2012 : Rapport Final
[32] IHME (2017). Source : http://www.healthdata.org/djibouti
[33] Ibid.
[34] Ministry of Health (2018) National Health Development Plan (Ministère De La Santé (2018) Plan National de Developpement Sanitaire (2018-2022)

of the challenges that still remain in improving access and quality of maternal and child health and nutrition services.

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

19. **Vertical healthcare programs in refugee camps, running parallel to the Djiboutian healthcare system, have led to inefficiencies that have ultimately affected quality of services provided to the beneficiaries.** Up until December 2017 two health sub-systems existed in Djibouti: (i) health facilities within refugee camps, managed by UNHCR and its implementing partners, which received substantial resources from humanitarian partners; and (ii) the public health system under the authority of the MOH with limited resources to provide quality services to local and displaced populations.[35]Refugees (both registered and unregistered) also seek care in state health facilities, which has further overburdened health facilities in the public sector. The new refugee law and the transfer of health facilities in refugee camps to the Government will deepen the integration between host communities and refugees by getting rid of the parallel health system and reducing the inefficiencies.

D. Institutional context

20. **In its National Health Development Plan (2013-2017 and 2018-2022), the Government of Djibouti identifies RBF as a central strategy for health system strengthening, as well as to improve the performance of health services and the quality of health service delivery.** The RBF approach aims to correct market failures to attain health gains by focusing on results defined as the quality and quantity of service outputs, and inclusion of vulnerable persons.[36, 37] In addition, it uses a bottom-up approach to help health systems move to greater accountability and channels more resources from the central level to the point of service delivery at primary health care facilities. This has been shown to enhance motivation among health personnel. Improvement in staff attitude and morale is closely linked to the increase in resources, goods and equipment acquired through RBF funds. The financial bonuses received by health facility staff serve as a strong motivator for staff members to meet and exceed the expectations given via their assigned designations and roles within facilities.

21. **The RBF approach takes the form of a contractual relationship between different actors of the health system**. It stipulates that the purchaser (e.g. payment agency) will pay financial incentives to health care providers and regulatory bodies in accordance with their performance, as measured by the quantity and quality of predefined health services provided to the target population. By implementing and progressively scaling up RBF in Djibouti through the PAPSS project, the Government seeks to change the behavior of health providers at the facility

[36] Soeters, R. et al, Performance-based financing in Action theory and instruments. Version March 2018. Source: *www.sina-health.com*
[37] Ministry of Health (2018) National Health Development Plan (Ministère De La Santé (2018) Plan National de Developpement Sanitaire (2018-2022)

level to promote delivery of better quality services by (i) providing incentives to facilities in order to increase productivity and quality of care, especially for the identified key indicators, and (ii) providing financial resources at the facility level to cover the local operations and maintenance costs. The specific details for the implementation of the RBF mechanism in Djibouti such as the contracted indicators at different levels of the health system, the verification system, the institutional arrangements and the financial flow of funds and terms of payment for contracted health care providers are included in the RBF manual that was developed under the parent project.

E. Project Performance

22. The PAPSS project was conceived to introduce RBF for the existing public health facilities at the primary level in Djibouti-Ville and, through a phased approach, to cover all institutions at the primary and secondary levels in the five regions. With the first additional financing (AF1) from the HRITF in 2015, RBF was extended to cover all public primary and second level facilities in the whole country. In April 2017 three tertiary level facilities were added to the RBF scheme. Over 99 percent of the IDA credit and 94 percent of the HIRTF funding have been disbursed to date. Progress toward achievement of the Project Development Objective (PDO) and overall implementation are both rated as Moderately Satisfactory.

23. **The MOH transformed five primary level community health centers in Djibouti-Ville to secondary level polyclinics in 2017 to better cater to the health needs of almost 80 percent of the country's population**, all of whom reside in Djibouti-Ville. These polyclinics provide services closer to households including basic specialties important for maternal and child health and other common conditions, thereby decreasing the high utilization of tertiary care facilities. The polyclinics aim to provide 24-hour emergency and delivery care, and outpatient services in dentistry, optometry, otolaryngology and nutrition, and each contains a laboratory and pharmacy. Three of the polyclinics are in Balbala, covering almost half the population of the capital, and the other two are in the commune of Boulaos. As part of the conversion of the primary level facilities to polyclinics the MOH improved the infrastructure and purchased equipment through the PAPSS RBF project. In addition, the MOH expanded the number of health workers and support staff in each polyclinic. In the first six months of implementation, there has been an increase in the service utilization rates.

24. **Due to the slow startup of the project progress towards achieving the PDO has been more gradual than expected.** The slow start up at the beginning was due to capacity and implementation challenges as well as the novelty of the RBF strategy and its implementation. With the provision of technical assistance and training at both the central and decentralized levels as well as increased buy-in and ownership of the RBF strategy the implementation pace picked up significantly. As of September 2018, the target was surpassed for two PDO indicators, namely, percentage of children fully immunized before their first birthday and the number of women receiving prenatal care. The project targets have not been reached for the remaining PDO indicators, namely, average facility quality and the number of HIV+ pregnant women on antiretroviral (ARV) therapy. The original target for the indicator "HIV+ pregnant women on ARV therapy", was set too high and will be revised with the project restructuring. As for the average quality of facilities, it varies depending on the different levels of care, with the secondary and tertiary health facilities having a much higher average quality score (60-80 percent) than health posts (43 percent). Regarding the intermediate results indicators, some have surpassed

the target (e.g. family planning, nutrition services, assisted births, and curative visits per person), while the indicator for pregnant women receiving two doses of tetanus toxoid has achieved 32 percent of the target as of end 2017.

F. Rationale for Additional Financing (AF)

25. **Given the escalating humanitarian crisis, rapidly growing numbers of displaced persons, increasing health needs of refugees, migrants and host communities, and the fragility of the health system, the Government of Djibouti seeks an AF to the PAPSS project** to reinforce the activities currently being implemented in the parent project and ensure the availability of critical, quality health services for refugees, asylum seekers, migrants and Djiboutians. Moreover, the proposed AF2 seeks to enhance the effectiveness, quality and national ownership of the RBF program in Djibouti.

26. **The modified and scaled-up activities are fully consistent with the parent project and align with key strategies and contribute to promoting human capital formation**. The activities to be supported by the proposed AF2 are consistent with the current PDO, which remains highly relevant but will be revised to better capture the main focus of the project activities. In addition, they are aligned with the country's Vision 2035, the WBG's Djibouti Country Partnership Strategy for FY14-17[38] (Report No. 83874-DJ , discussed by the Board of Executive Directors on March 13, 2014), the Djibouti Systematic Country Diagnostic (Report No. 134321-DJ) and the Government's strategy to improve the living conditions and health of refugees, asylum seekers, migrants and host populations, which is in line with the purpose of IDA RSW. The AF2 is fully aligned with the WBG's Middle East and North Africa Regional Strategy, particularly its pillars on renewing the social contract (by improving the quality of health services for the vulnerable and hence building trust between citizens and local/national authorities) and building resilience to IDP/refugee shocks (as the country hosts significant flows of refugees and other displaced populations from neighboring countries). Also, AF2 contributes to the achievement of the WBG's twin goals of ending extreme poverty and boosting shared prosperity in a sustainable manner by supporting quality health service delivery for stronger human capital.

