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Report No: 94188-DJ

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL FINANCING

IN THE AMOUNT OF US$7 MILLION
FUNDED FROM HEALTH RESULTS INNOVATION TRUST FUND

TO THE

REPUBLIC OF DJIBOUTI

FOR THE

IMPROVING HEALTH SECTOR PERFORMANCE PROJECT

April 8, 2015

Health, Nutrition and Population Global Practice
Middle East and North Africa

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2015)

1 USD = 178 FDJ

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADDS	Djiboutian Agency for Social Development *(Agence Djiboutienne pour le Développement Social)*
CAMME	Drug Fund *(Centrale d'Achat des Médicaments et Matériels Essentiels)*
CAS	Country Assistance Strategy
CAP	Purchasing Unit (*Cellule d'achat de Performance*)
CMH	Regional Health Centers (*Centres medico-hospitaliers)*
COGES	Health Management Committees (*Comités de Gestion de Santé*)
COSAN	Health Committee *(Comité de santé)*
CREN	Centers for Recovery and Nutrition Education
CSC	Community Health Centers (*Centres de Santé Communautaire*)
DEPCI	*Direction des Etudes, Planification et Coopération Internationale*
DISED	National Statistics Office (*Direction Statistique de Djibouti*)
DOTS	Directly Observed Treatment Short-course
DPS	Heath Promotion Directorate *(Direction de la Promotion de la Santé)*
DRHF	Directorate of Human and Financial Resources *(Direction des Ressources Humaines et Financières)*
DRS	Regional Health Directorates *(Direction des Régions Sanitaires)*
DSME	Directorate of Maternal and Infant Health (*Direction de Santé Maternelle et Infantile)*
EEP	Eligible Expenditure Payments
EIA	Environmental Impact Assessment
EMP	Environmental Management Plan
FDI	Foreign Direct Investment
HRITF	Health Results Innovation Trust Fund
HSDP	Health Sector Development Project
IGSS	Inspectorate General of Health Services (*Inspection Générale des Services de Santé)*
IFR	Interim Financial Report
IMCI	Integrated Management of Childhood Illnesses
INDS	National Initiative for Social Development (*Initiative Nationale de Développement Social*)
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goal
MEFIP	Ministry of Economy and Finance, in charge of Industry and Planning
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
PAPSS	*Projet d'Amélioration de la Performance du Secteur de la Santé*
PBF	Performance Based Financing

POM	Project Operational Manual
PAPFAM	Pan Arab Project for Family Health
PEV	Expanded Programme for Immunization *(Programme Elargi de Vaccination)*
PFS	Project Financial Statements
PIU	Project Implementation Unit
PNDS	National Health Development Plan (*Plan National de Développement de la Santé)*
PRSP	Poverty Reduction Strategy Paper
RBF	Results-Based Financing
SIS	Health Information System *(Système d'Informations Sanitaires)*
SOE	Statement of Expenditure
STI	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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DJIBOUTI

HEALTH HRITF PROJECT

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HEALTH HRITF PROJECT

ADDITIONAL FINANCING DATA SHEET

Basic Information - Additional Financing (AF)	
Acting Country Director: Poonam Gupta Practice Manager/Senior Global Practice Director: Enis Barış/Timothy Evans Team Leader: Emre Özaltın Project ID: P152705 Expected Effectiveness Date: June 30, 2015 Lending Instrument: IPF Additional Financing Type: Scale up	Sectors: Health (100%) Themes: Health system performance (40%), Child health (25%), Population and reproductive health (25%), HIV/AIDS (5%), Other communicable dis eases (5%) Environmental category: B Expected Closing Date: December 31, 2018 Joint IFC: No Joint Level:
Basic Information - Original Project	
Project ID: P131194 Project Name: Improving Health Sector Performance Joint Level: No Lending Instrument: Investment Project Financing	Environmental category: B Expected Closing Date: December 31, 2018 Joint IFC: No Fragility or Capacity Constraints [ ] Financial Intermediary [ ] Series of Projects [ ]
AF Project Financing Data	
[ ] Loan [ ] Credit [X] Grant [ ] Guarantee [ ] Other: Proposed terms:	
AF Financing Plan (US$m)	
Source	**Total Amount (US $m)**
Total Project Cost: Cofinancing: Borrower: Total Bank Financing: IBRD IDA HRITF Grant New Recommitted	**7** **7** 7
Client Information	

Recipient: Ministry of Finance
Responsible Agency: Ministry of Health
Contact Person: H.E. Dr Kassim Issak Osman
Telephone No.: 253-21356300
Fax No.:
Email:

AF Estimated Disbursements (Bank FY/US$m)

FY	2015	2016	2017	2018		
Annual	1	1	2.8	2.2		
Cumulative	1	2	4.8	7		

Project Development Objective and Description

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

Revised project development objective: to improve the utilization of quality health care services for maternal and child health and communicable disease control programs (HIV/AIDS and tuberculosis). The revised PDO will be applicable to the original IDA Credit as well.

Project description: Component 1: Improving health service delivery performance. This component supports the delivery of improvements in: (i) child health services such as immunization, Integrated Management of Childhood Illnesses (IMCI), and treatment of malnutrition; (ii) maternal child health services such as prenatal care, family planning, skilled-attended delivery, and emergency obstetric care; and (iii) prevention and treatment services of HIV/AIDS and other prevalent communicable diseases. (Component 1 of the original Project as well as the additional financing is amended to exclude malaria.) Component 2: Strengthening health system management. This component supports activities aimed at strengthening the management capacity of the Ministry of Health (MOH) and improving the performance of the different health systems in support of health services. Component 3: Strengthening project management and monitoring and evaluation capacity. This component supports the Project Implementation Unit (PIU) in managing project activities and fiduciary functions, including financial management, procurement, and environment. Component 2 exists in the original project but not in the additional financing. For the purposes of the additional financing, and hereafter in this document, Component 1 is referred to as Component A and Component 3 is referred to as Component B.

