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The World Bank

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Report No: PAD2842

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 10.5 MILLION
(US$15 MILLION EQUIVALENT)

TO THE

REPUBLIC OF DJIBOUTI

FOR THE

TOWARDS ZERO STUNTING IN DJIBOUTI PROJECT

June 4, 2018

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

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2018)

Currency Unit	=	Djibouti Francs (DJF)
DJF 177	=	US$1
US$1.44	=	SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Asad Alam
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Ernest E. Massiah
Task Team Leader(s):	Elizabeth Mziray

ABBREVIATIONS AND ACRONYMS

AARR	Average Annual Rate of Reduction
ANC	Antenatal Care
BCC	Behavior Change Communication
CAMME	Centrale d'Achat des Médicaments et Matériels Essentiels
CCT	Conditional Cash Transfer
CDD	Community Driven Development
CERC	Contingent Emergency Response
CHW	Community Health Worker
CPS	Country Partnership Strategy
DALY	Disability-Adjusted Life Years
DHR	Department of Health Regions
DHIS	District Health Information System
DHP	Department of Health Promotion
DIS	Direction de l'information sanitaire (Department of Health Information)
DISED	Direction La Direction de la Statistique et des Études Démographiques
DJF	Djibouti Francs
DLI	Disbursement-linked Indicator
DPs	Development Partners
DPS	Direction de la promotion de la santé (Department of Health Promotion)
EEP	Eligible Expenditure Programs
EROM	Emergency Response Operational Manual
ESMF	Environmental and Social Management Framework
EU	European Union
FAO	Food and Agriculture Organization
GAM	Global Acute Malnutrition
GDP	Gross Domestic Product
GoD	Government of Djibouti
GRM	Grievance Redress Mechanism
HCW	Health Care Worker
HNP	Health, Nutrition and Population
HMIS	Health Management Information System
IFA	Iron-folic acid
IFR	Interim Un-Audited Financial Reports
IYCF	Infant and Young Child Feeding
IMR	Infant Mortality Rate
KAP	Knowledge, Attitude, Practice
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MMR	Maternal Mortality Ratio
MoFW	Ministry of Family and Women
MoA	Ministry of Agriculture
MoH	Ministry of Health

MUAC	mid-upper arm circumference
NCN	National Council on Nutrition
NGO	Non-governmental organization
NNFCA	National Nutrition and Food Coordination Authority
PAPSS	Projet d'Amélioration de la Performance du Secteur de la Santé (Improving Health Sector Performance Project)
PDO	Project Development Objective
PFS	Project Financial Statement
PNC	Postnatal Care
PLW	Pregnant and lactating women
PMU	Project Management Unit
POM	Project Operational Manual
PPP	Purchasing Power Parity
PPSD	Project Procurement Strategy for Development
PRODERMO	Projet de Développement Communautaire Rural de Mobilisation des Eaux (Rural Community Development and Water Mobilization Project)
PSNP	Productive Safety Net Program
RBF	Results Based Financing
RF	Results Framework
SAI	Supreme Audit Institution
SAM	Severe Acute Malnutrition
SC	Steering Committee
SCD	Systematic Country Diagnostic
SDSA	Société Djiboutienne de Sécurité Alimentaire
SHINE	Sanitation, Hygiene, Infant Nutrition Efficacy
SMART	Standardized Monitoring and Assessment of Relief and Transition
SSSA	State Secretariat for Social Affairs
TB	Tuberculosis
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

BASIC INFORMATION

Country(ies)	Project Name	
Djibouti	Towards Zero Stunting in Djibouti	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P164164	Investment Project Financing	B-Partial Assessment

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)	

Expected Approval Date	Expected Closing Date
25-Jun-2018	31-Dec-2023

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The project development objective is to reduce stunting among children under five in Djibouti.

Components

Component Name	Cost (US$, millions)
High-impact Health and Nutrition Services to Reduce Stunting	11.60

Strengthening Multi-sectoral Interventions for Stunting Reduction	3.30
Strengthening Coordination, Project Management and Monitoring and Evaluation	4.40
Contingent Emergency Response	0.00

Organizations

Borrower:	Ministry of Economy and Finance
Implementing Agency:	Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	19.30
Total Financing	19.30
of which IBRD/IDA	15.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	15.00
IDA Credit	15.00

Non-World Bank Group Financing

Counterpart Funding	4.30
Borrower	4.30

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Total Amount
National PBA	15.00	0.00	15.00
Total	**15.00**	**0.00**	**15.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2018	2019	2020	2021	2022	2023	2024
Annual	0.00	0.50	1.75	3.25	4.50	3.50	1.50
Cumulative	0.00	0.50	2.25	5.50	10.00	13.50	15.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Social Protection & Labor

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

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial

6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	Substantial
10. Overall	Substantial

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

No later than three (3) months after the Effective Date, or such later date as agreed by the Association, appoint and thereafter maintain, at all times during the implementation of the Project, an independent verification agent with qualifications and experience and under terms of reference acceptable to the Association ("Verification Agent"), to verify the data and other evidence supporting the achievement of one or more DLIs as set forth in the table in the Annex to Schedule 2 and to recommend corresponding payments to be made, as applicable, under Category 2 (Schedule 2, Section I. E. 1 (b) of the Financing Agreement).	

Conditions

DJIBOUTI
TOWARDS ZERO STUNTING IN DJIBOUTI

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I. STRATEGIC CONTEXT

A. Country Context

1. Djibouti is a small lower-middle income country which occupies a pivotal position for trade and security in the Horn of Africa and the Gulf of Aden. It overcame violent civil conflict in the early 1990s to reach a political accommodation between the major ethnic groups in the country, and has been able to accelerate economic growth by securing foreign direct investments and rents from foreign countries for military bases and for port services. The growth rate of the annual gross domestic product (GDP) was estimated at 6.5 percent in 2016, and inflation increased to 3.5 percent in 2016 from 2.6 percent in 2015, spurred mainly by demand for housing and services.

2. Djibouti remains a fragile state and faces serious obstacles to poverty reduction and to the improved health of its population. In 2013, an estimated 40.7 percent of Djiboutians lived in poverty, consuming less than DJF 117,134 per capita per year (US$2.98 per day in 2011 purchasing power parity, PPP). In the same year, 23 percent of Djiboutians lived in conditions of extreme poverty, spending less than DJF 78,157 per capita per year (US$1.99 per day in 2011 PPP), with rural areas showing higher rates of extreme poverty (44 percent). Unemployment remains widespread, with the rate reaching 39 percent in 2015 according to official estimates; the rate is higher among women (49 percent) and in rural areas (59 percent).

3. There are persistent concerns with food insecurity, mainly due to limited arable land and low rainfall, which have adverse effects on livelihoods and agricultural production. The location of Djibouti also means that it has an arid desert climate, high temperatures year-round, prolonged droughts, limited rainfall, limited arable land, and a scarcity of ground water. As a result, agriculture is almost nonexistent, accounting only for about 3 percent of GDP and 2 percent of employment. The country is heavily dependent on food imports, as well as imports of manufactured goods and energy products. Furthermore, the recent prolonged drought in Djibouti exposed at least 20 percent of the population in Djibouti city and 75 percent of rural households to food insecurity.

4. A key factor behind the limited transmission of growth to prosperity and poverty reduction is the accompanying rise in inequality, which increased in Djibouti between 2002 and 2017. Inequality, poverty and food insecurity lead to a multitude of challenges, with childhood malnutrition being particularly damaging. Despite improvements in the last 20 years in Djibouti's score on the Global Hunger Index (from 46.7 in 2000 to 31.4 in 2017) – a composite indicator of child undernourishment, undernutrition, and mortality – Djibouti continues to be among the worst performers, ranking 100th out of 119 countries in 2017.[1]

5. In this context, Djibouti's Vision 2035 as well as the Social Protection Strategy (2012-2022) set an ambitious agenda for improving the standard of living. Through Vision 2035, the Government of Djibouti (GoD) recognizes the importance of nutrition in building human capital, and the Social Protection Strategy recognizes the critical role of social safety nets in alleviating the devastating effects of poverty. The latter emphasizes the importance of a long-term, development-oriented approach integrating different forms of social assistance, including those associated with improving the nutrition status of the population.

[1] IFPRI. 2017. Global Hunger Index.