27. **Improving access and utilization of reproductive, maternal and child health and nutrition services is key to promoting gender equality in Djibouti.** Similar to the parent project, the proposed AF2 applies a gender lens by including: (a) collection of gender-disaggregated data and gender statistics in the project's results framework to the extent possible, ensuring availability of comparable, gender-disaggregated data as part of project monitoring and evaluation which will be important to maintain and enhance the gender lens within the project; (b) improving access and utilization of health services through greater awareness about these services to the community, taking into consideration the full and equal participation of women and men; and (c) improved access to family planning, maternal and reproductive health services . The proposed AF2 is also aligned with the World Bank Gender Strategy and contributes to the first pillar – "improving gaps in human endowments" - through providing access to health and nutrition services during the vulnerable periods of life and new knowledge and skills on maternal and child health and nutrition practices.

28. **The proposed AF2 will also include the restructuring of the parent project to**: (i) revise the Project Development Objective (PDO) to reflect the current context; (ii) revise the Results Framework to better capture

[38] The Djibouti Country Partnership Strategy was extended to FY18.

project activities and to reflect the activities under the AF2; (iii) extend project closing date from April 30, 2019 to December 31, 2020; (iv) change the procurement guidelines to be followed to the new *World Bank Procurement Regulations for IPF Borrowers* (dated July 2016, revised November 2017 and August 2018); and (v) include a Contingent Emergency Response Component (CERC) as Component 4 and additional activities under Component 1.

II. DESCRIPTION OF ADDITIONAL FINANCING

A. Project Components and Financing

29. The proposed AF2 will support the continuation of activities initiated under the parent project (Component 1, 2 and 3) as well as some additional activities to: (i) mitigate the health and economic impact of the influx of more than 150,000 displaced populations; (ii) meet the increasing health needs of refugees, asylum seekers, migrants and vulnerable Djiboutians to increase and protect their human capital; and (iii) enhance the effectiveness, quality and national ownership of the project.

Component 1: Improving health service delivery performance (US$3.915 million)

30. This component will continue to support the delivery of improvements in: (i) maternal and neonatal health services such as prenatal care, family planning, skilled birth attendance, and emergency obstetric care; (ii) integrated management of childhood Illnesses; (iii) nutrition services such as the prevention and treatment of malnutrition; (iii) expanded program on immunization; (iv) child health services such as immunization, and; (v) prevention, diagnosis and treatment services of communicable diseases such as HIV prevention and treatment services, and detection and treatment of tuberculosis. This component finances healthcare services by disbursing the project proceeds to health providers based on specific quantifiable outputs of the health facilities through an RBF mechanism.

31. In addition, the proposed AF2 will support: (i) scaling up of the RBF component for the delivery of health services to refugees and host communities in selected refugee camps of Holl Holl, Ali-Addeh and Obock, and the pediatric ward of the Peltier Hospital in Djibouti-Ville; and (ii) support the Directorate of Health Regions (*Direction des Régions Sanitaires*) in providing specialized health services to refugees and host communities in selected areas through the provision of mobile "Caravan" clinics.

Component 2: Strengthening health system management (US$0.745 million)

32. Under the parent project, this component has been supporting activities aimed at strengthening the management capacity of the MOH and improving the performance of the different health systems in support of health services. These include: (i) MOH directorates such as: health regions, health promotion, human resources, information systems, planning, health service inspections, maternal and child health, immunizations; (ii) training service directorates; (iii) the HIV/AIDS, Tuberculosis and malaria control programs; and iv) the drug fund. Specifically, this component is intended to strengthen MOH's health system management capacity and improve the performance of the different health systems through supporting capacity building,

performance management and clarifying the roles of different departments within MoH through the provision of training, goods and consultant services

33. The proposed AF2 will also support: (i) the MOH's efforts to improve the routine Health Management Information System through selection of core indicators, harmonization of data collection tools, and introduction of District Health Information Software (DHIS2) as a data management tool (used for storage, analysis and feedback report production and dissemination). The initial preparatory work for DHIS2 was undertaken by the United Nations Development Programme (UNDP) with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The AF2 will finance the identified gaps for nationwide roll-out of DHIS2 building up on the initial support from the Global Fund; (ii) carry out surveys on the quality of health services; and (iii) support implementation of selected health care waste management measures, specifically the installation of small artisanal incinerators at five health facilities in Dikhil, Tadjourah, Obock, and Arta regions.

Component 3: Strengthening project management and monitoring and evaluation capacity (US$1.34 million)

34. The ongoing activities for this component under the parent project include: (i) supporting the Project Implementation Unit (PIU) in managing project activities and fiduciary functions, including financial management, procurement, and environment; and (ii) strengthening the monitoring and evaluation of the program, including financing independent technical audits to validate and verify the achievements of health facilities outputs on a quarterly basis. In addition, this component has been covering the necessary funds for office equipment, office supplies, technical assistance, PIU operating costs, and PIU staff training.

35. The proposed AF2 will support ongoing activities as well as an enhanced RBF capacity building program at national, regional and facility levels including the provision of specialized international technical assistance. For Monitoring and Evaluation purposes the RBF portal, that facilitates the daily management of the RBF scheme, will be upgraded and maintained including ensuring linkages and interoperability with DHIS2. The RBF portal managed by the PIU provides timely access to reliable data, thereby improving efficiency and reducing costs.

Component 4: Contingent Emergency Response Component – CERC (US$0)

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

Table 1: Cost by Component (US$ million)

Component	Original cost (revised)	First AF (May 2015)	Proposed Second AF	Total
1 Improving health service delivery performance	3.975	4.875	3.915	12.765
2 Strengthening health system management	0.800	-	0.745	1.545
3 Strengthening project management and monitoring and evaluation capacity	2.225	2.125	1.340	5.690
4 CERC	-	-	0	0
Total	7.000	7.000	6.000	20.000

B. PDO

37. The PDO of the parent project will be revised as follows: "to improve the utilization of quality maternal and child health services" to be in line with the main focus of the project activities. The term "communicable diseases control programs (HIV/AIDS and tuberculosis)" has been removed from the PDO due to the following reasons: (i) the prevalence rates of the Communicable Diseases (CDs) have been lower than expected at the preparation phase of the parent project; (ii) among the refugee population, the prevalence rates are very low; and (iii) health services supported by this project include screening and providing treatment for the CDs. While CDs are removed from the PDO, they are still reflected in project activities and progress will be captured through intermediate results indicators.

C. PDO and Intermediate Indicators

38. The target values of the PDO indicators have been revised to reflect the addition of new beneficiaries and the extended project duration, and the HIV indicator will be converted to an intermediate results indicator in line with the revised PDO.

- Original indicators
  1. Number of women completing 2 or more prenatal visits: this indicator was renamed from "number of women receiving 2-4 prenatal visits and the end target is revised.
  2. Percentage of children fully immunized before their first birthday: the end target is revised.
  3. Average facility quality: the and end target is revised.
- Original PDO indicator reclassified as an intermediate results indicator
  4. Number of HIV positive pregnant women receiving treatment according to protocol: the number of HIV positive pregnant women has been lower than previously estimated. The relevant services will be continued, and targets will be reclassified as an intermediate result indicator. The end target is revised.