Safeguard and Exception to Policies

Safeguard policies triggered:	
Environmental Assessment (OP/BP 4.01)	[X]Yes [ ] No
Natural Habitats (OP/BP 4.04)	[ ]Yes [X] No
Forests (OP/BP 4.36)	[ ]Yes [X] No
Pest Management (OP 4.09)	[ ]Yes [X] No
Physical Cultural Resources (OP/BP 4.11)	[ ]Yes [X] No
Indigenous Peoples (OP/BP 4.10)	[ ]Yes [X] No
Involuntary Resettlement (OP/BP 4.12)	[ ]Yes [X] No
Safety of Dams (OP/BP 4.37)	[ ]Yes [X] No
Projects on International Waterways (OP/BP 7.50)	[ ]Yes [X] No
Projects in Disputed Areas (OP/BP 7.60)	[ ]Yes [X] No

Is approval of any policy waiver sought from the Board (or MD if RETF operation is RVP approved)? Has this been endorsed by Bank Management? (*Only applies to Board approved operations*) Does the project require any exception to Bank policy? Has this been approved by Bank Management?	[ ]Yes [X] No [ ]Yes [ ] No [ ]Yes [X] No [ ]Yes [ ] No

Conditions and Legal Covenants:		
Financing Agreement Reference	Description of Condition/Covenant	Date Due
Article IV, 4.01 (a)	The execution and delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action;	By effectiveness
Article IV, 4.01 (b)	The Project Steering Committee (PSC) has been established with a composition and terms of reference acceptable to the Association.	By effectiveness
Schedule 2, Section II.B.4	The Recipient shall recruit an external auditor whose qualifications, experience and terms of reference shall be acceptable to the Association.	Not later than two (2) months after Effective Date
Schedule 2, Section I.F.1(a)	The Recipient shall appoint external monitoring and evaluation experts ("Independent Verifiers"), to act as third-party verifiers of the proper fulfillment of the DLIs set forth in RBF Manual and the respective Participating Health Care Provider Agreement.	Not later than one (1) month after the Effective Date
Schedule 2, Section I.F.1(b)	The Recipient shall cause the Independent Verifiers to carry out, prior to each Withdrawal, an assessment of the level of fulfillment of DLIs set forth in RBF Manual and the respective Participating Health Care Provider Agreement, and provide to the Recipient and the World Bank, an Independent Verification Report containing, *inter alia*, said assessment on the fulfillment of the pertinent DLIs and a proposal for disbursement under each Withdrawal.	Every calendar trimester starting six (6) months after the Effective Date

Schedule 2, Section IV.B.1	No withdrawal shall be made for payments made under Category (1) unless (i) the MoH has adopted the RBF Manual in a manner satisfactory to the Association; (ii) the relevant EEP Spending and Assessment Report has been submitted to, and found satisfactory by, the Association in accordance with the Independent Verification Reports; and (iii) any applicable Disbursement-Linked Indicators as set forth in the RBF Manual and the respective Participating Health Care Provider Agreement have been met by the Recipient satisfactory to the World Bank.	Before first disbursement and every calendar trimester starting six (6) months after the Effective Date

I. Introduction

1. This Project Paper seeks the approval of the MNA RVP of an Additional Financing (AF) Grant in the amount of US$7 million funded from the Multi-Donor Trust Fund for Health Results and Innovation Trust Fund (HRITF).

2. The PAPSS is a five-year Performance-based Financing (PBF) project. The Project was conceived to cover all existing basic health institutions at the primary level in Djibouti-ville, and through a phased approach to cover all institutions at the primary and secondary level in the five regions. The original Project, which became effective on July 11, 2013, is funded from IDA for US$7 million equivalent and has been in the 'pilot' phase since June 2014. The proposed AF includes revisions to the Results Framework. The Project's closing date remains unchanged.

3. All existing primary public health facilities in Djibouti-ville and primary and secondary public health facilities in two regions (Tadjourah and Ali- Sabieh) are contracted through a public purchaser approach and remunerated based on indicators related to delivery of health services (see Annex 3). The contracts are between the Project Implementing Unit (PIU) and the health facility or, in the case of health posts (PS), between the regional hospital (CMH) and the PS.[1] After preparing a business plan that is ratified by the PIU, contracted facilities are given an initial investment amount. Thereafter, contracted indicators are verified monthly by the *Cellule d'Achat de Performance* (CAP) (Performance Purchasing Unit). A system for counter-verification through surveying of a subsample of those receiving care is implemented by local organizations. A trimestral validation study is undertaken by a third-party autonomous agency. Finally, a trimestral quality study is undertaken by a team from the PIU and MoH. Equity is addressed through differential pricing of indicators (with a higher coefficient given for rural and remote areas) and through an indicator which directly remunerates health services delivered to the poor (see Annex 3).

4. In Djibouti-ville, 13 public health centers (CSC) are contracted, while in the two regions 18 health facilities are contracted: 16 health posts (PS) and the two regional hospitals (CMH). This initial phase of the PBF project covers 80 percent of the population of Djibouti (709,523 out of 891,810 in 2014). Tables 1 and 2 summarize select health indicators for Djibouti.

Table 1. Population, MCH and Nutrition Indicators by Region

	Region						
	Ali Sabieh	Arta	Dikhil	Obock	Tadjourah	Djibouti ville	**National**
Population	70,562	43,651	41,389	41,389	73,636	519,663	**846,147**
Skilled Birth Attendance (%)	75.9	63.7	78.2	60.8	56.5	98.8	**87.4**
Female Genital Mutilation (%)	70.1	69.2	75.9	94.7	85.3	78.5	**78.4**
Antenatal care (4+ visits)	10.7	8.4	22.7	17.6	16.6	26.5	**22.6**
Postnatal care (%)	66.4	60.2	78.2	68.8	50.6	78.7	**54.4**
Underweight (% children <5)	29.6	35.8	34.7	45.2	41.4	25.4	**29.8**

[1] All contracts will be between the PIU and health facility, including health posts, under the AF.

Stunting (% children <5)	35.8	34.2	36.6	44.4	44.6	29.8	**33.5**
Wasting (% children <5)	22.7	32.8	24.5	30.3	23.2	18.8	**21.5**

Source: EDSF/PAPFAM 2012

Table 2. Select Health Indicators by urban/rural

Indicator	Urban	Rural	National
Maternal Mortality Ratio (per 100,000 live births)	-	-	383
Child Mortality (per 1,000 live births)	69	64	68
Infant Mortality (per 1,000 live births)	59	56	58
Neonatal Mortality (per 1,000 live births)	35	40	36
HIV prevalence (%)	-	-	1.4
Tuberculosis prevalence (%)	-	-	1.0
Malaria prevalence (%)	-	-	0.0
Children under five fully vaccinated (%)			35.0
Average household size	6	5	5.8
Electricity (%)	68.5	7.2	55.9
Chronic condition (%)	3.3	3.9	3.4
Contraceptive prevalence	21.4	10.3	19.0