B. Sectoral and Institutional Context

6. 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.[2] Despite recent gains in maternal and child survival and some improvement in overall nutrition status, Djibouti lags behind neighboring countries, as well as countries with a similar income level. While the fertility rate has steadily decreased to 3.1 per 1,000 live births, infant mortality rate (IMR) and maternal mortality ratio (MMR) remain higher than those of economically comparable nations and countries within Djibouti's geographic region.[3] The MMR, although decreasing, is still estimated at 229 per 100,000 live births (2012), markedly higher than the target of 185 that was set for 2015.[4] This data is indicative of the challenges that remain in improving access to and quality of obstetric and neonatal care. Only 23 percent of women receive four or more antenatal care visits, and only 54 percent of women receive any form of postnatal care.[5] At the same time, although the IMR decreased from 71.7 in 2005 to 54.2 in 2015, the rate remains high.[6]

7. Chronic malnutrition (stunting) rates in children remain unacceptably high in Djibouti. Stunting (height-for-age) is an urgent nutrition and a human development crisis in Djibouti, and affected over 30,000 children in 2013 (30 percent of children under 5). Between 2002 and 2013 stunting increased by 3 percentage points, with an annual average rate of reduction of negative 2.2 percent, calling for the need to first reverse this trend and then aim for an overall decrease in the stunting rate in Djibouti. The age group most affected by stunting are children 12-23 months of age, with approximately 41.5 percent of this age group suffering from stunting. Prevalence of underweight (weight-for-age) among children under 5 is 30 percent. Exclusive breastfeeding protects infants from illness and provides essential nutrition during the first six months of life, but in 2014 only 13.4 percent of infants less than six months were exclusively breastfed – one of the lowest rates in the world.[7] In addition, there is a steep and progressive rise in stunting after weaning (i.e., from 19.5 percent in 6-11-month-olds, to 34.4 percent in 12-23-month-olds). This is a common pattern in many developing countries, as a child is introduced to greater disease risks through inadequate complementary feeding and inappropriate water, hygiene and sanitation conditions and practices.

8. Acute malnutrition (wasting) rates in children are very high and far exceed the World Health Organization's severity threshold. Wasting (weight-for-height) remains high at 17.8 percent among children under 5,[8] and 5.7 percent of children are severely wasted. Djibouti has one of the highest wasting prevalence rates globally. Given the direct link between wasting and child mortality, the high rates of wasting in children under 5 signal a critical situation requiring an urgent response (wasting prevalence rates above 15 percent are classified by the World Health Organization (WHO) as being critical levels of public health significance[9]).

9. Stunting and wasting are national challenges, affecting all geographical areas and wealth quintiles, although the poor and rural populations are at a proportionately higher risk. Djibouti has one of the highest proportions of

[2] Institute of Health Metrics and Evaluation. 2016 Djibouti Country Profile.
[3] Ibid.
[4] Ibid.
[5] Ministry of Health Djibouti - Statistics and Studies Department, and Pan Arab Project for Family Health. 2012. Djibouti Family Health Survey.
[6] Ibid.
[7] Ministry of Health Djibouti, UNICEF and the European Union. 2013. National survey on nutrition using SMART methodology 2013.
[8] SMART survey, 2013.
[9] WHO. Nutrition Landscape Information System (NLIS) country profile indicators: interpretation guide. 2010

urban populations among the lower middle-income countries in Middle East and North Africa (MENA) and Sub-Saharan Africa (with around 80 percent of the population in urban areas and 60 percent in Djibouti City). The prevalence of stunting is higher among rural residents, compared to their urban counterparts (42.3 percent vs. 30.0 percent). Obock, Dikhil and Tadjourah regions have the highest stunting rates at 45.9%, 44.2% and 40.8%, respectively. Malnutrition is also linked to the socio-economic status of the household, and stunting is higher among the poorest twenty percent of the population as compared to the richest (37.2 percent vs. 18.2 percent).

10. It is estimated that, globally, one-third of perinatal deaths and one-tenth of maternal mortality are attributable to iron deficiency anemia, and anemia increases the risk of premature delivery and low birthweight. The adequate intake of micronutrients, particularly iron, vitamin A, iodine and zinc, from conception to age 24 months is critical for child growth and mental development. In Djibouti, nearly half (43 percent) of children under five and one-third (32 percent) of pregnant women suffer from anemia. This form of malnutrition increases mortality, weakens immunity, hinders cognitive development, and results in birth complications. In addition, vitamin A supplementation rates have dropped from 95 percent in 2011 to 50 percent in 2015. Adolescence is a time of rapid physical growth, second only to the first year after birth; and is a period in which one can gain up to 50 percent of their adult weight and skeletal mass, and more than 20 percent of their adult height. Adolescent girls have an increased risk of being undernourished since their rapid growth during puberty increases their needs for protein, iron and other micronutrients, and undernourished girls are more prone to complications of labor and delivery, and to give birth to low birth weight babies. Therefore, it is important to reach adolescents girls and women early and improve their health and nutrition status prior to entering their reproductive health years, such as through intermittent weekly iron and folic acid supplementation.

11. According to a contextual analysis conducted by the Ministry of Health (MoH) in 2014, and presented during the Identification Mission, the underlying determinants of stunting include poor infant and young child feeding (IYCF) practices, environmental health and food insecurity. In addition, access to and utilization of essential health services are constrained by both supply and demand side barriers. Community-based interventions are essential for promoting appropriate nutrition knowledge and behaviors as well as for increasing demand for essential services. In January 2018, the government has elaborated and validated a new national strategy for the prevention of malnutrition. This strategy is yet to be implemented.

12. All the regions in Djibouti have both critical levels of stunting (i.e., over 30 percent) and low coverage of key nutrition actions such as counseling on exclusive and complementary feeding, maternal health and nutrition interventions, education on sanitation and hygiene, and cash transfers for the vulnerable. Furthermore, the coverage of high impact nutrition interventions at the facility, community, and household levels (e.g., deworming, vitamin A supplementation, growth promotion, etc.,) is low in general and varies widely by region depending on the presence and support provided by development partners (DPs). Health care workers (HCW) have limited training in nutrition and therefore are unable to encourage necessary behavior changes essential to improving nutrition outcomes. Beginning in 2012, the community health worker (CHW) program in Djibouti was re-organized to focus on provision of services at the health facility level, thereby diminishing their role in the active identification and referral of children with malnutrition in the community. Meanwhile, Djibouti has the capacity to treat malnutrition cases, if they are properly identified and referred. The country has one nutrition referral center in each of the five regions, and one national nutrition referral center in Djiboutiville; these referral centers/hospitals can treat severe acute malnutrition with complications that requires hospitalization of patients. The country has seven nutritionists working in the referral centers (two based in Djiboutiville, and one in each of the five regions).

13. On the demand side, socio-cultural beliefs and practices, geographic and financial impediments including long distances to facilities, and general high levels of poverty and vulnerability all impede demand for health and nutrition services and behavior change that lead to favorable nutrition outcomes. For example, while 88 percent of women aged 15-49 years had at least one visit with a skilled health professional during pregnancy, less than a quarter (23 percent) complete all four WHO-recommended antenatal care visits. In rural areas, the distances to health care facilities, lack of awareness regarding the need for regular health check-ups, financial barriers and the poor condition of roads mean that the time, effort, and cost required to arrive at the point of delivery can be substantial.

14. Aside from low access to and utilization of basic services, high levels of food insecurity are contributing to high malnutrition rates. Djibouti imports most food consumed, and the domestic market prices of food items are affected by volatility in international food prices – it is estimated that more than 40 percent of a rise in international food prices is passed through to domestic food prices in Djibouti. Households with low purchasing power have difficulties accessing markets, even when prices are stable. In addition to seasonal obstacles in accessing food, households may experience shocks (i.e., drought, prolonged dry spells) that affects their ability to access food. Although current domestic food prices are forecast to be stable (Food and Agriculture Organization, FAO's June 2017 outlook predicts low and stable international food prices), the poor remain exposed to future volatility in food prices and hence risk of malnutrition.

15. Similar to many other countries in the region, Djibouti has taken a look at innovative solutions for addressing issues of food and nutrition insecurity, as well as water and sanitation, but there is still an urgent need to improve access to safe drinking water, sanitation and hygiene and nutritious foods throughout the country. Given the fact that the country is heavily reliant on imports for key staples, it has sought solutions to reduce its exposure to global market fluctuations for basic commodities, including the establishment of the Djiboutian Food Security Company (*Société Djiboutienne de Sécurité Alimentaire,* SDSA), charged with keeping food prices manageable. In addition, the country has legislation mandating the fortification of domestic wheat flour with iron, zinc and folic acid – currently 95 percent of wheat is fortified in Djibouti.[10]

16. Infants and children from vulnerable and poor households in rural areas have significant deficits in environmental health, that places them at a greater risk of stunting. In the last decade, there has been improvement in access to improved water and sanitation. Nevertheless, more than 23 percent of Djibouti's population practices open defecation, and 78 percent still lack access to improved toilets. There are also significant disparities between urban and rural areas: 77 percent of rural inhabitants practice open defecation compared to only 7 percent of urban habitants, and 70.4 percent of urban inhabitants have access to sanitation facilities while only 16.4 percent of the rural population has access to latrines.[11] Not only is water a scarce commodity in Djibouti, but recurrent droughts since 2009 have been negatively affecting the rural and urban vulnerable communities.

17. The presence of refugees and migrants has created additional pressure on infrastructure and has further stretched the limited capacity of the health system to provide basic health and nutrition services. In two out of the three main refugee camps in Djibouti, global acute malnutrition (GAM) rates exceed WHO's serious (10-14 percent) and/or critical (>=15 percent) severity thresholds. Obock, the region with the highest stunting and wasting rates in the country, is currently hosting the largest refugee population from Yemen. Refugees, asylum seekers and migrants

[10] Food Fortification Initiative. Djibouti Country Profile.
[11] WHO/UNICEF. Joint Program for Water Supply (JMP). 2017.

are fleeing from Somalia, Yemen and Ethiopia due to recurring armed conflicts and extreme poverty to seek asylum in Djibouti or to transit through Djibouti to the Gulf countries in search of better living conditions.[12] According to the United Nations, more than a quarter million people needed humanitarian assistance in Djibouti in 2017, which includes Djiboutians living in extreme poverty, refugees and asylum-seekers as well as migrants.