39. Four new intermediate level indicators have been proposed, and as mentioned above, one PDO level indicator has been reclassified as an intermediate results indicator. The end targets of the existing intermediate results

indicators are revised to reflect the addition of new beneficiaries and extended project duration, and one indicator has been dropped:

- New indicators
  1. Community surveys conducted, and results shared with contracted facilities
  2. Number of health care providers trained on DHIS2
  3. Percentage of beneficiaries satisfied with health services
  4. Number of displaced persons (refugees, asylum seekers and migrants) receiving services at health facilities
- Reclassified from a PDO level indicator to an intermediate indicator
  5. Number of HIV positive pregnant women receiving treatment according to protocol: the end target is revised.
- Existing indicators
  6. People who have received essential health, nutrition and population (HNP) services (a Corporate Results Indicator – CRI) and its sub indicators, “People who have received essential health, nutrition, and population (HNP) services - Female”, “Number of children immunized”, “Number of women and children who have received basic nutrition services”, and “Number of deliveries attended by skilled health personnel”:[39] the end targets are revised.
  7. Number of women giving birth in a contracted facility assisted by qualified personnel: this indicator will be marked for deletion, but the same data will be captured under the CRI sub-indicator, “Number of deliveries attended by skilled health personnel number of deliveries attended by skilled health personnel”, and the end target is revised.
  8. Number of new curative visits per person per year in the public system; the end target is revised
  9. Number of women of child bearing age (WCBA) visiting the public system to obtain modern family planning (oral contraceptives and injections): the end target is revised.
  10. Pregnant/lactating women, adolescent girls and/or children under five reached by basic nutrition services: marked for deletion as a stand-alone indicator, but the same data are captured under the CRI sub-indicator, “Number of women and children who have received basic nutrition services”, and the end target is revised.
  11. Percentage of pregnant women receiving at least two doses of tetanus toxoid (TT2); the end target is revised.
  12. People receiving tuberculosis treatment in accordance with the WHO-recommended “Directly Observed Treatment Strategy (DOTS): the end target is revised.
- Dropped indicator
  13. Direct project beneficiaries and its sub-indicator, “Female beneficiaries (percentage)”: the number of visits/consultations instead of people has been captured; the CRI replaces this indicator.

[39] The CRI was introduced in December 2018 in the results framework as part of the corporate exercise to ensure the inclusion of the CRI in all relevant operations. This change did not require restructuring.

D. Project Beneficiaries

40. Djiboutians and non-Djiboutians (refugees, asylum seekers) – mothers and children in particular – who receive services at contracted health facilities are considered as the main beneficiaries of the project as they will benefit from services of improved quality. Displaced populations were among the main beneficiaries of the activities under the parent project but were not specifically monitored; with the proposed AF2, progress towards reaching them will be captured. Healthcare providers and their support staff in the health facilities contracted under RBF, including those at the three health facilities inside the refugee camps, will benefit from financial incentives contingent upon the volume and quality of services they will provide. The various departments within the MOH will also benefit from technical assistance and capacity building.

E. Lessons learned and reflected in the project design

41. The RBF approach has been shown as an effective mechanism for improving the quality, availability and utilization of health services in several countries including Cameroon,[40] Burundi[41] and Nigeria, which are also facing humanitarian crises, and an influx of refugees.

42. Experiences from Burundi[42] and Benin[43] show that strong political will and country ownership are pre-requisites for the sustainability of an RBF program. In the absence of these elements, critical reforms will not be implemented, and national-level decisions needed to transform the RBF project into a sustainable national program will not be taken. Therefore, the design of the proposed AF2 places more emphasis on strengthening the RBF implementation capacity of stakeholders at the community, regional and national level. This should lead to broader and more effective participation and engagement of the population, greater empowerment of the implementing actors including the MOH, and greater country ownership of RBF as a financing strategy.

43. RBF is complex to design and implement, particularly in a fragility, conflict and violence setting. Therefore, it is prudent to implement RBF progressively, while learning and adjusting, using simple design that allows for flexibility.[44] The RBF system in Djibouti has been implemented gradually, with time taken to adapt the project design to the country context. RBF is currently better understood and widely adopted by the government, which will allow for a smooth implementation of the proposed AF2 activities.

44. In the context of weak national systems, providing parallel service delivery in refugee-hosting countries, as part of a humanitarian response, is unsustainable, inefficient and costly. A humanitarian response to forced displacement often includes the creation of parallel service delivery systems with little synergy with

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[40] De Walque, D; Robyn, PJ; Saidou, H; Sorgho, G; Steenland. 2017. "Looking into the Performance-Based Financing Black Box. Evidence from an Impact Evaluation in the Health Sector in Cameroon."
[41] Bonfrer, I; Soeters, R, van de Poel, E; Basenya, O; Longin, G; van de Looij, F; van Doorslaer, E. 2013. "The Effects of Performance-Based Financing on the Use and Quality of Health Care in Burundi: An Impact Evaluation."
[42] WBG (2018) The Republic of Burundi Health Sector Development Support Implementation, Implementation Completion and Results Report.
[43] WBG (2018). The Republic of Benin Health System Performance. Implementation, Implementation Completion and Results Report.
[44] WBG (2016). The Republic of Zambia Malaria Booster and Health Results-Based financing project. Implementation completion and results report.

mainstream government provisioning, often leading to duplication of infrastructure, low quality services, and poor outcomes for both refugees and host communities. It is also unsustainable over the medium and long term.

45. Experience from the Yemen Health and Population project shows that projects developed and implemented in a country undergoing a humanitarian crisis should focus on strengthening human resource management and ensuring the availability of critical medicines and equipment at the health facilities and referral centers.[45]

46. The “New Way of Working”[46] shows that strong partnership and dialogue between Government, Humanitarian and Development partners is critical for the development and delivery of a comprehensive and effective humanitarian response in the short term, and a smooth and sustainable humanitarian-to-development transition in the longer term.

F. Project implementation

47. The institutional arrangements for implementation, technical assistance and oversight arrangements will remain the same as for the parent project. The implementing agency is the MOH and its different technical departments and health facilities. The PIU is responsible for coordination of project activities, training, procurement, monitoring and reporting, financial management, and disbursement related functions. Responsibilities of the regional health facilities include maintaining a sub-account at the regional health facilities level to facilitate financial audits related to RBF funds and keeping track of the necessary technical information related to the project indicators to track progress and have the information needed to carry out the Project’s final assessment of achievement of project objectives.

48. To ensure adequate supervision of the RBF component (Component 1) of the Project, a Steering Committee (Comité de Pilotage) has been established, comprised of representatives of the Ministry of Economy and Finance, in charge of Industry and Planning (MEFIP) and the MOH, including the MOH directorates, as well as technical and financial partners of the MOH and civil society. This Committee is responsible for the general governance and overall coordination of RBF implementation including reviewing the technical aspects of the RBF indicators to be used in the disbursement of funds. Similar to the parent project, the PIU will contract: (i) independent verifiers who act as third-party verifiers of the fulfilment of the result-based financed activities by the health facilities under the RBF on a monthly basis; and (ii) an independent verification agency that conducts quarterly independent verification audits.