Source: EDSF/PAPFAM 2012

5. The project's original development objective was to improve the utilization of quality health care services for maternal and child health and communicable disease control programs (HIV/AIDS, tuberculosis and malaria). However, during the one year between project effectiveness and contract signing, it was decided that malaria was no longer a priority and, as a result, malaria was not a contracted indicator and no data on malaria has been collected to date. The purpose of the AF is to (1) close the funding gap necessary to introduce methodological adjustments and (2) to scale up the PBF component to expand the project to all geographical areas of the country. The AF will be used to update and improve implementation by a) revising the incentives currently used to encourage health facilities to improve performance; b) introducing the quality adjustment component; c) integrating incentives for management at the PIU; d) piloting facility autonomy in managing drug revolving funds to improve the drug supply; and e) improving coaching and accompaniment for health facilities. The AF will additionally formalize links with the World Bank-financed Social Safety Net Project (Cr. H7790) by facilitating subcontracting between health facilities and community peer educators. For the national scale-up, in addition to Djibouti-ville, Ali-Sabieh and Tadjourah, the AF proposes to expand the PBF to include health facilities in Arta, Dikhil and Obock. The closing date of the original project is December 31, 2018; the AF will have the same closing date.

II. Background and Rationale for Additional Financing in the amount of US$7 million

6. The modified and scaled-up activities are fully consistent with little substantive departures from the original, approved, project. The activities to be supported through the AF are consistent with the current PDO which remains highly relevant. They are consistent with the country's Vision 2035, which includes the consolidation of human capital as one of its four pillars and which aims to reduce

extreme poverty and build the foundations for shared growth by harnessing the country's human and economic potential, and the World Bank Group's Country Partnership Strategy for Djibouti FY2014-2017 (Report 83874-DJ), directly supporting the first pillar of the strategy: reducing vulnerability. The activities are also fully aligned with MNA's Health, Nutrition and Population Strategy (2013-18), focusing on fairness and accountability of the health system. The Project is also aligned with MENA's Regional Strategy, supporting the pillar on ensuring social and economic inclusion.

7. The Project is also aligned with the Poverty Reduction Strategy Paper (PRSP), INDS (*Initiative Nationale de Développement Social*) and PNDS II (*Plan National de Développement de la Santé)* by: (i) improving the organization, management, and operation of the health system; (ii) adapting the operation and the quality of health services to the needs of the population; (iii) adapting financing and use of financial resources to the needs of the health system; (iv) developing human resources according to the needs of the health system; and (v) improving the availability, access, and rational use of quality drugs.

8. While the effectiveness date of the original project is July 2013, facilities have only been contracted since June 2014. In addition to the delays, a number of methodological adjustments (either planned and not implemented or requiring introduction) are necessary and constitute the funding gap. With the AF, and given that the RBF Manual is in place and the PBF activities have begun, implementation can be expected to accelerate. The Project Operational Manual and the RBF Manual will be updated to reflect methodological changes associated with the AF. Additionally, the original project 'pilot' covers 80 percent of the population and there is no reason why, at this juncture, the remaining population should be excluded. The Project is still in the early phase of implementation, with the pilot in Djibouti-ville, Ali-Sabieh and Tadjoura having started in June 2014 (See Annex 6 for contracted indicators to date and baseline quality scores for each facility). As such, progress towards achievement of the PDO, which remains highly relevant and achievable, has only begun. Implementation progress and achievement of the PDO are rated MS in the latest ISR. All loan covenants have been complied with, with the exception of creation of a steering committee (COPI) to oversee technical aspects of the PBF indicators to be used to disburse funds. This committee was formed on January 29, 2015; compliance with Terms of Reference remain to be verified.

9. The Borrower has requested assistance from the World Bank to scale-up the PBF component of the project nationally. No changes are anticipated in the project's fiduciary or safeguards arrangements. Fiduciary and procurement performance are moderately satisfactory and satisfactory, respectively. The AF does not trigger additional safeguards policies, change the safeguard categories or raise safeguard-related issues that were not covered in the original project. The Environmental Impact Assessment (EIA) and Environmental Management Plan (EMP) were revised to include the expanded geographical scope of the AF and inclusion of the private sector and have been disclosed in country and on InfoShop.

III. Proposed Changes

A. Changes to the project's PDO & Outcomes

10. The project development objective (PDO) will drop reference to malaria; the AF will amend the PDO to the following: "to improve the utilization of quality healthcare services for maternal and child health and communicable disease control programs (HIV/AIDS and tuberculosis)". The project closing date will remain unchanged. The key project results and indicators have been changed to reflect updated contracted indicators and baseline measurements.

11. The original project covered healthcare providers and their support staff in 29 targeted health facilities. An additional two CSCs have been constructed in Djibouti-ville. The AF will expand the project to 54 facilities (including two additional CSCs in Djibouti-ville that have just been constructed; three CMHs; and 20 PS), plus the nutrition referral center at Balbala 2. This is an increase from an estimated 509 to 689 personnel (Table 3).

Table 3. Facilities and Personnel in 3 regions

Region	FOSA	Administrative	Support	Doctor	Nurse	Midwife	Total
Dihkil	CMH Dikhil	0	0	1	0	0	**1**
Dihkil	PS Sankal	0	0	1	1	0	**2**
Dihkil	PS Galamo	2	0	1	2	0	**5**
Dihkil	PS Yoboki	0	0	0	1	1	**2**
Dihkil	PS Gorabous	0	0	1	2	0	**3**
Dihkil	PS Kouta Bouya	0	1	1	1	0	**3**
Dihkil	PS As- Eyla	0	0	1	2	0	**3**
Dihkil	PS Mouloud	2	0	0	1	1	**4**
Obock	CMH Obock	3	0	1	3	2	**9**
Obock	PS Assassan	0	0	1	1	1	**3**
Obock	PS Dalay AF	1	1	0	2	1	**5**
Obock	PS Alaillou	0	1	0	2	1	**4**
Obock	PS Khor Angar	0	0	1	1	0	**2**
Obock	PS Waddi	1	0	1	0	0	**2**
Obock	PS Medeho	1	0	1	1	0	**3**
Arta	CMH d'Arta	8	45	9	28	7	**97**
Arta	PS Karta	0	3	0	1	0	**4**
Arta	PS Chebelley	0	2	0	1	0	**3**
Arta	PS Damerjog	2	4	0	3	1	**10**
Arta	PS Douda	0	4	0	1	1	**6**
Arta	PS Wéah	0	4	0	1	1	**6**
Arta	PS PK 51	0	2	0	1	0	**3**
Total		**20**	**67**	**20**	**56**	**17**	**180**