18. While the Government of Djibouti has demonstrated its commitment to improving nutrition by adopting a new strategy for preventing all forms of malnutrition and instituting national policies and initiatives, ongoing challenges remain. In 2006, a National Nutrition Policy (2008-2012) was developed to guide government actions in nutrition. Recently, in early 2018, the strategy for preventing all forms of malnutrition was developed with a focus on the 1,000-day "window of opportunity". Ongoing challenges include: inadequate numbers and poorly distributed human resources (especially at community level); inadequate supply of nutrition services; limited training of health workers to manage and treat acute and moderate malnutrition, as well as follow-up on defaulters; poor physical and financial access to health and nutrition services; low coverage of key nutrition interventions; weak links between health structures and the community; and stock outs of nutritional products at the health facility level**.**

19. At the same time, managerial and technical capacity gaps at all levels hinder progress. Specifically, poor managerial capacity for coordination and human resource constraints have limited the MoH's capacity to deliver nutritional services under the National Nutrition Program and to provide overall coordination for a multi-sectoral national nutrition agenda. The major challenge is therefore to refocus efforts on prevention at the community level, as the cost to prevent malnutrition is half the cost to treat it, and to ensure the involvement of other sectors that are critical in various aspects of nutrition service delivery by integrating nutrition-sensitive interventions.

20. Finally, the coordination and financing of nutrition interventions need to be improved to promote convergence of multi-sectoral efforts - e.g., health, agriculture, food security, nutrition, water, sanitation and hygiene (WASH), early stimulation, and social protection. International research shows that while nutrition-specific interventions are key to accelerating progress in stunting reduction, it is also critical that other sectors—like agriculture, education, and social welfare— develop nutrition-sensitive interventions. A truly multi-sectoral approach will achieve optimal nutrition outcomes through greater coverage, while also helping other programs achieve more powerful results and demonstrate their own potential for impact.

21. While Djibouti benefits from financing for nutrition from several major development partners such as the Bank, the European Union (EU), United Sates Agency for International Development (USAID), United Nations Children's Fund (UNICEF), World Food Programme (WFP), there are persistent financing gaps and challenges in ensuring synergies between investments. All five regions benefit from some funding for interventions, but few of the required interventions are provided to scale, and coverage of beneficiaries varies widely. In addition, a clear focus on stunting prevention at the community level with a comprehensive package of interventions is still largely missing.

C. Higher Level Objectives to which the Project Contributes

22. The proposed project is fully aligned with the Djibouti Country Partnership Strategy (CPS) for FY14-FY17 discussed by the Board on March 13, 2014. The CPS supports Djibouti Vision 2035, the Government's long-term approach to development. Vision 2035 includes a pillar on the consolidation of human capital to ensure the well-being of the population, to which the CPS' pillar of "reducing vulnerability" corresponds. One of the outcomes under

[12] UNOCHA. 2017. UN Humanitarian Response Plan.

this pillar of reducing vulnerability is improved utilization of good quality maternal and child health (MCH) care services and communicable disease control programs. The proposed project would contribute to better MCH outcomes by targeting women of reproductive age, including pregnant and lactating women, and adolescent girls. It would also tackle childhood malnutrition in general and stunting in particular, which is a key component of, and significant challenge for, improving MCH outcomes.

23. The upcoming Systematic Country Diagnostic (SCD)[13] identifies child nutrition as essential for transforming human capital in Djibouti. One of the priority areas of the SCD is "tackling reforms to health and nutrition services" by strengthening service delivery and expanding the availability and capacity of skilled health workers. The proposed project would contribute to this priority area, as it aims to improve access to quality health and nutrition services, as well as improving the overall capacity for scaling-up nutrition interventions, involving different government entities and other stakeholders.

24. In addition, this project is fully aligned with the MENA regional strategy that is focused on building greater citizen engagement, more effective protection of the poor and vulnerable, inclusive and accountable service delivery, and a stronger private sector that can create jobs and opportunities. With the focus on scaling-up the delivery and improving the accessibility of quality health and nutrition services, improving beneficiary tracking and monitoring by supporting the development of new tools and technologies (including modernizing ICT systems), and incorporating mechanisms for citizens to provide feedback on the quality of services, the proposed project contributes to two pillars of the MENA Regional Strategy – "renewing the social contract" and "resilience to refugee/IDP shocks". The project addresses the latter pillar on resilience to refugees/IDPs through support to the already overburdened health system due to the growing number of refugees.

25. The project is also aligned with the World Bank Gender Strategy and contributes to the first pillar – "improving gaps in human endowments" - through improved access and quality of health and nutrition services, in combination with new knowledge and skills on maternal and child nutrition, at specific periods of the life cycle.

26. Djibouti is one of the priority countries under the World Bank's "Investing in Early Years" initiative, and this project will make a key contribution to this initiative. This agenda is focused on significantly increasing investments and supporting multi-sectoral interventions from pregnancy to five years of age, given the importance of good early child development outcomes for longer term development and productivity.

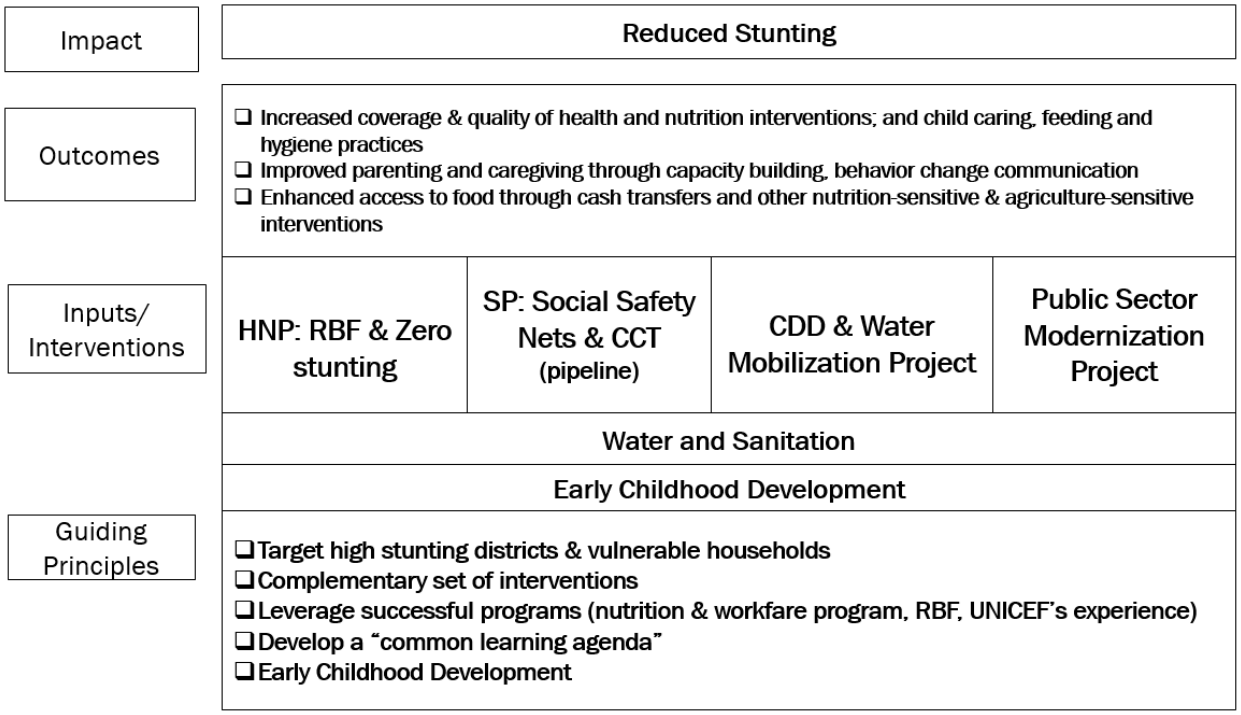
27. This project will encourage convergence of interventions critical for stunting reductions by leveraging existing and upcoming World Bank financed projects in various sectors. The World Bank program includes six projects in Health, Nutrition and Population (HNP), Social Protection, Community Driven Development (CDD) and Water, and Governance that will contribute to addressing the immediate and underlying causes of stunting and support a wide range of complementary interventions to maximize synergies and promote convergence (see Fig. 1 below). The program will be coordinated across the sectors and will draw on the best global evidence, and facilitate knowledge sharing across countries, with a commitment to a "joint learning agenda". The convergence envisioned under the project includes: leveraging other key platforms for delivering services, such as through the CHW program, and enhanced local government capacity, which are critical for the effective delivery of services across multiple sectors; as well as promote multi-sectoral coordination at the community level by advocating for the creation of "nutrition committees". The project also includes several cross-cutting dimensions such as *behavioral change communication* to bring about a change in infant and young child feeding and care behaviors and WASH practices;

[13] The SCD is scheduled to go to the Board in June 2018.

and *service delivery innovations*, such as interactive technologies and integrated information systems for prompt identification of children at-risk of stunting.