49. Health Management Committees (Comités de Gestion de Santé - COGESs). Health management committees established in the Regional Health Centers (Centre-medico Hospitalier) and the Committee Health Centers (Centre de sante communautaire) (Djibouti-Ville) adhere to the principle of efficient community participation in the planning, management and definition of community health needs. The COGES, as described by the

[45] WBG (2018) The Republic of Yemen’s Health and population project. Implementation completion and results report.
[46] The New Way of Working frames the work of development and humanitarian actors, along with national and local counterparts, in support of collective outcomes that reduce risk and vulnerability and serve as instalments towards achieving the SDGs. OCHA, et al (2017). New Way of Working. Source: https://www.unocha.org/story/new-way-working

existing decree, oversees the management of financial and material resources, including the pharmaceutical supply to the facilities, to ensure community participation. The COGESs constitute an integral element of the institutional arrangements. The MOH, through its Directorate of Health Regions (*Direction des Régions Sanitaires*), monitors the functionality of these structures throughout the project cycle in order to guarantee its sustainability.

III. KEY RISKS

50. The overall risk rating for the project remains **Substantial** with Institutional Capacity for Implementation and Sustainability risk and Political and Governance risk rated Substantial.

51. **Institutional Capacity for Implementation and Sustainability is Substantial.** It has been a long process for the government to adopt and implement the RBF mechanism. Mitigating factors are the MOH's strong commitment to the health sector agenda supported by the Project, the PIU's demonstrated capacity to fulfill the World Bank's fiduciary requirements, and the satisfactory progress in the implementation of the ongoing project. In addition, the concerted capacity building efforts on RBF at both the technical and policy levels, that will be part of AF2, will ensure continued ownership and future sustainability of the RBF mechanism. The implementation arrangements under the project and the proposed AF2 provide assurance that most of these risks are adequately mitigated.

52. **Political and governance risk is Substantial.** As noted earlier, the political commitment for supporting the refugees is strong. However, refugee movements and their impacts on host communities remain fluid. The uncertainty around the cessation of conflict and restoration of peace in Somalia and Yemen contribute to the protracted nature of the instability and to the changing case load of refugees. This uncertainty is mitigated by the project's support to all primary and secondary level health facilities, including those in refugee sites. These facilities located in both refugee sites and host communities can continue to ensure access to basic, life-saving health services to everyone irrespective of their legal status, thereby mitigating the negative health impacts of the refugee crisis.

53. **Other risk - Refugee protection – is Moderate.** The Government of Djibouti has a well-established, four-decade long history of welcoming and hosting refugees and has demonstrated a willingness to pursue a more comprehensive approach to the refugee situation. The Government is working towards refugee management policies that enhance the self-reliance of refugees while responding to the development needs of the hosting communities to mitigate the impact of the refugee presence on host communities to safeguard the asylum space, thereby preventing refugees from remaining in legal and humanitarian limbo. The Government of Djibouti has been providing refugee protection through legislative reforms and has embraced the CRRF. The WBG in consultation with UNHCR has determined that Djibouti adheres to a framework for protection of refugees. However, it will be important to continue monitoring the implementation of the Government's response to the refugee crisis given the fluid nature of refugee movements and the protracted instability in Yemen and Somalia to ensure that the response is adequate. This uncertainty will be mitigated by monitoring these factors during the implementation of the project so as to adjust the focus of the WBG's efforts in real

time (within the broader context of a country program) and ensure that Djibouti continues to adhere to the refugee protection framework.

IV. APPRAISAL SUMMARY

A. Economic Analysis

54. **The proposed AF2 will strengthen the development impact of the parent project by ensuring that displaced persons (current and incoming) and vulnerable host populations have sustainable and equitable access to high-impact, quality health and nutrition interventions.** The economic analysis conducted for the parent project remains relevant and the project remains economically justified. The new activities supported by the proposed AF2 will have a direct impact on the leading causes of Disability-adjusted Life Years in the country and will contribute to Djibouti's long-term development agenda by: (i) improving the survival of displaced persons and host populations, and reducing maternal and child mortality, and morbidities and mortalities related to communicable diseases, (ii) increasing household earnings, and saving unnecessary healthcare and social care costs; (iii) increasing productivity, labor supply, and human capital; (iv) improving health system efficiency; and (v) promoting equity and shared prosperity.

55. **Rationale for public sector financing**: This proposed AF2 will support activities that are in the public sector and are of a public good nature. The private sector has no incentives to finance any of these activities. In the absence of financing by the World Bank, the Government of Djibouti may not be able to finance these activities, and the country will continue to experience political and economic pressures from migrations. According to article 33 (refoulement) of the of the United Nations Human Rights Convention on the status of refugees (1951), the Government of Djibouti is responsible to ensure that refugees do not return to a territory where their lives or freedoms would be threatened. In accordance with the requirements of the Convention and Protocol, states often provide for services to migrants, namely those who are in the process of applying for asylum or have already secured refugee status. In theory, refugees often have access to the same services as the citizen of a country. These services include legal status support, health care, education and employment opportunities. The government plays a key role in the handling of a range of issues that can only (or predominantly) be accomplished or implemented through government actions. The main rationale warranting public action includes the incorporation of externalities or spillovers, redistribution, and social and political concerns related to host communities and refugees.

56. **Value added of WBG's support**: The WBG's support will allow the Government to reach its strategic objectives in the management of refugees and refugee hosting communities. The strategy involves the transition from the provision of humanitarian support to include refugees in a longer-term agenda of development and social protection. Underlying the transition is a potential reduction of humanitarian support by UN agencies, particularly UNHCR. It is in this context that the WBG is well placed to support such a transition, not only leveraging but also adding value to the foundational support provided to refugees and displaced populations by key humanitarian partners, including UNHCR, WFP, UNICEF, as well as national and international NGOs. The WBG financed project will also leverage its substantial experience and practice in several sectors related to forced displacement, governance, service delivery, and human development, and will pair with and

complement other projects in the WBG's portfolio in Djibouti, to cover the basic human development needs of refugees and hosting communities.

B. Technical

57. As the proposed AF2 will scale up the RBF approach of the parent project to health facilities in refugee camps, the technical design would remain the same as under the parent project. All health services that will be rolled out to refugees, asylum seekers, migrants and their host communities were informed by lessons on international best practices, including experiences in fragile and conflict affected states, as well as extensive discussions with Government counterparts during the preparation mission, and consultations with multi- and bi-lateral donors (including UNHCR), who have extensive experience implementing these types of programs.

C. Financial Management

58. The World Bank Financial Management (FM) team reviewed the financial management arrangement at the Ministry of Health, based on the result of the assessment, the FM risk, as a component of the fiduciary risk is rated as Moderate. The MOH will need to maintain the current FM arrangements under the ongoing Health Project in order to maintain the risk level at moderate.

59. The proposed AF2 will be implemented according to World Bank guidelines, using the implementation framework of the ongoing parent Project, and disbursement arrangements, and using the human resources of Project Implementing Unit (PIU).

60. The project activities will be mainstreamed through current PIU activities. The PIU has been performing well and has acquired solid capacity in fiduciary procedures applicable to Bank-financed projects. The FM rating for the ongoing parent project is Moderately Satisfactory. In view of the risks identified and the weaknesses observed, the overall financial management risk is deemed to be Moderate. The following are the risks identified: (i) delays in the submission of quarterly Interim Un-Audited Financial Reports (IFRs); and (ii) delays in the submission of the internal audit reports.

61. Staffing: The current PIU has a dedicated financial team to manage the FM aspects of the ongoing Health Project. This team will be utilized to implement the activities of the AF. The PIU performance has been satisfactory.