12. The expected increased staff performance should impact the quality and quantity of the following services, calculated for 2014:
    a) maternal health with a potential target population (at the national level) estimated at **33,889**[2] pregnant women (or expected pregnancies, of which about **20,000**[3] in Djibouti-ville);
    b) infant health with an estimated national target of **101,666**[4] children aged 0 to 5 years (of which about **59,000**[5] live in Djibouti-ville);
    c) HIV prevention and AIDS treatment with an estimated target of **35,500**[6] (of which an estimated 9,000-10,000 people are living with HIV and about 1,500 people are currently benefiting from antiretroviral drugs); and other transmissible diseases such as tuberculosis, with about **5,150** targeted patients.[7]

13. The results framework is modified. The reason for the changes to specific indicators can be classified in five broad categories. Changes were made if : (1) baselines were not correctly estimated – the first round of verification has allowed the correct estimation of baselines and the subsequent adjustment of targets; (2) the indicator was not appropriate to the PBF design – a number of indicators in the grant were not part of the contracted DLIs and not measured to date (and some not possible to measure using Djibouti HIS); (3) the indicator included services sought at the tertiary level and not covered by the project; and (4) where population denominators could not credibly be estimated.

B. Proposed Methodological Changes

i. Revising the incentives currently used to encourage health facilities to improve performance.[8] The AF proposes to increase the number of PBF indicators purchased at facilities from 13 to 20 and to increase the amounts paid for each indicator (see Annex 3 for revised indicators and fees). In all PBF approaches the fee setting has to be reviewed frequently early on; the proposed indicators and pricing will again be reviewed after 6 months and it is expected that further equity adjustments based on geography will be introduced.

ii. Implementing the quarterly quality checklists and applying the results to the performance payments. Purchasing quantity conditional on quality is a core element of PBF approaches which is not yet integrated in Djibouti (it pays only for the quantity). Additionally, quality verification

[2] DISED. The percentage of pregnant women or expected pregnancies was estimated in 2009 to be 3.8 percent of the total Djiboutian population.
[3] Using 3.8% estimate on 2014 population of Djibouti-ville (519,669 persons).
[4] DISED, General Population Census. 2009.
[5] Idem, 2009.
[6] Estimated numbers provided by the National Program against HIV/AIDS - *Programme National de Lutte contre le VIH/SIDA, le Paludisme, et la Tuberculose* .
[7] Projection of the number of tuberculosis cases to be discovered in 2013 established by the National Program against Tuberculosis - *Programme National de Lutte contre le VIH/SIDA, le Paludisme, la Tuberculose*.
[8] The initial fee-setting, financial risk forecasting was conservative, meaning that fees were set low and targets high to accommodate higher than expected performance. Baselines were not known very well, while different sources provided conflicting information on these baselines. Initial experience show low baselines and very slow increase in performance only. Increased performance in PBF approaches depends on a host of interlinked factors, chief among which are budget available to pay for performance, the level of autonomy of health facilities, the separation of functions (credible verification), high quality data systems and strong coaching and technical assistance. This is why the financial risk forecasting has been revised and fee-sets are considerably higher than those offered at the onset.

mechanisms will be revised (quality verification in regions done by the regional hospitals) and added to the performance score and payments as originally intended.

iii. **Performance contracting for the project implementation and the purchasing units.**[9] The PIU and the CAP functions are currently staffed by a mix of consultants and civil servants (who have a variety of tasks and responsibilities outside the project). To strengthen the PIU and CAP functions, while reinforcing the stewardship of the MOH, performance contracting will be implemented for the PIU/CAP by signing a contract between the COPI and the PIU/CAP and a monthly verification of the PIU/CAPs performance on an agreed upon set of indicators tied to incentive payments.

iv. **Piloting pharmaceutical management autonomy in six CSCs.** To ensure the availability of medicines in health facilities[10] a study is proposed in six (6) CSC in Djibouti-ville, giving them autonomy of financial management of medicines by depositing revolving funds directly into their PBF accounts and using the index tool to ensure use of funds for drug reserves, investments, savings, and for motivation bonuses.

v. **Strengthening technical assistance and coaching from the MOH**. Field observations show that knowledge on the PBF approach is very patchy even among those that have been trained, let alone by those that have not been trained. The AF proposes to write new guidelines for TA & coaching which will be implemented during the monthly verification and trimestral quality assessment visits.

vi. **Instituting links with the World Bank-financed Social Safety Net Project.**[11] The AF proposes to support health facilities, through the index tool, to subcontract with community peer educators[12] to use part of their revenues as an incentive to individuals or community-based organizations to improve access and use of services especially for the most vulnerable populations.

C. Additional proposed methodological modifications

vii. **Contracting health posts directly through the purchasing unit**. Currently, the regional hospitals are sub-contracting their health posts. This should not be their function and health posts ought to be contracted directly by the purchasing unit (CAP). Direct contractualization and fund management autonomy for facilities is a key component of PBF methodology, as specified in the RBF manual.

[9] In well-designed public or quasi-public purchaser approaches that cover an entire country (examples: Rwanda; Burundi; Congo-Brazzaville) or significant parts of a country (examples: DRC; Nigeria; Burkina Faso), the Ministry of Health, which has vital functions in the PBF approach, is subject to internal contracting and performance frameworks.

[10] While the central medical stores (CAMME) now has adequate supplies, health facilities continue to suffer stockouts creating a high risk for the project. Currently, the MoH collects funds earned by health facilities through their 'community pharmacies' and restocks them based on these earnings.

[11] Under this program, eligible households in a number of urban clusters receive nutrition services oriented towards pregnant women and children under two. Interventions include behavior change communication, sensitization sessions, growth monitoring sessions for children, targeted supplements for children 6-24 mo and healthy pregnancy practices including pre/post natal care and facility delivery.

[12] Peer educators (role model mothers) are volunteers and facilitators trained to deliver nutrition services, who originate from the communities or local associations of targeted areas.

viii. **Improve the separation of functions in the MOH by recruiting verifiers on a contractual basis instead of using MOH staff**. Currently the MOH combines quantity and quality verification and uses a team of central MOH staff to execute this each quarter. This will be changed with verification being the responsibility of an expanded CAP. The CAP will function autonomously within the PIU with functions within the PIU.

ix. **A new procurement method for procurement of Goods and Non-consulting Services**, under Framework Agreements in accordance with procedures which have been found acceptable to the World Bank is allowed under the additional financing and applies, under amendment, to the original project.

x. **Independent Verification.** External monitoring and evaluation experts ("Independent Verifiers") will be appointed to act as third-party verifiers of the proper fulfillment of the DLIs set forth in RBF Manual and the respective Participating Health Care Provider Agreement. The Independent Verifiers will provide regular reports ("(EEP Spending and Assessment Report") containing, inter alia, said assessment on the fulfillment of the pertinent DLIs and a proposal for disbursement under each Withdrawal.