28. Considering the shift in 2012 to focus CHW at the health facility level, there is the need to support the revitalization of the CHW program at the community level. As such, the project will help to develop a revitalized CHW strategy to improve the CHW programming and performance through trainings and re-trainings on a revised nutrition curriculum, promote supportive supervision and mentorship by health center personnel, support the use of new technologies to enhance their effectiveness and strengthen their links with the community, and strengthen the commodity supply chain. Incentives for CHWs will include the use of performance-based contracts, training and career progression opportunities.

Figure 1: Convergence of interventions Critical for Reducing Stunting



II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

29. The project development objective is to reduce stunting among children under five in Djibouti.

B. Project Beneficiaries

30. The main project beneficiaries will consist of children under five, as well as pregnant and lactating women, with a specific focus on the 1,000-day "window of opportunity" (pregnancy through the second birthday) before stunting becomes largely irreversible. To have impact in this period, the project will also focus on adolescent girls by providing

iron and folic acid. Refugees, migrants and asylum seekers living in host communities outside of camps will benefit from the project activities as they seek care at health facilities and attend community level activities. Direct beneficiaries of the nutrition services are estimated to be about 150,000 (of which 100,000 female). In addition, HCWs, including CHWs, will also benefit from this project through training, and community health volunteers will receive technical supervision and quality assurance of their activities. Personnel within the MoH, MoA, MoFW and SSSA will also benefit from improved overall capacity. The general public will be exposed to communication campaigns as well.

C. PDO level indicators

31. Progress towards stunting reduction will be monitored through appropriate impact indicators and intermediate indicators that focus on practices and behaviors that are known to have an impact on the nutritional status of infants, children, and pregnant and lactating women. The main PDO level indicators are: (i) Percentage of infants 0-6 months exclusively breastfed; (ii) Percentage of children 6-23 months consuming a minimum acceptable diet/diverse diet; (iii) Women who attended at least four antenatal care visits during their most recent pregnancy; (iv) Percentage of children 6-59 months who are stunted; (v) Women referred by CHWs and registered at the health facility within 4 months of pregnancy (disbursement-linked indicator - DLI - #1A); (vi) Women referred by CHWs, who completed at least 3 antenatal care visits at the health facility (DLI #1B); and (vii) Women referred by CHWs, who completed at least 2 postnatal visits at the health facility (DLI #1C).

32. The targets for the indicators have been agreed with government counterparts, and are included in the Results Framework (Section VII). The government has set the goal of reducing stunting from 30 percent in 2017 to 24 percent in 2025 through the scale-up of a prioritized package of essential nutrition-specific and nutrition-sensitive interventions.

III. PROJECT DESCRIPTION

A. Project Components

33. The project will support the Government of Djibouti in combating stunting multi-sectorally through the adoption of a "Zero stunting" strategy that is centered around a community based approach along with scaling up the delivery of high impact nutrition and health services. The Government has prioritized a package of essential nutrition-specific and nutrition-sensitive interventions that need to be implemented at scale. The project draws on global best practices and focuses on a national scale-up of high impact, cost effective interventions. The project will focus primarily on stunting reduction considering that the Government, other DPs including UNICEF and WFP, and the ongoing World Bank financed health project (PAPSS) are already focused on identification and treatment of acute malnutrition.

34. To achieve the PDO, the proposed project will expand the scope, scale, and coverage of ongoing nutrition interventions nationwide. The proposed project will include three main components emphasizing the scale-up and quality of both supply and demand side interventions. Several approaches will be implemented to improve the quality, coverage and uptake of nutrition services in Djibouti, including: (i) delivery of high quality essential health and nutrition services at health facilities and in the communities that respond effectively to women and children's needs in health, nutrition, and early stimulation; (ii) strengthening the capacity of health care providers, community health workers and community volunteers to deliver high quality nutrition services; (iii) behavior change communication to reach parents, caregivers and children in the communities to enhance their knowledge and create an environment

conducive to care seeking behavior; and (iv) policy, coordination and monitoring and evaluation support at the national level in order to ensure that all relevant sectors are involved and progress is captured and tracked. The Project will adopt a financing structure with an investment project financing (IPF) portion for Subcomponents 1.1 and 1.2a, Component 2, and Subcomponent 3.1; and a results-based financing (RBF) portion using Disbursement Linked Indicators (DLIs) for Subcomponent 1.2b and Subcomponent 3.2.

35. Component 1: High-impact Health and Nutrition Services to Reduce Stunting (US$11.6 million, of which US$7.3 million IDA). This component focuses on the delivery of services and interventions that address stunting at both the facility and community levels.

36. ***Sub-component 1.1: Strengthening of health and nutrition services at the facility level (US$9.4 million, of which US$5.1 million IDA).*** To address gaps in service delivery, this sub-component will improve the provision, quality and utilization of an enhanced package of high-impact nutrition and health interventions at the facility level. These interventions include those identified in the government's National Nutrition Program which are in line with the 2008/2013 Lancet recommendations of the most effective interventions in reducing stunting, including: (i) growth monitoring and promotion and effective tracking of faltering children, exclusive breastfeeding from birth to six months and appropriate complementary feeding thereafter, deworming, and micronutrient supplementation (i.e., Vitamin A supplementation, therapeutic zinc supplementation with Oral Rehydration Salts, and multiple micronutrient supplement powders); (ii) critical nutrition and health interventions for women (i.e., four antenatal care visits, four postnatal care visits, iron/folic acid supplementation, post-partum family planning, counseling on child care, and complementary feeding and hygiene); (iii) improving water, sanitation and hygiene (WASH) in health care facilities including through water treatment, safe water storage, and promotion of hygienic practices in health facilities; and (iv) improving linkages, referrals and counter-referrals between health facilities and the community. The project will also support the training of Central Medical Stores (Centrale d'Achat des Medicaments et Matériels Essentiels) staff on nutrition supply management and improving the management of nutrition supply system. Health facilities will be held accountable to provide these interventions, as well as benefit from training, and commodities and logistical support from the national level. For nutrition referral centers, the project will aim to improve the quality of treatment for services provided at the regional and national levels. Through the ongoing PAPSS, incentives are provided to health workers/health facilities for nutrition service delivery at the facility level utilizing results based financing.

37. ***Sub-component 1.2: Prevention and management of stunting and wasting at the community level (US$2.2 million IDA).*** This sub-component will support the delivery of health and nutrition services at the community level, as well as the critical element of community sensitization and promotion. This subcomponent will be financed through an investment project financing (IPF) portion for Subcomponent 1.2a and an RBF portion using DLIs for subcomponent 1.2b.

38. ***Sub-component 1.2a Supporting behavior change and outreach at the community level (US$0.75 million IDA).*** Through this portion of the sub-component, financed through IPF, the project will: (i) support behavior change, health promotion, and community mobilization and sensitization by utilizing a Behavioral Change Communication (BCC) strategy, that incorporates locally appropriate messaging on maternal nutrition, IYCF and WASH; (ii) define a common community participation strategy between the different sectors and facilitate convergence of a multi-sectoral minimum package of services at community level; (iii) utilize the positive deviance approach by identifying good practices from mothers in the community who have well-nourished children; (iv) address the essential WASH elements by providing targeted support to vulnerable households to improve access to WASH interventions (i.e., water treatment, handwashing stations with soap and safe water storage); (v) provide adolescent girls with iron and folic

acid supplementation; and (vi) increase the number of mobile clinics/teams and the number of visits they conduct to ensure rural and nomadic populations have access to health and nutrition services. The nutrition services offered by both the mobile clinics and the bi-annual medical caravans will be strengthened with support from the project.

39. In addition, this sub-component 1.2a will support increased country-level awareness and action in nutrition through the formation of "nutrition committees" that will be provided with training and communications materials. These committees are not only key in making the invisible problem of stunting visible at the community level but also for the integration of nutrition in health and WASH activities and policies, and for collecting data on nutrition issues. A mechanism for citizen engagement will also be developed to facilitate the feedback of the beneficiaries on the quality and appropriateness of nutrition services delivered at the community level and in health facilities.

40. ***Sub-component 1.2b Strengthening the role of community health workers (US$1.45 million IDA).*** Through this portion of the sub-component, financed through results based financing (DLIs), the project will provide training, mentoring, equipment and incentives to CHWs and community volunteers to identify, refer and follow-up on children at-risk of stunting. The MoH has an existing cadre of CHWs that will be supported through the project to play an enhanced role in community outreach that is critical for the behavior change needed to prevent and reduce stunting.