62. Internal control: The project is being implemented through a global POM which includes all implementation procedures of the parent project, in addition to an RBF specific manual which constitute a condition for disbursement for the RBF category. The RBF manual will be updated to include the activities under the AF2 and will be subject to World Bank clearance. General FM arrangements and execution following the POM and RBF manuals have been satisfactory.

63. An internal auditor has been recruited to support the efficiency and effectiveness of project operations. The internal audit reports are prepared on a quarterly basis. The second additional financing will follow the same arrangements and will be audited by the internal auditor with internal audit reports prepared and submitted on a quarterly basis.

64. Budgeting: The consolidated budget of the project is prepared with inputs from various departments and used as a managing tool to track progress and analyze variances. The PIU will prepare a budget plan and disbursements plan for each fiscal year related to the AF2 and will submit these plans for the World Bank's approval.

65. Project accounting system: The transactions will be registered in the accounting system under the control of the Financial and Administrative Manager. The project Financial Manager is responsible for preparing the IFRs before their transmission to the PIU director for approval. Periodic reconciliation between accounting statements and IFRs is also done by the Financial Officer.

66. The PIU will follow the same accounting principles adopted for the ongoing Health Project which will cover all sources and uses of project funds, including payments made and expenses incurred. All transactions related to the project will be entered into the cash-based accounting system.

67. An independent verification agency will be contracted to do the counter-verification of results on a quarterly basis and will provide regular reports ("Independent Verification Reports") containing, *inter alia*, said assessment on the fulfillment of the pertinent results and a proposal for disbursement under each Withdrawal.

68. Audit of the project financial statements: the ongoing project has been subject to yearly audit and all audit reports have been submitted on time with an unqualified "clean" auditor's opinion. An annual audit will also be required for the additional financing and will cover the financial transactions, internal control and financial management systems and will include a comprehensive review of SOEs. An external auditor will be appointed within three months of effectiveness of the additional financing according to Terms of Reference acceptable to the World Bank. The annual reports will be submitted to the World Bank within six months from the closure of each fiscal year.

Disbursements Arrangements

69. The project funds will be disbursed according to the World Bank guidelines to finance project activities. Project funds will be disbursed using advances to a designated account, direct payments, special commitments, and reimbursements for eligible expenditures accompanied by supporting documents or, for statements of expenditure for sums less than the predefined thresholds for each expenditure category, following the applicable procedures and the World Bank's Disbursement Handbook.

70. Designated Accounts (DA). To facilitate fund and disbursement management for eligible expenditures, two separate DAs in US Dollars will be opened at a commercial bank in Djibouti acceptable to the World Bank: one designated account, DA-A for Category 1 and DA-B for Category 2 and 3 will be opened. Advances from the project account will be transferred to the designated accounts to be used for the specific project expenditures. Payments of eligible expenses will be made through the designated accounts based on the instructions signed by the MOH, Ministry of Budget and the Ministry of Finance. The allocation of each category will be US$3,790,000 equivalent for the first category, US$2,085,000 equivalent for the second category, and US$125,000 equivalent for the third category. Each DA will be pooled between the Grant and the Credit since expenditures will be financed through a pari passu ratio mechanism. The PIU will be responsible for submitting monthly replenishment applications for DA-A and DA-B respectively with appropriate supporting

documentation.

Category	Amount Allocated in US$ equivalent	Percentage of Expenditures to be Financed (Inclusive of Taxes)
(1) Eligible Expenditure Payments to the Participating Health Care Providers under Part 1.A of the Project	3,790,000	100%
(2) Goods, non-consulting services, consultants' services, Training and Incremental Operating Costs under Parts 2 and 3 of the Project	2,085,000	100%
(3) Goods, non-consulting services, consultants' services and Incremental Operating Costs under Part I.B of the Project	125,000	100%
(4) Emergency Expenditures under Part 4 of the Project.		
Total	6,000,000	

71. **Withdrawals Conditions.** Disbursement conditions are listed in the legal condition section in this project paper.

D. Procurement

72. All goods, works , non-consulting and consulting services required for the Project and to be financed out of the proceeds of the Financing shall be procured in accordance with the requirements set forth or referred to in the "World Bank Procurement Regulations for Borrowers under Investment Project Financing" dated July 2016, revised in November 2017 and August 2018 ("Procurement Regulations"), and the provisions of the Procurement Plan. The Borrower shall ensure that the Project is carried out in accordance with the provisions of the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006 and revised in January 2011 and as of July 1, 2016 ("Anti-Corruption Guidelines").

73. As part of the project preparation, the client has prepared a project procurement strategy for development (PPSD) and submitted to the World Bank in early March 2019. Given the nature and less complexity of contracts envisioned in the additional financing, the client has used the short-form PPSD. The PIU was already trained in the preparation of PPSD and has its first experience with the PPSD for the recently approved project "Towards Zero Stunting in Djibouti".

74. The PPSD revealed that only 17 contracts in amount less than $900,000 will involve procurement. All these contracts are of small value and less complex to fit in the national market. A special attention would be required for procurement of the platform for the installation of a health information system, which represents the relatively biggest contract in value ($215,000) requiring a proper identification of technical needs and specifications.

E. Social (including Safeguards)

75. The proposed AF2 includes a geographical extension which will benefit new service providers and health service recipients. This is likely to provide an even playing field to enhancing access to health service across the country and will potentially reach more disadvantaged and economically marginalized groups, particularly displaced populations and traditional nomadic herders. The AF2 will not fund new types of activities, although it will extend its geographic coverage. New project areas will include: refugee camps in Holl Holl, Ali-Addeh and Obock; the pediatric ward at the Peltier Hospital in Djibouti-Ville; and remote areas covered by the mobile "Caravan" clinic.

76. The proposed AF2 will also extend activities by supporting mobile "Caravan" clinics, which provide specialized health services for refugees and host populations, as specified under component 1. The AF2 will not support construction or other activities that will lead to land acquisition and involuntary resettlement, therefore OP/BP 4.12 on Involuntary Resettlement was not triggered. Likewise, Djibouti has no population that would qualify as indigenous people, as defined by OP 4.10, the policy was therefore not triggered.

77. **Citizen engagement:** Stakeholder consultations were undertaken as part of the preparation of the Environmental and Social Impact Assessment. Consultations with medical staff and local authorities were held in Dikhil, Ali Sabieh (including the health post in the refugee camps), Obock, Tadjourah, and Arta. Focus groups were also conducted with civil society and local residents in Tadjourah, Demerjog, Obock and Arta. Their key concerns were related to the smoke emanations from the ongoing burning of the medical waste and the dangers of manipulating biomedical waste. The consultation process identified that residents tended to turn to the local community management committees (COGES in French) for questions or grievances. The COGES, which are composed of voluntary community member representatives, play the role of facilitators between the residents and health centers and are experienced in conducting consultations.

78. The project will put in place a consultation and community awareness campaign about child immunization services, maternal health, nutrition, HIV/AIDS and tuberculosis and risks related to medical waste manipulation. As part of RBF implementation, community-based associations will be contracted to authenticate community-based data declared by the health facilities and assess the population's degree of satisfaction in regard to service provision. The results will be shared with the contracted health facilities so as to improve the quality of health services at the facility level. In addition, a specific consultation process with the communities residing around the health centers where the new incinerators will be located will also be conducted. The awareness campaign and consultation process will use the local management committees for the resident engagement information and consultation campaigns and as a channel to receive grievances. The project will strengthen the

capacity of the COGES to disseminate information and gather concerns related to the project activities as well as put in place a grievance redress system that can be monitored and consolidated by the PIU.