D. Costs by Component

14. The AF will focus funding on service delivery (component 1) and strengthening project management and M&E (components 2 and 3) (Table 6). The reallocations in Table 6 do not change the amounts in the disbursement categories of the original project. Full financing for AF is in Annex 4.

Table 6. Costs by component (US$ million)

	Component	***Original Cost***	***Original Cost (revised)***	***Additional Financing***	***Total***
1	Improving health service delivery performance	4.000	3.975	4.875	**8.850**
2	Strengthening health system management	1.000	0.800	-	**0.800**
3	Strengthening project management and monitoring and evaluation capacity	2.000	2.225	2.125	**4.350**
	Total	7	7	7	**14**

IV. Appraisal Summary

15. Priorities for additional funding from PAPSS. The program's development goal is altered to remove reference to malaria. The original project closing date remains unchanged. The goals of additional financing are: 1) to cover the financing gap to fund and monitor the implementation of project activities underway and include activities not yet funded by PAPSS but which are nevertheless listed

as priority in the project, including: i) ensuring inclusion of the quality and the applicable reimbursement mechanisms (which was not included so far); ii) review project indicators and cost of retribution, iii) support the establishment of the institutions required for project governance (Community, Regional, National), iv) incentivize the central level by putting the PIU under a performance contract, v) develop a functional link between the PBF and social safety nets being implemented by ADDS; vi) ensure the capacity building of stakeholders in the implementation of the PBF; and vii) complete a methodological review of the project and make adjustments; and 2) to extend the PBF to all regions in Djibouti.

16. The economic analysis remains relevant and the project remains economically justified. In the original project, 57 percent of funding went directly to facilities and communities, 29 percent for administrative fees and 14 percent for investment; with the additional financing, the total budget allocates 69 percent directly to facilities and communities, 25 percent for administrative fees and 6 percent for investment. Furthermore, the yearly per capita spending is increased to US$3.16.

17. The additional financing retains the Environmental Assessment category of the original project, i.e. category 'B' according to the World Bank's environmental assessment policy (OP 4.01). For the additional financing, the Borrower has updated the environmental impact assessment and the medical waste management plan and environmental management plan that were prepared during the original project. These are provided in the updated environmental assessment, which was published in country and disclosed at the Infoshop on November 17, 2014.

18. Social safeguards policies remain non-triggered under the additional financing project. As the parent project, the proposed activities will not require involuntary land acquisition resulting in: a) Involuntary resettlement of people and/or loss of (or access to) assets, means of livelihoods or resources; and b) The involuntary restriction of access to legally designated parks and protected areas resulting in adverse impacts on the livelihoods of the displaced persons

19. There are no exceptions or waivers of Bank policy being sought.

V. World Bank Grievance Redress

20. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

Project Development Objectives

PDO Statement

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

Project Development Objective Indicators

Status	Indicator Name	Core	Unit of Measure	Baseline	Target Values					Frequency	Data Source/ Methodology	Responsibility Data Collection
					YR1	YR2	YR3	YR4	YR5			
Revised	Number of women receiving prenatal visits 2-4	☐	Number	6,100	6,710	12,419	15,798	19,287	22,886	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
Revised	Percentage of children fully immunized before their first birthday	☐	Percentage	32.0	33.5	37.8	42.8	47.8	51.5	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
Revised	Average facility quality*	☐	Percentage	29.0	35.0	40.0	45.0	50.0	60.0	Every 3 months	Facility Quality Assessment	MOH
Revised	Number of HIV	☐	Number	63	150	200	250	275	300	Monthly	MOH/ PBF	MOH

	positive pregnant women receiving antiretroviral therapy according to protocol									(independent verification every 3 months)	HIS	
Dropped	Percentage of positive pulmonary TB cases detected (case detection rate)	☐	Percentage	35.00	40	43	48	55	60.00	Yearly	MOH/HIS/ PNLT WHO	MOH
Dropped	Percentage of pulmonary TB patients cured (Pulmonary TB cure rate)	☐	Percentage	80.00	82	83	84	84	85.00	Yearly	MOH/HIS/ PNLT WHO	MOH

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure	Baseline	Target Values					Frequency	Data Source/ Methodology	Responsibility Data Collection
					YR1	YR2	YR3	YR4	End Target			
Revised	Number of women giving birth in a contracted facility assisted by qualified personnel	☐	Number	1,026	1,245	3,356	5,844	7,305	7,775	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
Revised	Number of new curative care visits	☐	Number	0.15	0.18	0.29	0.39	0.46	0.52	Monthly (independent	MOH/ PBF HIS	MOH

	(nurse) per person per year in the public system									verification every 3 months)		
Revised	Percentage of pregnant women receiving at least two doses of tetanus toxoid (TT2)	☐	Percentage	20.0	25	30	35	40	45	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
Revised	Number of WCBA visiting the public system to obtain modern family planning (oral contraceptives and injections)	☐	Number	7,304	10,000	15,000	20,000	25,000	35,000	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
Revised	Pregnant/lactating women, adolescent girls and/or children under age five-reached by basic nutrition services (number)	☒	Number	7,117	10,000	20,000	30,000	40,000	50,000	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
No Change	People receiving tuberculosis treatment in accordance with the WHO-recommended	☒	Number	300	325	375	425	475	500	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH

	"Directly Observed Treatment Strategy" (DOTS) (number)											
No Change	Direct project beneficiaries	☒	Number	0	50,000	100,000	160,000	215,000	300,000	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
No Change	Direct project beneficiaries which are Female	☒	Percentage Sub-Type Supplemental	0	20,000	45,000	100,000	160,000	210,000	Monthly (independent verification every 3 months)	MOH/ PBF HIS	MOH
Dropped	Children between the age of 6 and 59 months receiving Vitamin A supplementation (number)	☒	Number Sub-Type Breakdown	50000	60000	70000	78000	85000	90000	Yearly		MOH
Dropped	People with access to a basic package of health, nutrition, or reproductive health services (number)	☒	Number	155000	165000	175000	185000	195000	200500	Yearly		MOH
Dropped	Percentage of child nutritional growth monitoring visits (well-baby clinic	☐	Percentage	5.00	10	15	23	30	40.00	Yearly	RBF database	MOH

	visits)											
Dropped	Percentage of HIV test results received by all persons tested for HIV	☐	Percentage	70.00	75	78	83	85	87.00	Yearly	MOH/HISP LSS	MOH
Dropped	Percentage of suspected malaria cases that are tested and confirmed	☐	Percentage	11.00	10	8	7	5	5.00	Yearly		MOH
Dropped	Percentage of established and functioning COGESs in CSCs and CMHs	☐	Percentage	15.00	90	95	100	100	100.00	Yearly		MOH
Dropped	Percentage of women receiving two postnatal care visits (PoNC1 and PoNC2) between 8th and 42nd day after delivery	☐	Percentage	9.00	15	25	35	40	45.00	Yearly	MOH/HIS, DSME	MOH