41. CHWs and other community health actors, including *mères conseillères* and community health volunteers, are a critical link in improving access to health and nutrition services in Djibouti. This subcomponent will support increased productivity and performance of CHWs through enhanced training, improved supervision and mentorship, new and innovative technologies to enhance their effectiveness and strengthen links between the community and health facilities, and strengthening of the commodity supply chain. The DLIs - "1A-Number of women **referred** by community health workers and **registered** at the health facility within the first 4 months of pregnancy; 1B-Number of women referred by community health workers who **completed at least 3 antenatal visits** at the health facility; and 1C-Number of women referred by community health workers who **completed at least 2 postnatal visits** at the health facility" (total DLI value = $1.45 million) are proposed to revitalize the CHW program and promote expedited progress in the implementation of community-based interventions by CHWs that are important for stunting reduction in the first 1000 days. CHWs will provide supportive supervision and ensure technical quality of community based nutrition interventions including the work of mères conseillères and being the linkage between the community and the health facilities. CHWs are salaried MoH staff who work in a catchment area of a health facility, while mères conseillères are volunteers who interface directly with households at the community level; those supported by the Bank's Social Safety Net project receive food rations. One CHW will have several mères conseillères working in his/her intervention area that they would provide support to.

42. **Component 2: Strengthening Multi-sectoral Interventions for Stunting Reduction (US$3.3 million IDA).** This component will focus on creating an enabling environment for strengthening multi-sectoral interventions that are critical for reduction of stunting.

43. ***Sub-component 2.1: Using multi-sectoral platforms for the prevention and management of stunting (US$2.27 million IDA).*** Under this sub-component a mass media and Behavioral Change Communication (BCC) strategy will be developed (informed by Knowledge, Attitude, Practice – KAP - surveys and stakeholder consultations) to facilitate the development of locally appropriate stunting prevention messaging, including the consumption of fish which is a good source of protein but is not widely consumed in Djibouti. Additionally, this component seeks to ensure linkages with the WB Djibouti Crisis Response Social Safety Net Project and the Rural Community Development and Water Mobilization Project (PRODERMO) when conducting follow-up of stunting cases, case management, and prevention.

44. ***Sub-component 2.2: Addressing stunting in relevant policies and strategies (US$0.5 million IDA).*** This sub-component will support and engage the line ministries involved in the multi-sectoral response to create an enabling environment for stunting prevention. The line ministries will be supported to formulate or update their policies, strategies, norms, guidelines and protocols to facilitate an enabling environment for the implementation of multi-sectoral nutrition interventions.

45. ***Sub-component 2.3: Multi-sectoral capacity building (US$0.53 million IDA).*** To strengthen the capacity of sectoral institutions to deliver nutrition interventions, this sub-component will complement and scale-up ongoing initiatives under the National Nutrition Program, including technical assistance, training, coordination, supportive supervision, and associated materials to build the capacity to deliver multi-sectoral nutrition services to communities; as well as focus on improving capacity at all levels (national, regional, health facilities, etc.) to address the multi-sectoral nature of stunting. As a first step, a gap analysis will be undertaken to identify capacity needs at a national, regional and facility level to ensure effective targeting of the support provided through the project. Specifically, the subcomponent will: (i) Support multi-sectorial coordination at political and technical levels; (ii) Strengthen the leadership and capacity of the MoH national and regional nutrition programs so as to more effectively play a coordination and facilitation function; and (iii) Support the development of a National Nutrition and Food Coordination Authority (NNFCA) that will aim to strengthen the capacity of key stakeholders involved in the delivery of nutrition services, including health professionals and organizations/associations working at the community level.

46. **Component 3: Strengthening Coordination, Project Management and Monitoring and Evaluation (M&E) (US$4.4 million IDA).** The activities under this component support and complement the interventions under Components 1 and 2, aiming to improve the capacity of national implementing entities to effectively manage project implementation, coordinate various entities, monitor implementation progress, and evaluate effects of the project. This component will be financed through an investment project financing (IPF) portion for Sub-component 3.1 and an RBF portion using a DLI for Sub-component 3.2.

47. ***Sub-component 3.1: Institutional strengthening for coordination, project management and M&E (US$3.9 million IDA).*** This IPF-financed sub-component will support: (i) the day-to-day management of project activities, including fiduciary activities; (ii) technical assistance and capacity building activities to support the implementing entities; (iii) building capacity for programmatic mapping, including geospatial mapping for strategic planning and to identify gaps in service provision (see Box 1 below); and (iv) M&E activities such as periodic surveys, nutrition surveys and assessments, and impact evaluations to draw timely lessons on what works, how much it costs, and how it can be scaled up, and monitor implementation progress and address any implementation challenges.

48. ***Sub-component 3.2: Strengthening the use of information systems for enhanced M&E capacity (US$0.5 million IDA).*** This DLI-financed sub-component will support the development, promotion and use of information systems to identify, refer and track children and women, early malnutrition detection, as well as ensure that the correct structures and systems are in place to implement and monitor nutrition interventions. The DLI #2 - “Percentage of health facilities that have annual disaggregated data using the District Health Information System (DHIS2)” (total DLI value = $0.5 million) is proposed to accelerate progress in this area, the achievement of which will lead to transformational change for Djibouti. This will be important for: (i) the project, both in terms of the application of technological solutions for beneficiary tracking and monitoring as well as timely availability of data from both health facility and community levels; and (ii) strengthening the health system more broadly. As part of the effort to improve the health information system, the existing disease surveillance mechanism will also be strengthened to capture any early warnings for

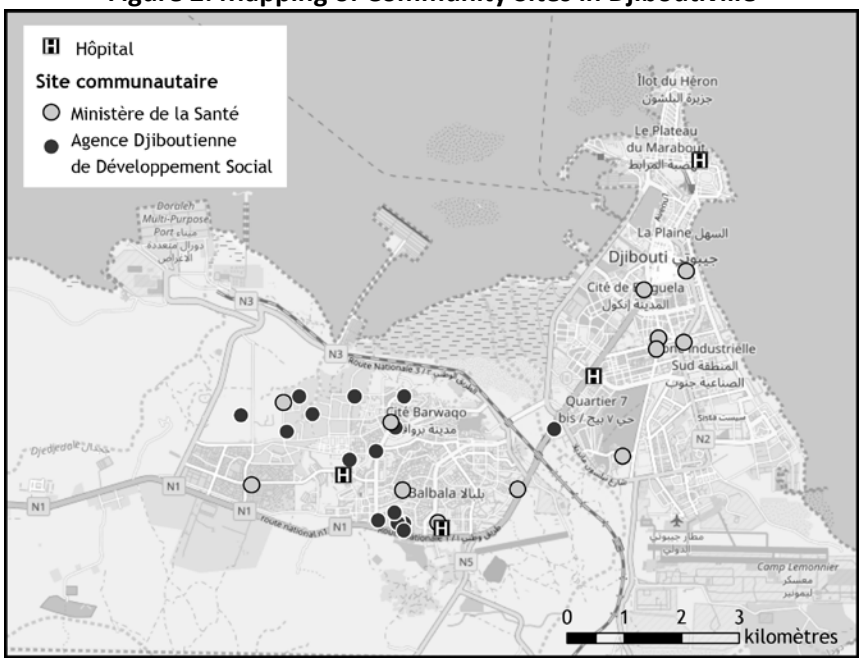
possible consequences of climate change, such as extreme temperatures and drought, which have been identified as having high potential impact on project implementation.

Box 1: Programmatic Mapping

Programmatic Mapping to inform Project Design and Implementation Roll-out. The Bank is providing technical assistance to the Ministry of Health and its partners in programmatic mapping to inform prioritization, targeting and scale up of a national multi-sectoral nutrition program in Djibouti.

The proposed work will help to answer the question "who is doing what where", and "what parts of the minimum package of nutrition services are currently being offered, and by whom". The programmatic mapping will enable the generation of evidence at the local level that will inform the planning and delivery of services. It will include a mapping of existing healthcare infrastructure and nutrition service delivery points as well as outreach areas for mobile health teams, community health workers or community volunteers that can be factored into the program design, and can help in the identification of gaps that may need addressing and establish referral linkages between the community and health-care facilities and vice versa. The results of the mapping will inform the development of a service delivery model across the continuum of care and between models of service delivery (including clinical care settings, outreach, household and communities). As a result of the aforementioned data, the prioritization, targeting and scale-up plans will be developed for both the IDA-financed project, as well as for the broader national nutrition program that is financed by the Government as well as other development partners, e.g., UNICEF's project funded by the EU. Below is an example of a map that has been created as part of project preparation.

Figure 2: Mapping of Community Sites in Djiboutiville



49. ***Component 4: Contingent Emergency Response Component (CERC) (US$0).*** A CERC is included in the project as a US$0 component, in accordance with Operational Policy (OP) 10.00 paragraphs 12-14, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the

event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact with public health consequences.

50. An "Emergency Response Operational Manual" (EROM) will be prepared as part of the Project Operational Manual (POM). Triggers for the CERC will be clearly outlined in the EROM acceptable to the World Bank. 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.