F. Environment (including Safeguards)

79. The proposed AF2 is Scaling up component 1 (the RBF component) to health facilities in new areas of the refugee camps of Holl Holl, Ali-Addeh and Obock, and the pediatric ward of the Peltier Hospital in Djibouti-Ville and rolling out mobile "Caravan" clinics for provision of specialized health services for refugees and host populations, as well as funding incinerators in five health facilities at Dikhil, Tadjourah, Obock, and Arta regions (previously planned to be funded by the governmental part). These activities will generate environmental risks/impacts related essentially to medical waste management and Occupational and Community health and Safety.

80. An Environmental and Social Impact Assessment with a Medical Waste Management Plan has been produced for the parent project. This assessment has been updated to take in account the new areas covered by the proposed AF2 and the improved artisanal incinerators to be built in the five selected health facilities.

81. The proposed AF2, similar to the parent project, is still categorized as B. The impacts are site-specific, few (if any) are irreversible, and can be mitigated by implementing the ESMP and Medical waste Management Plan included in the updated Environmental and Social Assessment.

82. The draft updated ESIA was consulted with stakeholders, NGOs and local communities' representatives. The final version incorporating the consultation results was disclosed in the MOH and WBG websites on March 15, 2019. Paper versions of the updated ESIA will be made available to the beneficiary populations in the health structures involved in the project.

G. Climate Change Adaptation by Improved Health Outcome for Women and Children

83. Climate change and its impact can jeopardize the WBG's mission in Djibouti and thus directly affect the efforts made under this project and any other activities in the country. Djibouti is highly vulnerable to four types of natural disasters: coastal flooding exacerbated by sea level rise; extreme heat; wildfires; and volcanos. In addition, it is also prone to drought. These threats to economic development and poverty alleviation, which are already probable, will grow in frequency and severity as temperatures increase, precipitation shifts, and sea levels rise. Low income populations, especially the 23 percent of Djiboutians who live below the national poverty line (2014), are particularly vulnerable, as they lack the capacity to adapt to climate-induced shocks. As extreme weather disrupts them, they will disrupt society. Most of all, Djibouti, like the rest of the Middle East and North Africa region, suffers from water insecurity. As highlighted in "Beyond Scarcity: Water Security in the Middle East and North Africa",[47] water shortages will reduce Middle East and North Africa region's GDP growth by 6 percent to 14 percent by 2050. Climate change, in short, will exacerbate these pre-existing vulnerabilities, and amplify fragility.

[47] https://www.worldbank.org/en/topic/water/publication/beyond-scarcity-water-security-in-the-middle-east-and-north-africa

84. Djibouti's Nationally Determined Contribution (2016) recognizes the challenge of climate change and calls for an ambitious response, including US$6.5 billion in adaptation and mitigation funding. Djibouti's Country Partnership Strategy, 2014-2017, notes the nation's extreme vulnerability to climate change, lack of resilience capacity, and suggests projects in disaster risk management.

85. This operation has been screened for short- and long-term climate change and disaster risks. In addition, extreme temperature and drought have been identified as having high potential for impact on project implementation. Such climate change effects will negatively impact health outcomes especially for women and children living in poverty. People's livelihoods and lifestyles are affected through different pathways. The last major drought claimed nearly four percent of GDP annually between 2008 and 2011 and impacted more than half of Djibouti's population. In the short term, the impacts of extreme weather events contribute to injuries, household food insecurity, disease and disability, increased population displacement, and insecurity.

86. Climate change can exacerbate ill health among children and women. It is therefore the intent of the project to address climate change and disaster risk considerations in its design to further enhance the efforts to adapt to Climate Change. Poor health weakens people's resilience to, and ability to, adapt to climatic shocks. In summary, climate change can worsen health outcomes through two main causal pathways: (i) Impacts environmental health and access to health services; and (ii) Impacts on household access to sufficient, safe, and adequate food.

87. The project aims to contribute directly to reducing risks to health outcomes due to climate change through several interventions. Through the parent project, five primary level health facilities have been converted to secondary level polyclinics making more services available to those in urban areas with high level of poverty, who would otherwise have to go to a tertiary level hospital further away to seek care not available at a primary care facility. Furthermore, the proposed AF2 supports additional health facilities in refugee sites as well as mobile "caravan" clinics which offer specialized care to refugees and host populations in rural areas. By enabling access to more health services close to home especially for mothers and children living in poverty, the project contributes to helping the beneficiaries and caregivers adapt to any change in the morbidity pattern. Also, the additional financing will support activities related to preparatory work for the country to adopt the DHIS2. Such a system will facilitate the detection of any increase or change in a disease pattern related to climate change (e.g., increase in heat exhaustion or communicable disease cases) at an early stage for the government to respond in a timely manner.

V. WORLD BANK GRIEVANCE REDRESS

88. Communities and individuals who believe that they are adversely affected by a WBG supported project may submit complaints to existing project-level grievance redress mechanisms or the WBG's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns. Project affected communities and individuals may submit their complaint to the WBG's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WBG non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought

directly to the WBG's attention, and WBG Management has been given an opportunity to respond. For information on how to submit complaints to the WBG's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the WBG's Inspection Panel, please visit http://www.inspectionpanel.org

VI. SUMMARY TABLE OF CHANGES

	Changed	Not Changed
Project's Development Objectives	✓	
Results Framework	✓	
Components and Cost	✓	
Loan Closing Date(s)	✓	
Procurement	✓	
Implementing Agency		✓
Cancellations Proposed		✓
Reallocation between Disbursement Categories		✓
Disbursements Arrangements		✓
Safeguard Policies Triggered		✓
EA category		✓
Legal Covenants		✓
Institutional Arrangements		✓
Financial Management		✓
APA Reliance		✓
Other Change(s)		✓

VII. DETAILED CHANGE(S)

PROJECT DEVELOPMENT OBJECTIVE

Current PDO

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

Proposed New PDO

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

COMPONENTS

Current Component Name	Current Cost (US$, millions)	Action	Proposed Component Name	Proposed Cost (US$, millions)
Improving health services delivery performance	8.85	Revised	Improving health services delivery performance	12.77
Strengthening health system management	0.80	Revised	Strengthening health system management	1.54
Strengthening program management and monitoring and evaluation capacity	4.35	Revised	Strengthening program management and monitoring and evaluation capacity	5.69
	0.00	New	Contingent Emergency Response Component (CERC)	0.00
TOTAL	**14.00**			**20.00**

LOAN CLOSING DATE(S)

Ln/Cr/Tf	Status	Original Closing	Current Closing(s)	Proposed Closing	Proposed Deadline for Withdrawal Applications
IDA-52160	Effective	31-Dec-2018	30-Apr-2019	31-Dec-2020	30-Apr-2021
TF-19258	Effective	31-Dec-2018	30-Apr-2019	31-Dec-2020	30-Apr-2021

Expected Disbursements (in US$)

Fiscal Year	Annual	Cumulative
2013	0.00	0.00
2014	704,572.98	704,572.98
2015	1,344,873.00	2,049,445.98
2016	2,305,769.37	4,355,215.35
2017	2,255,919.89	6,611,135.24

2018	2,999,383.13	9,610,518.37
2019	3,689,481.63	13,300,000.00
2020	4,500,000.00	17,800,000.00
2021	2,200,000.00	20,000,000.00

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Latest ISR Rating	Current Rating
Political and Governance	Moderate	Substantial
Macroeconomic	Moderate	Moderate
Sector Strategies and Policies	Low	Low
Technical Design of Project or Program	Moderate	Moderate
Institutional Capacity for Implementation and Sustainability	Substantial	Substantial
Fiduciary	Moderate	Moderate
Environment and Social	Moderate	Moderate
Stakeholders	Moderate	Moderate
Other		Moderate
Overall	Substantial	Substantial

LEGAL COVENANTS – Improving Health Sector Performance Project Second Additional Financing (P168250)

Sections and Description
Section I.A.6 of Schedule 2: The Recipient shall not later than three (3) months after the Effective Date, recruit, and thereafter maintain during the implementation of the Project, an external auditor for the Project, with qualifications, experience and terms ofreference satisfactory to the Association.