Annex 2: Systematic Operations Risk-rating Tool

Risk category	Rating
1. Political and Governance	M
2. Macroeconomic	M
3. Sector Strategies and Policies	M
4. Technical Design of Project or Program	S
5. Institutional Capacity for Implementation and Sustainability	S
6. Fiduciary	M
7. Environment and Social	M
8. Stakeholders	M
9. Other	
OVERALL	M

Annex 3: PBF Indicators

	Indicator	CSC	CMH	PS
1	New curative care visit (seen by nurse)	$ 0.49	$ 0.57	$ 0.61
2	New curative care visit for a poor/vulnerable patient	$ 2.00	$ 2.30	2.40
3	New curative care visit (seen by doctor)	$ 1.00	$ 1.15	-
4	Children fully vaccinated	$ 7.50	$ 8.75	$ 9.25
5	Nutrition consultation	$ 0.80	$ 0.90	$ 0.95
6	Admission day	-	$ 2.85	$3.05*
7	Admission day at nutrition center	$ 7.50	$ 8.65	-
8	Admission day for poor/vulnerable patient	-	$ 2.85	-
9	Pregnant women receiving tetanus toxoid (2-4)	$ 3.00	$ 3.50	$ 3.70
10	Postnatal visit (first)	$ 5.00	$ 5.75	$ 6.00
11	ANC1 (before 4 months)	$ 5.00	$ 5.75	$ 6.00
12	ANC (2-4)	$ 4.90	$ 5.70	$ 6.10
13	Facility delivery	$ 20.00	$ 23.50	$ 25.00
14	Referral of complicated cases to hospital	$ 15.00	$ 17.50	$ 18.50
15	Family planning : pills or injectables	$ 4.00	$ 4.70	$ 5.00
16	Family planning : implants or IUDs	$ 4.90	$ 5.70	$ 6.10
17	HIV test results received by person tested	$ 1.50	$ 1.73	$ 1.84
18	HIV positive pregnant women receiving antiretroviral therapy	$ 20.00	$ 23.50	$ 25.00
19	Positive pulmonary TB cases detected	$ 15.00	$ 17.25	$ 18.50
20	Pulmonary TB patients cured	$ 39.50	$ 46.00	$ 49.00
21	Quality Investment (one-time payment)	$7,000 (without delivery) ; $9,000 (with delivery)	$15,000	$5,000

**The admission days in the PS reflect overnight observations for a maximum duration of 72 hours*.

Annex 4: Additional Financing Budget

	Budget 2015	Budget 2016	Budget 2017	Budget 2018	Total
Human Resources					
PIU	$ 27,000	$ 27,000	$ 27,000	$ 27,000	**$ 108,000**
CAP	$ 207,595	$ 207,595	$ 207,595	$ 207,595	**$ 830,378**
TA	-	-	-	-	**-**
Investments in Quality					
Investments: PIU/CAP	$ 42,000	$ 0	$ 0	$ 0	**$ 42,000**
Investments MSP	-	-	-	-	**-**
Subsidizing health Facilities					
Indicators, quality, and indigence	$ 526,964	$ 387,283	$ 2,055,331	$ 1,599,421	**$ 4,569,000**
Starting investment	$ 306,000	$ 0	$ 0	$ 0	**$ 306,000**
Quality Assurance					
CMH	$ 46,638	$ 46,638	$ 46,638	$ 46,638	**186,550**
PIU/CAP	$ 35,000	$ 35,000	$ 35,000	$ 35,000	**140,000**
Counter verification: ABC & AVI					
ABC	$ 62,343	$ 62,343	$ 62,343	$ 62,343	**$ 249,372**
AVI	$ 0	$ 0	$ 0	$ 0	**$ 0**
Operational costs PIU/CAP					
Operating costs PIU/CAP	$ 103,319	$ 103,319	$ 103,319	$ 103,319	**$ 413,275**
Training, studies, research					
Training	$ 77,713	$ 77,713	$ 0	$ 0	**$ 155,425**
TOTAL:	**1,434,571**	**946,890**	**2,537,225**	**2,081,315**	**7,000,000**

Annex 5: Quality Assessment Tool Summary

Domain	Points	Weight
General Organization	23	9.4%
M&E and HIS	23	9.4%
Hygiene, environment & sanitation	20	8.1%
Outpatient	32	13.0%
Maternity	16	6.5%
Family Planning	11	4.5%
Prenatal care	14	5.7%
Vaccination & follow up children 0-5	13	5.3%
HIV	24	9.8%
TB	15	6.1%
Lab	7.6	3.1%
Basic surgery	5.4	2.2%
Pharmacy & Equipment	21.5	8.8%
Financial Management	20	8.1%
	245.5	100.0%

Annex 6: Project Results to Date

Contracted Indicators by facility (June – October, 2014)

Indicator	Facility															
	Ambouli	Arnaud	Angella	Farah-had	Ibrahim-Balala	Khor-Bourhan	Balbara 1	Balbala 2	Waleh-Daba	Dolaraleh	Hayabeleh	PK12	CMH Ali-Sabieh	CMH Tadjourah	CMH Warabley	Total
New consultation	3305	3392	6979	5843	3491	2777	4509	3621	1946	887	3939	5026	6710	3179	2989	**58593**
Children fully vaccinated	116	157	333	120	162	157	315	340	134	14	233	405	214	134	62	**2896**
Child nutritional growth monitoring visit	210	361	300	160	289	54	211	330	259	148	282	722	286	157	430	**4199**
Pregnant women receiving second dose of tetanus toxoid	94	211	207	146	92	137	200	146	81	15	261	169	145	70	50	**2024**
Women receiving two postnatal care visits between 8th and 42nd day after delivery	4	50	9	45	41	22	40	32	9	5	38	41	51	1	5	**393**
Pregnant women receiving a prenatal visit before the end of the first trimester of pregnancy	126	83	229	81	72	99	88	129	59	8	114	86	119	27	45	**1365**
Women giving birth in a facility assisted by qualified personnel	-	-	-	-	-	-	-	-	-	1	301	366	198	111	-	**977**
Modern birth control (new and repeat cases)	320	488	472	193	203	256	292	169	188	12	336	321	252	124	28	**3654**
HIV test	313	347	1033	255	298	534	804	532	0	26	685	880	198	204	0	**6109**
HIV positive pregnant women receiving antiretroviral therapy	5	9	10	2	3	6	3	8	0	0	3	8	1	2	0	**60**
Positive pulmonary TB cases detected	34	56	46	15	34	24	29	29	0	0	27	35	19	12	0	**360**
Pulmonary TB patients cured	13	24	37	14	15	10	24	48	0	0	47	3	11	5	0	**251**