B. Project Cost and Financing

Project Components	Project Cost US$	IDA Financing US$	Counterpart Funding
Component 1: High-impact Health and Nutrition Services to Reduce Stunting	11,600,000	7,300,000	4,300,000
Component 2: Strengthening Multi-sectoral Interventions for Stunting Reduction	3,300,000	3,300,000	
Component 3: Strengthen Coordination, Project Management and Monitoring and Evaluation	4,400,000	4,400,000	
Component 4: Contingent Emergency Response	0	0	
Total Costs	19,300,000	15,000,000	4,300,000
Total Project Costs			
Total Financing Required	19,300,000	15,000,000	4,300,000

C. Lessons Learned and Reflected in the Project Design

51. The project focuses on scaling up the nutrition interventions which have the strongest evidence of impact (see Box 2) - and that are feasible and cost-effective – as well as considers lessons from other countries on what it takes to prevent and reduce the burden of stunting. Careful attention was given to the implementation experience to date in Djibouti, as well as other countries such as Peru, Ethiopia and Rwanda. The key lessons that are incorporated in the design can be summarized as follows:

(a) The benefits of a multi-sectoral approach that incorporates all relevant sectors and has a mix of interventions focusing on both the supply and demand of services. International studies show that scaling up nutrition-specific interventions reduce stunting levels by about 20 percent, while scaling up multi-sectoral interventions at the same time contribute to reducing the remaining 80 percent (Lancet 2013). Because stunting has multiple causes, the interventions to reduce it must involve various sectors. Implementation experience from Ethiopia - where stunting rates dropped from 50.7 percent in 2005 to 40.4 percent in 2014 – demonstrates the importance of involving sectors outside of health (for nutrition sensitive interventions) from the beginning in

program design, and integrating nutrition-related actions in various initiatives. Most notably, nutrition priorities were aligned with the national food security strategy and integrated into the 4th phase of the country's Productive Safety Net Program (PSNP). However, even though there is not necessarily a fixed combination of interventions that consistently demonstrate greatest benefit in all contexts, implementation experience from other countries clearly demonstrates the importance of multiple sectors and actors. To that extent, the proposed project will align its activities with other World Bank operations in Djibouti to achieve convergence of interventions proven to have the greatest impact on stunting reduction.

(b) Preventing stunting by improving nutrition for women and children during the first 1,000 days is key to ensuring that every child reaches his/her full potential. This includes promoting healthy eating during pregnancy, early initiation of breastfeeding and exclusive breastfeeding, complementary feeding, and dietary diversity. In 2006, only 1.3 percent of the Djibouti mothers were exclusively breastfeeding and significant effort is needed to improve breastfeeding practice across the country. Previous projects in Djibouti have used grandmothers for the promotion of exclusive breastfeeding and nutrition of pregnant and lactating women and complementary feeding after six months. The package of interventions to be implemented through this project will include a specific focus on the critical 1,000-day window, including pregnancy.

(c) Strategic planning and coordination together with community engagement is key to effective nutrition programming, as well as awareness creation at all levels. Countries such as Peru demonstrate how a combination of factors can achieve significant and lasting changes in stunting, including: (i) political will, served by the adoption of clear and ambitious targets to reduce stunting and evidence-based programs; (ii) strong coordination between government ministries, health professionals and non-governmental organizations (NGOs); (iii) broad societal participation; (iv) increased government spending ; and (v) strategies focused on increasing the coverage of health and nutrition services among the most vulnerable. At the same time, a strong communications strategy led by NGOs, the government and international partners made the "invisible problem" of stunting in Peru visible, and ensured that households and communities had the opportunity to change health, nutrition and hygiene practices.

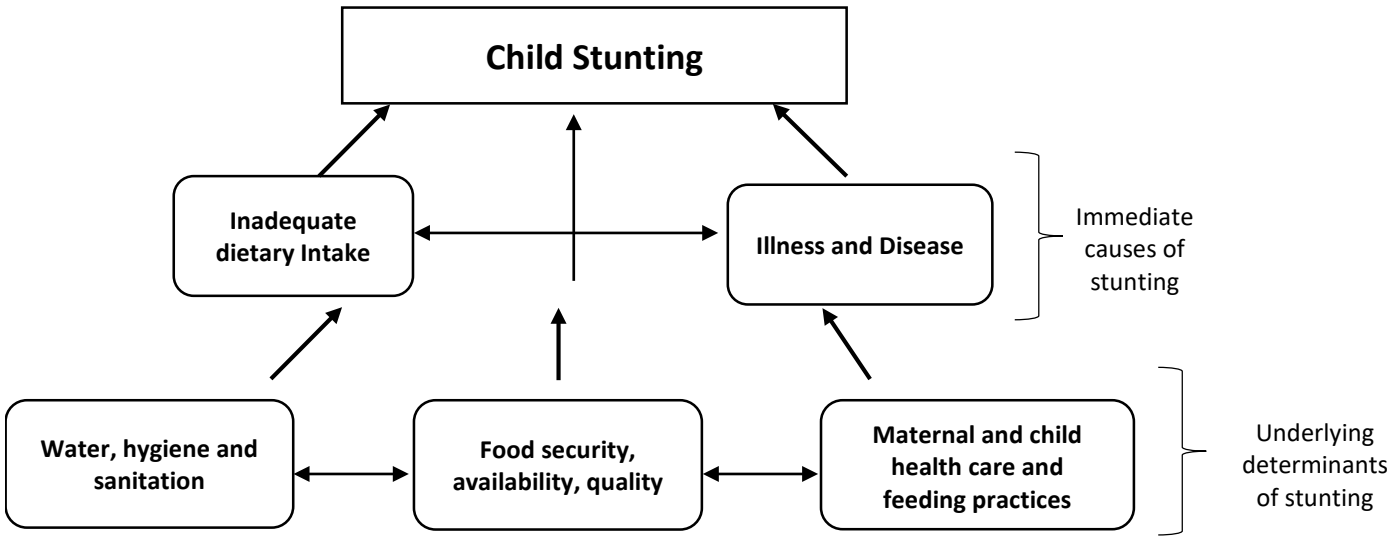
(d) CHWs play an important role in changing behaviors and improving nutrition. CHWs are a key point of contact for families during the critical 1,000-day window when poor nutrition and lack of stimulation may cause irreversible physical and cognitive losses, as well as equip families with the knowledge and skills to prevent malnutrition. Experiences from other countries like Senegal, where a focus was placed on improving nutrition through a community-based holistic strategy, show how critical CHWs are in changing nutrition-related behaviors and practices such as breastfeeding and hygiene, and contributing significantly to the reduction of stunting. Therefore, this project will support the revitalized community health workers program in Djibouti through enhanced trainings and easy-to-use tools focused on reinforcing household behavior change on breastfeeding, complementary feeding and WASH. The CHWs will provide mentoring and supportive supervision support for mères conseillères and other types of volunteers working on community based nutrition interventions, creating that essential link between health facilities and the community.

Box 2: Global Evidence on Stunting Reduction

Stunting is largely irreversible if not addressed in the first 1,000 days. The first 1,000 days, from a woman's pregnancy to the child's first two years, is a critical window of growth and development. Stunting, or a manifestation of chronic malnutrition, during this period is largely irreversible and is associated with diminished cognitive and physical development, reduced productive capacity, and an increased risk of chronic diseases later in life, which have immediate and long-term effects at individual, community and national levels. In Africa, child undernutrition is associated with up to 0.2 to 3.6 years less of schooling, as much as 22 percent loss of yearly income in adulthood,[14] and 1.9 percent to 16.5 percent of GDP.[15]

The determinants of stunting are not exclusively within the health sector. As outlined in UNICEF's conceptual framework[16] of child undernutrition, the determinants of stunting include poor dietary intake, frequent and repeated episodes of illness and disease, and poor birth outcomes, such as low birth weight and premature birth. These are in turn caused by complex and multi-sectoral determinants, including poor maternal, infant and young child care and feeding practices; poor water, sanitation, and hygiene; and household food insecurity (including poor diet quality and insufficient quantity).[17] Figure 3 presents a simplified version of the UNICEF conceptual framework adapted to Djibouti.

Figure 3. Immediate and Underlying Determinants of Stunting in Djibouti



[14] Grantham-McGregor, S; Cheung, YB; Cueto, S; Glewwe, P; Richter, L; Strupp, B. 2007. Developmental potential in the first 5 years for children in developing countries. *Lancet* 369 (9555): 60-70

[15] African Union Commission, NEPAD Planning and Coordinating Agency, UN Economic Commission for Africa, and UN World Food Programme. 2014. The Cost of Hunger in Africa: Social and Economic Impact of Child Undernutrition in Egypt, Ethiopia, Swaziland and Uganda. Report. Addis Ababa: UNECA.

[16] UNICEF. 1991. Conceptual Framework on the Causes of Malnutrition.

[17] Black et al 2013 (Lancet)

It is evident from the framework above that achieving sustainable reductions in stunting is dependent on multiple factors. Global evidence has shown that scaling up nutrition-specific interventions to address the immediate determinants of child nutrition is essential, through a combination of health and nutrition-focused interventions. Complementary nutrition-sensitive interventions to address the underlying determinants of child nutrition are necessary to optimize reductions in stunting. The Lancet Nutrition series of 2013[18] estimated that scaling up 10 key nutrition interventions to 90 percent of coverage could result in a 15 percent reduction of under-five mortality, a 20 percent reduction in stunting, and a 61 percent reduction in severe wasting. Among the 10 most effective interventions identified and considering that the main underlying determinants of stunting in Djibouti include poor infant and young child feeding practices and water, sanitation and hygiene, the project will support the following high impact evidence-based nutrition specific interventions: (i) Peri-conceptual iron and folic acid supplementation; (ii) Promotion of breastfeeding; (iii) Appropriate complementary feeding; (iv) Vitamin A supplementation;, and (v) Prevention and management of severe and moderate acute malnutrition. At the same time, key nutrition-sensitive multi-sectoral actions will be implemented to improve water and sanitation and strengthen health services.