Conditions

Type	Description
Disbursement	Under Categories (1) and (2), unless and until, the amount allocated for the equivalent category, respectively, under the Original Financing Agreement and the Grant Agreement have been disbursed or committed in full; Under Category (4), unless and until the Association is satisfied, and has notified the Recipient of its satisfaction, that all of the following conditions have been

	met in respect of said expenditures: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include the proposed activities in the Emergency Response Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has ensured that all Safeguard Instruments required for said activities have been prepared and disclosed, and the Recipient has ensured that any actions which are required to be taken under said instruments in advance of said activities have been implemented; (iii) the entities in charge of coordinating and implementing the Emergency Response Part have adequate staff and resources, in accordance with the provisions of section I.E of this Schedule, for the purposes of said activities; and (iv) the Recipient has adopted the CER Manual, in form and substance acceptable to the Association, and the provisions of the CER Manual remain - or have been updated in accordance with the provisions of section I.E of this Schedule so as to be - appropriate for the inclusion and implementation of the Emergency Response Part.
Type Effectiveness	Description The Association is satisfied that the Recipient has an adequate refugee protection framework.

VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Djibouti
Improving Health Sector Performance Project Second Additional Financing

Project Development Objective(s)

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

Project Development Objective Indicators by Objectives/ Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
To improve the utilization of maternal and child health services ***(Action: This Objective has been Revised)***									
Number of women completing 2 or more prenatal visits (Number)		6,100.00	6,710.00	19,129.00	34,927.00	54,214.00	77,100.00	85,000.00	95,700.00
Action: This indicator has been Revised	***Rationale:*** ***The Indicator was renamed from "number of women receiving prenatal visits 2-4". End target was revised to reflect the additional funding and extended period of implementation.***								
Percentage of children fully immunized before their first birthday (Percentage)		32.00	33.50	37.80	42.80	47.80	51.50	70.00	85.00
Action: This indicator has been Revised	***Rationale:*** ***End target was revised to reflect the additional funding and extended period of implementation. The data used to be collected for project-funded primary health facilities, but given that immunization has often been taking place outside of those facilities, national data has been reported since 2017 to capture the***								

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
	coverage.								
Number of HIV positive pregnant women receiving treatment according to protocol (Number)		63.00	150.00	200.00	250.00	275.00	300.00		1,175.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***The number of HIV positive pregnant women has been smaller than previously estimated. The relevant services will be continued, and this will be reclassified as an intermediate result indicator.***								
Quality health care services *(Action: This Objective has been Revised)*									
Average facility quality (Percentage)		29.00	35.00	40.00	45.00	50.00	55.00	60.00	65.00
Action: This indicator has been Revised	***Rationale:*** ***The end target has been revised from 55% to 65%.***								

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
Improving health services delivery performance									
Number of WCBA visiting the public system to obtain modern family		7,304.00	10,000.00	15,000.00	20,000.00	25,000.00	90,000.00	115,000.00	130,000.00

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
planning (oral contraceptives and injections) (Number)									
Action: This indicator has been Revised	***Rationale:*** ***End target was revised to reflect the additional funding and extended period of implementation.***								
Pregnant/lactating women, adolescent girls and/or children under age five-reached by basic nutrition services (number) (Number)		7,117.00	10,000.00	20,000.00	30,000.00	40,000.00	50,000.00		150,000.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***This data will be captured as a sub-indicator of the Corporate Results Indicator.***								
Pregnant/lactating women, adolescent girls and/or children under age five-reached by basic nutrition services – Others (specify) (Number)		7,117.00							150,000.00
Action: This indicator has been Marked for Deletion									
Number of women giving birth in a contracted facility assisted by qualified personnel (Number)		1,026.00	1,245.00	3,356.00	5,844.00	7,305.00	7,775.00		25,525.00

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
Action: This indicator has been Marked for Deletion	***Rationale:*** ***This data will be captured as a sub-indicator of the Corporate Results Indicator***								
People receiving tuberculosis treatment in accordance with the WHO-recommended "Directly Observed Treatment Strategy" (DOTS) (Number)		300.00	325.00	700.00	1,125.00	1,600.00	2,100.00	2,500.00	2,800.00
Action: This indicator has been Revised	***Rationale:*** ***End target was revised to reflect the additional funding and extended period of implementation.***								
Direct project beneficiaries (Number)		0.00	50,000.00	100,000.00	160,000.00	215,000.00	300,000.00		825,000.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***The number of consultations instead of the number of beneficiaries was previously captured due to the difficulty in counting beneficiaries only once. This indicator is replaced by the Corporate Results Indictator.***								
Female beneficiaries (Percentage)		0.00							65.00
Action: This indicator has been Marked for Deletion									
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00					143,000.00	198,000.00	250,525.00

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
Action: This indicator has been Revised	***Rationale:*** ***The end target is revised to reflect the additional financing and extended project duration***								
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	6,245.00	15,371.00	26,470.00	39,794.00	81,500.00	114,000.00	143,025.00
Action: This indicator has been Revised	***Rationale:*** ***Intermediate targets are entered.***								
Number of children immunized (CRI, Number)		0.00	0.00	4,030.00	11,252.00	19,588.00	28,000.00	38,000.00	45,000.00
Action: This indicator has been Revised	***Rationale:*** ***The indicator was introduced as part of the CRI in December 2018. This captures children immunized at health facilities supported through the RBF component.***								
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	10,000.00	20,000.00	30,000.00	40,000.00	95,000.00	130,000.00	170,000.00
Action: This indicator has been Revised	***Rationale:*** ***Only children under 5 are captured. The end target has been revised.***								
Number of deliveries attended by skilled health personnel (CRI,		0.00	1,245.00	3,356.00	5,844.00	10,000.00	20,000.00	30,000.00	35,525.00

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
Number)									
Action: This indicator has been Revised	***Rationale:*** ***The data have been captured for the indicator "number of women giving birth in a contracted facility assisted by qualified personnel", which is now captured under the Corporate Results Indicator. End target is revised.***								
Number of HIV positive pregnant women receiving treatment according to protocol (Number)		63.00	150.00	200.00	250.00	275.00	300.00	375.00	400.00
Action: This indicator is New	***Rationale:*** ***The number of HIV positive pregnant women has been smaller than previously estimated. The relevant service will continue to be supported, and this indicator is reclassified as an intermediate results indicator.***								
Number of displaced persons (refugees, asylum seekers and migrants) receiving services at health facilities (Number (Thousand))		0.00	0.00	0.00	0.00	0.00	0.00	18,000.00	35,734.00
Action: This indicator is New	***Rationale:*** ***The project beneficiaries always included refugees and other displaced persons living in host communities, but the data specific to this population were not collected before. Since this is a new indicator, intermediate targets for the past years are not entered.***								
Percentage of pregnant women receiving at least two doses of tetanus toxoid (TT2) (Percentage)		20.00	25.00	30.00	35.00	40.00	45.00	50.00	55.00