Source: RBF HIS

Baseline quality scores by facility

Region	Health Facility	Quality Score (Baseline Assessment)
Ali Sabieh	CMH de Ali Sabieh	40.93%
	Goubetto	25.60%
	Holl Holl	26.40%
	Das Bio	20.90%
	Ali Addé	22.60%
	Guestir	14.00%
	Assamo	24.00%
Ali Sabieh Regional average		24.92%
Tadjoura	CMH Tadjoura	39.25%
	Day	15.80%
	Sagalou	17.40%
	Ripta	13.80%
	Adai-Lou	20.00%
	Adoyla	12.20%
	Assa Guela	32.00%
	Dorra	20.90%
	Balho	17.50%
	Guirorri	13.60%
	Randa	20.20%
Tadjoura Regional average		20.24%
Djibouti Ville	CSC Ambouli	35.77%
	CSC Arhiba	38.68%
	CSC Balbara1	38.86%
	CSC Balbara2	39.70%
	CSC Eingela	45.61%
	CSC Fara Had	52.04%
	CSC Hayabley	51.20%
	CSC Ibrahim Balala	45.48%
	CSC Khor Boulahan	48.17%
	CSC PK12	51.80%
	CSC Warabaley	20.94%
	CSC Walhedaba	35.14%
CSC average		41.95%
Global Average		29.04%

Source: RBF HIS

Annex 7: Financial Management

Financial Management Assessment

1. The Financial Management (FM) team of the Bank 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.

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

3. A new procurement method for procurement of Goods and Non-consulting Services, under Framework Agreements in accordance with procedures which have been found acceptable to the World Bank is allowed under the additional financing and applies, under amendment, to the original project.

4. 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 Financial Management rating for the ongoing Health Project is Moderately Satisfactory.

5. 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 certified Interim Un-audited Financial Reports (IFRs); (ii) delays in the recruitment of the internal auditor; and (iii) overall complexity of the project.

Financial Management and Disbursement Arrangements

1. *Staffing:* The current PIU has a dedicated financial team to handle the FM aspects of the ongoing Health Project; this team will be utilized to implement the activities of the additional financing. The team is comprised of the Head of the Administrative and Financial in charge of the overall FM aspects and is assisted by an accountant, a procurement specialist and a monitoring and evaluation specialist. The PIU is headed by a project coordinator in charge of overall implementation of the project. The FM team has substantial experience in implementing Bank financed projects.

2. *Internal control:* Project commitments will be subject to the local procurement procedures through the National Procurement Committee, for any amount exceeding the threshold fixed by the local regulations. This Committee will then be involved in monitoring all procurements steps. Payment of eligible expenses will be done based on instructions signed by the Ministry of Health, the Ministry of Finance (External Finance Department-EFD) and the Ministry of Budget (Debt Department). The PIU is responsible for monitoring the eligibility of all expenses.

3. The PIU has a Project Operational Manual (POM) which includes all implementation procedures of the ongoing project. The POM contains a financial management chapter describing all financial and accounting procedures in addition to roles and responsibilities of all staff members within the PIU. The operation manual is being adopted by the PIU and is acceptable to the Bank.

4. For the RBF component, a specific manual has been prepared and cleared by the Bank. The disbursement provisions of the RBF manual are used as a condition to disburse funds related to the first category; for the purpose of the additional financing, an RBF manual will be prepared and adopted by the project. This RBF manual will be used to disburse funds related to category 1 based on Disbursement Linked Indicators (DLI) in addition to the submission of a Spending and Assessment Report that is found satisfactory by the Bank in accordance with the Independent Verification Reports. The RBF manual will be cleared by the Bank. .

5. *Budgeting:* The consolidated budget of the entity is prepared after inputs from the various departments. Reconciliation with the previous year is established to better monitor differences.

6. The process of preparing the annual budget is completed before the start of the fiscal year so not to block the operations of the agency and allow commitments of budgeted expenditures.

7. The PIU will prepare a budget plan and disbursements plan for each fiscal year related to the project and will submit these plans for World Bank's approval.

8. *Project accounting system:* The transactions will be registered in the accounting system by the accountant under the control of the Financial Officer. The project Financial Officer is responsible for preparing the Interim Un-audited Financial Reports (IFRs) before their transmission to the PIU coordinator for approval. Periodical reconciliation between accounting statements and IFRs is also done by the Financial Officer.

9. 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 accrual accounting system.

10. Disbursements made from the project Designated Accounts (DA) will also be entered into the project accounting system. IFRs summarizing the commitments, receipts, and expenditures made under the project will be produced on a quarterly basis; the project chart of accounts will be in compliance with the classification of expenditures and sources of funds indicated in the project cost tables and the general budget breakdown in addition to the POM. The chart of accounts should allow for data entry to facilitate the financial monitoring of project expenditures by component, sub-component and category.

11. *Project reporting:* The project financial reporting includes quarterly IFRs and yearly Project Financial Statements (PFS). IFRs should include data on the financial situation of the project, including:

    1) Statement of Cash Receipts and Payments by category and component.
    2) Accounting policies and explanatory notes including a footnote disclosure on schedules: (i) "the list of all signed Contracts per category" showing Contract amounts committed, paid, and unpaid under each contract, (ii) Reconciliation Statement for the balance of the Project's Designated Account, (iii) Statement of Cash payments made using Statements of Expenditures (SOE) basis, (iv) a budget analysis statement indicating forecasts and discrepancies relative to the actual budget, and (v) a comprehensive list of all fixed assets.

12. External monitoring and evaluation experts ("Independent Verifiers") will be appointed to act as third-party verifiers of the proper fulfillment of the DLIs set forth in RBF Manual and the respective

Participating Health Care Provider Agreement. The Independent Verifiers will provide regular reports ("EEP Spending and Assessment Report") containing, inter alia, said assessment on the fulfillment of the pertinent DLIs and a proposal for disbursement under each Withdrawal.