Reducing stunting prevalence requires long-term, sustained policy and multi sectoral program support. Peru's success in halving stunting over eight years (from 28 percent to 13 percent, a reduction of about 1.9 percentage points/year) and Senegal's experience of reducing stunting from 33 percent to 19 percent over 11 years (about 1.3 percentage points/year). showed the importance of political commitment and multi-sectoral coordination; a focus on evidence based high impact health and nutrition interventions (such as those listed above); and a behavior change communication strategy rolled out to communities. The design of this program has also drawn upon recent evidence that showed that though combined nutrition-specific and -sensitive interventional packages result in the greatest reductions in stunting, there is not necessarily a fixed combination of interventions that consistently demonstrate the greatest benefit in all contexts. For example, results from the Sanitation Hygiene Infant Nutrition Efficacy ("SHINE") Trial, a community-based trial in rural Zimbabwe, showed that while WASH strategies were effective at reducing diarrhea, alone and together with other interventions they did not reduce growth faltering, highlighting the importance of developing comprehensive strategies, including improved collection of nutrition data and frequent monitoring of effectiveness, and testing new approaches that fit each context.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

52. Institutional arrangements for the National Program on Nutrition. Given the importance of the nutrition agenda in Djibouti, a National Council on Nutrition (NCN) composed of all the sectors involved in the agenda will be created. The establishment of the NCN was a key recommendation following the elaboration of the 2018 strategy to address prevention of the different forms of malnutrition, and emanated from the need to have a multi-sectoral coordination mechanism at the highest level. The NCN will be composed of several ministries (Ministry of Health, Ministry of Economy and Finance, Ministry of Agriculture, Ministry of Education, Ministry of Commerce, Ministry of Women and Family, and State Secretariat for Social Affairs), with representation at the Ministerial level, and it will

[18] Black, R. E., C. G .Victora, S. P. Walker, Z. A. Bhutta, P. Christian, M. de Onis, M. Ezzati, S. Grantham-Mc- gregor, J. Katz, R. Martorell, R. Uauy, and the Maternal and Child Nutrition Study Group. 2013. "Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries." *The Lancet* 382: 427–51.

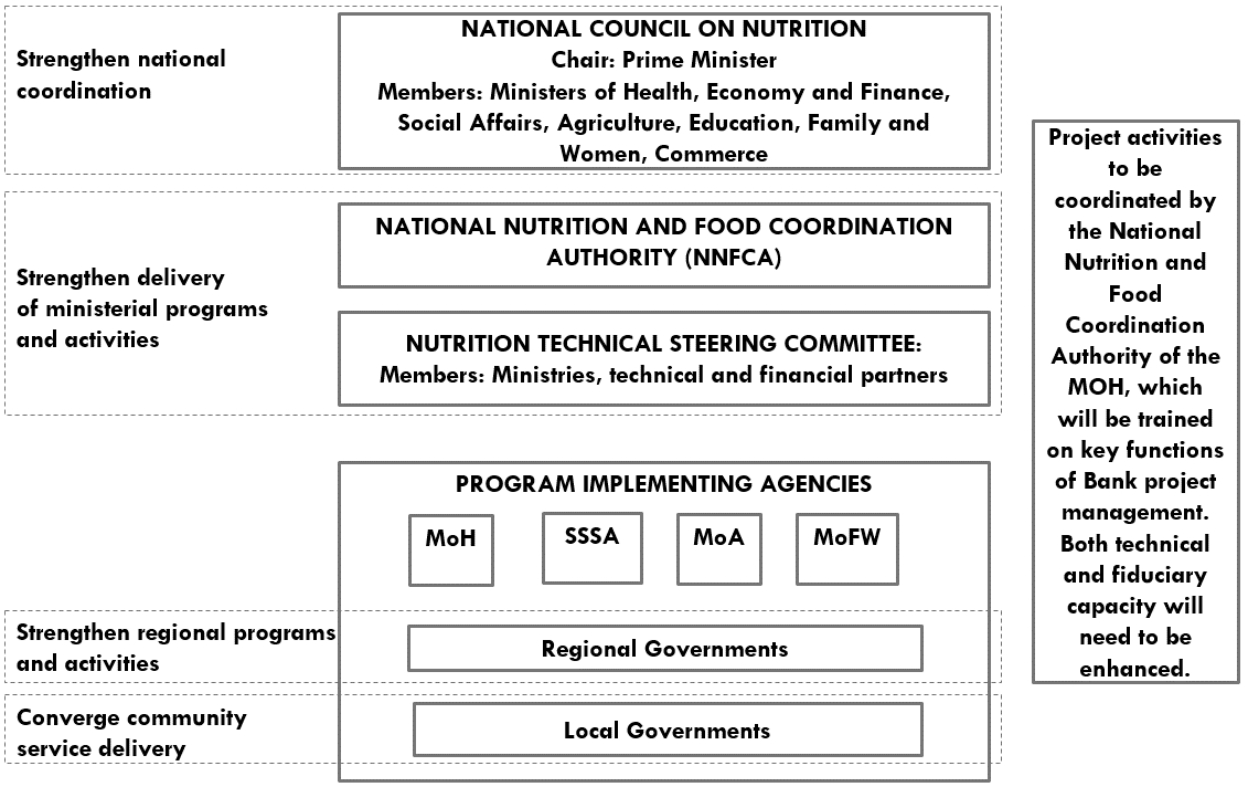
meet twice a year to review progress and national targets on the nutrition agenda. The focus of the NCN will be to review targets and progress made with respect to the different types of malnutrition.

53. Implementation arrangements for the project. A Project Steering Committee (SC) chaired by the Secretary General of Health and comprising the Secretary Generals of the following Ministries will be established: Ministry of Economy and Finance; Ministry of Agriculture; Ministry of Women and Family; and State Secretariat for Social Affairs. The SC will meet monthly during the first six months of project implementation, and every three months thereafter. The functions of the Steering Committee will be: (i) project oversight, including provision of overall project guidance; (ii) approval of annual work plans and budgets; (iii) facilitation of coordination of project activities; and (iv) preparation for the NCN Meetings that will be held every six months.

54. The project will be implemented by the National Nutrition and Food Coordination Authority in the MoH that will be formed on the basis of the current Nutrition Division which is under the Department of Maternal and Child Health. The new NNFCA will have a direct reporting line to the Minister of Health, and will ensure multi-sectoral coordination and action to address the different forms of malnutrition, and in particular to prevent and reduce the high stunting rates in Djibouti. The MoH has already appointed key technical staff (Director and staff responsible for M&E, social mobilization and communication) for the NNFCA, and they have been part of the Ministry's project preparation team. Fiduciary staff will be appointed no later than one month from Credit effectiveness. To achieve the PDO, a multi-sectoral response is required with the MoH leading the nutrition specific interventions and other Ministries (Ministry of Women and Family, Ministry of Agriculture; Ministry of Commerce; and the State Secretariat for Social Affairs) implementing nutrition sensitive interventions. In an effort to simplify implementation arrangements, and in recognition of the Djibouti country context, the MoH will be responsible for implementing activities based on its mandate and will also house the project management functions under the NNFCA (playing the coordination role and being responsible for the day to day management of the project).

55. The proposed arrangement would ensure that the nutrition program is integrated into the structure of the MoH. The NNFCA will be headed by a Director who will also serve as the Project Coordinator, and will report directly to the Minister of Health. The NNFCA will manage the national multi-sectoral nutrition program and coordinate with relevant ministries and stakeholders, as well as be responsible for the effective implementation of the project. The NNFCA will be responsible for carrying out: (i) the administrative and financial functions, including financial management by a financial officer and project procurement by a procurement specialist; and (ii) the technical functions that ensure the quality of the provision of nutrition services, the design of strategies for the promotion of adequate nutrition, the planning and organization of nutrition training, the monitoring and evaluation of all nutritional interventions, and communications. The NNFCA will monitor and evaluate the progress of the Project and prepare Project Progress Reports every semester, starting from Credit effectiveness, and submit them to the World Bank no later than one month after the end of the period covered by such report. The Progress Report will provide detailed reporting on project progress by components, procurement, financial management, verification reports received from the independent verification agency, and environmental and social issues. In addition, an annual external audit, combining both technical and financial audit, will be conducted to ensure the appropriate use of funds and to monitor progress of project activities.