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
Action: This indicator has been Revised	***Rationale:*** ***The end target is revised reflecting the additional financing and extended project duration.***								
Strengthening health system management									
Community survey conducted and results shared with contracted facilities (Yes/No)		No	No	No	No	No	No	Yes	Yes
Action: This indicator is New									
Number of health care providers trained on DHIS2 (Number)		0.00	0.00	0.00	0.00	0.00	0.00	250.00	312.00
Action: This indicator is New	***Rationale:*** ***Since this is a new indicator, intermediate targets for the past years are not entered.***								
Strengthening project management and monitoring and evaluation capacity ***(Action: This Component has been Revised)***									
Number of new curative care visits per person per year in the public system (Number)		0.15	0.18	0.29	0.39	0.46	0.52	0.57	0.65
Action: This indicator has been Revised	***Rationale:*** ***The end target is revised reflecting the additional resources and extended project duration.***								
Percentage of beneficiaries satisfied with health services (Percentage)		0.00	0.00	0.00	0.00	0.00	0.00	50.00	60.00

Indicator Name	DLI	Baseline	Intermediate Targets						End Target
			1	2	3	4	5	6	
Action: This indicator is New	***Rationale:*** ***Since this is a new indicator, intermediate targets for the past years are not entered.***								

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of women completing 2 or more prenatal visits	The target values presented are cumulative targets - the yearly targets are 6,710 (Y1), 12,419 (Y2), 15,798 (Y3), 19,287 (Y4), 22,886 (Y5) and 18,600 (Y6). The cumulative end target is 95,700.	Monthly (every 3 months for independen t verification)	MOH / RBF Health Information System (HIS)	Routinely collected data	MOH
Percentage of children fully immunized before their first birthday	Routine vaccination excluding vaccination campaigns	Yearly	MOH / HIS	Routinely collected data	MOH DIS
Number of HIV positive pregnant women receiving treatment according to protocol		MOH	MOH/PBF HIS		Monthly (independent verification every 3 months)
Average facility quality	For different levels of care, there are different sets of criteria to measure quality (availability of services, hygiene practices, data	Every 3 months following independen t verification	MOH/PBF Health Information System	Facilities visits to assess which quality criteria are met	MOH

	management, etc.). Each facility is rated on the extent to which criteria are met.				

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of WCBA visiting the public system to obtain modern family planning (oral contraceptives and injections)	The number of women of child bearing age who visit a health facility supported by the project and receive modern family planning commodities.	Monthly (every 3 months for independe nt verification)	MOH/PBF HIS	Routinely collected data	MOH
Pregnant/lactating women, adolescent girls and/or children under age five- reached by basic nutrition services (number)	This indicator includes total beneficiaries reached by any of the following services: direct feeding programs; programs promoting appropriate infant and young child feeding; nutrition programs for adolescent girls; provision of micronutrient supplements to pregnant/lactating women and children under five; food fortification;	MOH	MOH/PBF HIS		Monthly (independent verification every 3 months)

	deworming; monitoring of nutritional status; nutrition and food hygiene education; nutrition components of early childhood development programs, home gardens and small livestock production for improved dietary diversity; targeted emergency food aid and treatment of severe acute and moderate acute malnutrition.				
Pregnant/lactating women, adolescent girls and/or children under age five- reached by basic nutrition services – Others (specify)	This indicator would measure any other nutrition services that are not captured in the four choices above, including those services that target prevention and treatment of overweight or obesity. A description of the type of nutrition services reported on is required and should be entered under the comments in the ISR when reporting on the indicator.				
Number of women giving birth in a contracted facility assisted by qualified personnel					

People receiving tuberculosis treatment in accordance with the WHO-recommended "Directly Observed Treatment Strategy" (DOTS)	This indicator applies to IDA operations only. This indicator measures the cumulative number of people with tuberculosis receiving the national program-recommended treatment following WHO norms, in accordance with the DOTS strategy through a Bank-financed project. This includes people who are starting treatment and/or continuing previous treatment at the end of 12 months.	Monthly (every 3 months for independe nt verification)	MOH/RBF HIS	Routinely collected data	MOH
Direct project beneficiaries	Direct beneficiaries are people or groups who directly derive benefits from an intervention (i.e., children who benefit from an immunization program; families that have a new piped water connection). Please note that this indicator requires supplemental information. Supplemental Value: Female beneficiaries (percentage). Based on the assessment and definition of direct project	MOH	Health facilities		Monthly

	beneficiaries, specify what proportion of the direct project beneficiaries are female. This indicator is calculated as a percentage.				
Female beneficiaries	Based on the assessment and definition of direct project beneficiaries, specify what percentage of the beneficiaries are female.				
People who have received essential health, nutrition, and population (HNP) services		Bi-annual	MOH/RBF HIS	Routinely collected data	MOH
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Bi-annual	MOH /RBF HIS	Routinely collected data	MOH
Number of children immunized		Yearly	MOH/RBF HIS	Routinely collected data. Children immunized at a facility supported by the project; excludes immunization campaigns.	MOH
Number of women and children who have received basic nutrition services		Monthly (every 3 months for independent verification)	MOH /RBF HIS	Routinely collected data from facilities supported by the project	MOH

Number of deliveries attended by skilled health personnel		Monthly (every 3 months for independe nt verification)	MOH /RBF HIS	Routinely collected data from facilities supported by the project	MOH
Number of HIV positive pregnant women receiving treatment according to protocol	The number of pregnant women diagnosed with HIV and received mother-to-child transmission prevention treatment	Monthly (every 3 months for independe nt verification)	MOH / RBF HIS	Routinely collected data from health facilities supported by the project	MOH
Number of displaced persons (refugees, asylum seekers and migrants) receiving services at health facilities	Patients who receive care at health facilities supported by the project and identify themselves as non-Djiboutians	Biannual	MOH / RBF HIS	Data to be collected from health facilities supported by the project	MOH
Percentage of pregnant women receiving at least two doses of tetanus toxoid (TT2)	Percentage of pregnant women who receive at least two doses of tetanus toxoid during pregnancy; receiving at least two doses is considered effective.	Yearly	MOH/HIS/ DSME	Routinely collected data	MOH
Community survey conducted and results shared with contracted facilities	Community groups are engaged to collect feedback on the health	Yearly	MOH/PIU	Community groups to be engaged to conduct a survey	MOH

	services that the community members recently received. The results will be shared with health facilities.				
Number of health care providers trained on DHIS2	Trainees will include central and district level health officers as well as different cadres of health care providers.	Yearly	MOH/DIS	Department of Health Information to report the number of trainees	MOH
Number of new curative care visits per person per year in the public system	Total number of new curative visits per year divided by the catchment area population	Yearly	MOH/HIS	Routinely collected data	MOH
Percentage of beneficiaries satisfied with health services	Patient feedback on the services they recently received at a health facility supported by the project	Yearly	MOH/RBF HIS	Data to be collected from health facilities supported by the project	MOH