13. The IFRs should be certified by the external auditor and should be produced by the PIU every quarter and send to the World Bank within 45 days from the end of each quarter. PFS should be produced on an annual basis. The PFS should include (a) a cash flow statement; (b) a closing statement of financial position; (c) a statement of ongoing commitments; and (d) an analysis of payments and withdrawals from the project's account; (e) a statement of cash receipts and payments by category and component; (f) reconciliation statement for the balance of the Project's Designated Account; (g) statement of cash payments made using Statements of Expenditures (SOE) basis.

14. *Audit of the project financial statements:* An annual external audit of the project accounts will cover all aspects of the project, all uses of funds and all the committed expenditures of the project. It will also cover the financial transactions, internal control and financial management systems and will include a comprehensive review of SOEs.

15. An external auditor will be appointed within two months of effectiveness according to Terms of Reference acceptable to the Bank and should conduct the audit in accordance with international auditing standards. The auditor should produce: (i) an annual audit report including his opinion on the project's annual financial statements; (ii) a management letter on the project internal controls; and (iii) a limited review opinion on the IFRs. The annual reports will be submitted to the World Bank within six months from the closure of each fiscal year and the limited review opinion will be submitted to the World Bank with the IFRs.

16. *Flow of funds:* Two separate Designated Accounts (DA) in US Dollars will be opened at the Central Bank of Djibouti, one for each category. Advances from the Project account will be disbursed to the designated accounts to be used for the project expenditures.

17. For Category 1 of the Project, based on the independent purchasing and verification firm's review of the Health Information System (SIS) quarterly report and after receiving funds from the World Bank, the PIU will proceed with disbursement of the funds to sub-designated accounts opened by the health facilities, regions and programs on the basis of specific criteria to be included in the RBF manual and the submission of a Spending and Assessment Report (refer to the disbursement section for more details) . At the level of the health facilities, the new regulation would define the persons responsible for authorizing payments based on the double signature of the health facility and the public accountant (MEFIP). In order to facilitate the management of funds and disbursement procedures for eligible expenses, a sub-designated account in DJF for each regional health facility will be opened at a commercial bank in Djibouti acceptable to the World Bank. The regional health facility will file the original supporting documents.

18. *Flow of information*: The PIU will be responsible for preparing periodic reports on project implementation progress and on both physical and financial achievements. These reports will be based on project activity progress (by component and expenditure category), including technical and physical information reported on a quarterly basis.

19. The PIU will maintain the project bookkeeping, and will produce annual PFSs and quarterly IFRs.

Disbursement

20. The grant funds will be disbursed according to 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 Bank's Disbursement Handbook.

21. The Bank will honor eligible expenditures for services rendered and goods delivered by the project closing date. A four-month grace period will be granted to allow for the payment of any eligible expenditure incurred before the project closing date.

22. *Designated Accounts (DA)*. To facilitate fund and disbursement management for eligible expenditures, two separate designated accounts (DA) in US Dollars will be opened at the Central Bank of Djibouti: one designated account for each category 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 (MOB) and the MEFIP.

23. The ceiling of the designated accounts will be US$450,000 for the first category and US$200,000 for the second category. The PIU will be responsible for submitting monthly replenishment applications with appropriate supporting documentation.

24. *Statements of expenditures (SOEs).* Necessary supporting documents will be sent to the World Bank in connection with contracts that are above the prior review threshold, except for expenditures under contracts with an estimated value of (a) US$150,000 or more for goods and non-consulting services, (b) US$100,000 or more for consulting firms and (c) US$50,000 or more for individual consultants. In addition, all operating costs, training, workshops, study tours and audit fees, will be claimed on the basis of SOEs. The documentation supporting expenditures will be retained at the PIU and will be readily accessible for review by the external auditors and periodic Bank supervision missions. All disbursements will be subject to the conditions of the Financing Agreement and disbursement procedures as defined in the Disbursement Letter.

Allocation of the Grant's Proceeds:

Category	**Amount Allocated (US$)**	**Percentage of Expenditures to be Financed (Inclusive of Taxes)**
(1) EEPs to the participating Health Care Providers, under Part A of the Project	4,875,000	100% of amounts spent and reported under the EEP spending and assessment reports for each withdrawal.
(2) Goods, non-consulting services, consultants' services, audit, Training and Incremental Operating Costs under Part B of the Project	2,125,000	100%
Total	7,000,000	

Withdrawals Conditions for Category 1:

Withdrawals from category 1 of the project will be made based on the following conditions as set in the grant agreement:

(i) the MoH has adopted the RBF Manual in a manner satisfactory to the Association;

(ii) the relevant EEP Spending and Assessment Report has been submitted to, and found satisfactory by, the Association in accordance with the Independent Verification Reports; and

(ii) any applicable Disbursement-Linked Indicators as set forth in the RBF Manual and the respective Participating Health Care Provider Agreement have been met by the Recipient satisfactory to the World Bank.

25. Withdrawals shall be made in amounts not exceeding the total of the ceilings per each respective DLI as provided in RBF Manual, subject to submission to the Association of evidence satisfactory to the Association and as defined in the RBF Manual that the DLIs have been achieved.

26. *E-Disbursement*. The Bank has introduced e-Disbursement for all projects in Djibouti. Under e-Disbursement, all transactions will be conducted and associated supporting documents and SOEs scanned and transmitted online through the World Bank's Client connection system. The use of e-Disbursement functionality will streamline online payment processing to: (a) avoid common mistakes in filling out WAs; (b) reduce the time and cost of sending WAs to the Bank; and (c) expedite the Bank processing of disbursement requests.

Governance and anti-corruption

27. Fraud and corruption may affect the Project resources, thus impacting negatively the Project outcomes. The World Bank FMS worked closely with Project's Task Team Leader (TTL) as well as project's consultants and developed with the team an integrated understanding of possible vulnerabilities and agreed on actions to mitigate the risks. The above proposed fiduciary arrangements, including POM with a detailed FM chapter, internal auditor assignment, reporting and auditing and review arrangements are expected to address the risk of fraud and corruption that are likely to have a material impact on the Project outcomes.

Supervision Plan:

28. The financial management of the Project will be supervised by the Bank in conjunction with its overall supervision of the Project and conducted at least three times a year.

Supporting Documentation and Record Keeping:

29. All supporting documentation was obtained to support the conclusions recorded in the FM Assessment.