Figure 4: Institutional and Implementation Arrangement



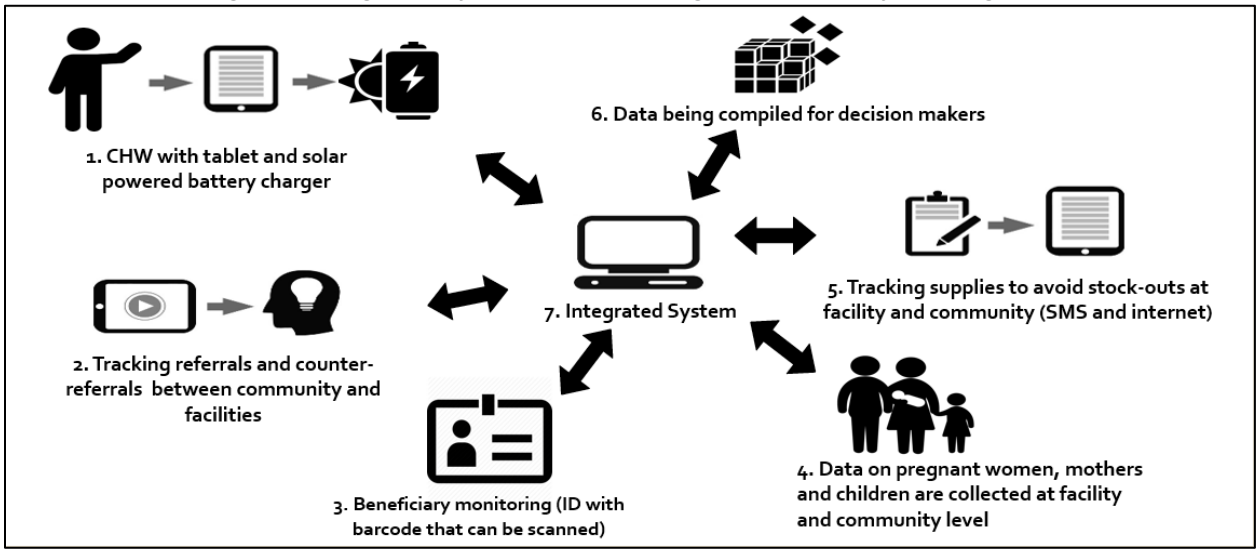
56. Institutionalization of the project to ensure sustainability. The Ministry of Finance and the MoH have expressed a desire to have the project institutionalized within the existing Government structures and not to establish parallel structures, e.g., a Project Management Unit (PMU) staffed with consultants that cannot be sustained beyond the life of the project. Therefore, with the establishment of the NNFCA within the MoH, the use of existing staff and the appointment of a few critical positions (including both technical and fiduciary capacity) will ensure institutionalization and sustainability of the program. See Annex 1 for the list of key positions.

B. Results Monitoring and Evaluation

57. Support for strengthening the national Health Management Information System (HMIS). A well-functioning HMIS system is critical for monitoring project progress. Therefore, the project will support the MoH in strengthening its HMIS to ensure that the system provides credible and timely data to inform program implementation, facilitate the monitoring of project activities at both facility and community level, as well as to improve the health sector's overall M&E capacity. The project will support the development and roll-out of the District Health Information System (DHIS2), building on the initial preparatory steps financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. The DHIS2 platform is a web-based open source information system with visualization features, including Geographical Information Systems, that can be customized to suit country specific needs, and is used to collect, manage and analyze data.

58. The project will support the development of an integrated HMIS system for routine monitoring as well as for tracking of beneficiaries and supplies, as summarized in Figure 5. In addition, progress of the project towards achieving the PDO will be assessed through a mix of PDO and intermediate result indicators. The baseline data for these indicators is drawn from existing sources, such as the Standardized Monitoring and Assessment of Relief and Transition survey (SMART), PAPFAM survey and routine data. Given that most of the population based surveys are outdated, the baseline data may be revised with the availability of new data – for example SMART survey results that may be available at the end of 2018. During the course of project implementation, opportunities for specific nutrition assessments and impact evaluations will be explored.

Figure 5: Integrated System for Monitoring and Beneficiary Tracking



59. The Project will support the Nutrition Program through two DLIs. These indicators are key in the prevention and reduction of stunting and the DLIs will be a signal to key stakeholders on the importance of focusing on these important and critical results. The two innovations for Djibouti that will be pioneered by this project are: (i) the development of an integrated monitoring and beneficiary tracking system that will capture nutrition interventions at both facility and community levels; and (ii) the enhanced focus at the community level with intensified household visits conducted by CHWs, which is key for the behavior change needed to prevent and reduce the high levels of stunting in the country.

60. The DLIs reflect not only key results of the Program but also the two main areas where it is important to have transformational change. The design of the DLIs was based on a number of criteria: (i) DLIs need to be achievable and challenging so as to induce transformational change and achieve the intended impact; (ii) DLIs should focus on the most challenging areas that have the potential to influence the success of the program; and (iii) DLIs should be aligned with government priorities, which will help to ensure sustainability.

61. The release of IDA funds will be linked to the achievement of the following DLIs – DLI 1 (under Sub-component 1.2b): 1A-Number of women referred by community health workers and **registered** at the health facility within the first 4 months of pregnancy; 1B-Number of women referred by community health workers who **completed at least 3 antenatal visits** at the health facility; and 1C-Number of women referred by community health workers who **completed at least 2 postnatal visits** at the health facility (US$1,450,000); and DLI 2 (Under Component 3); percentage of health facilities that have annual disaggregated data using District Health Information System (DHIS2) (US$500,000).

62. To achieve the identified results under the DLIs (see Annex 2: DLI Matrix and Verification Protocol), the MoH will use the Eligible Expenditure Programs (EEPs) identified in its budget and resources from the Credit proceeds. A total of US$4.3 million is expected to be allocated for the EEPs by the MoH during the five years of implementation.

63. The EEPs will finance operating costs of the NNFCA, Department of Health Promotion (DHP), Department of Maternal and Child Health, Departments of Health Regions (DHRs) for each of the five regions and Djiboutiville, and the Department of Health Information (a new Department that will have a budget allocation in the next MOH budget). These nine Departments will play a key role for the achievement of the Project objectives as they will contribute to the scaling-up of nutrition interventions, increased productivity and performance of CHWs that will be instrumental in creating the linkages and referrals between the community and health facilities and in scaling-up the utilization of antenatal and postnatal care services, through: (i) training activities to strengthen the capacity of CHWs; (ii) improved supervision and mentoring of CHWs; and (iii) promotion of the use of innovative technologies for beneficiary tracking and monitoring that will enhance the effectiveness of CHWs. In addition, they will contribute to the strengthening of the national health information system and its use for providing timely information that will be used for decision making and improving program implementation.

64. The list of indicative EEPs is as follows:

- Non-salary recurrent expenditures allocated through the MoH's budget for the NNFCA (the nutrition Division is currently under the Department of Maternal and Child Health, and will be upgraded to a national authority) that is responsible for managing the national nutrition program. Expenditures include payments incurred by the NNFCA for maintenance, office supplies, travel and non-consulting services.
- Non-salary recurrent expenditures allocated through the MoH's budget for the DHP that is responsible for all health promotion activities at the community level, including the work of CHWs. Expenditures include payments made by the DHP for maintenance, office supplies, health education travel and non-consulting services.
- Non-salary recurrent expenditures allocated through the MoH's budget for the DHRs (for Djiboutiville and each of the five health regions) that is responsible for planning and monitoring and evaluation of all health activities. Expenditures include payments made by the DHRs for maintenance, printing of registers for community health centers, nutrition recuperation center, food, transport costs, office supplies, and mobile clinics.
- Non-salary expenditures allocated through the MoH's budget for the Department of Health Information. Expenditures include payments made by the Department of Health Information on supervision, support for data collection, operating costs, and training of staff.

65. The budget for these departments for fiscal year 2017 and 2018 is presented below. The budget foresees an increase of around US$480,000 for these departments over five years, taking fiscal year 2017 as the base year. Thus, the total amount of the program is expected to be around US$4.3 million over the five years, and the DLIs will cover US$1.95 million.

MoH Budget Line Item	Description	Allocated Budget FY17		Allocated Budget FY18	
		DJF	US$	DJF	US$
14-02-06	Department of Mother and Child	7,550,000	42,482	10,550,000	59,363
14-02-08	Department of Health Promotion	5,150,000	28,973	5,150,000	28,973
14-02-09	Department of Health Regions - Djibouti	27,800,000	156,426	35,050,000	197,220
14-02-10	Department of Health Regions - Arta	18,200,000	102,408	20,450,000	115,069

14-02-11	Department of Health Regions - Ali Sabieh	20,450,000	115,069	20,450,000	115,069
14-02-12	Department of Health Regions - Dikhil	18,200,000	102,408	20,450,000	115,069
14-02-13	Department of Health Regions - Tadjourah	20,450,000	115,069	20,450,000	115,069
14-02-14	Department of Health Regions - Obock	18,200,000	102,408	20,450,000	115,069
Total		**136,000,000**	**765,243**	**153,000,000**	**860,901**

Exchange rate: US$/DJF=177.72

66. An independent verification agency will be used to verify the DLI achievements. The process for verification of DLIs is included in Annex 2 and will be further outlined in the POM.

C. Sustainability

67. The proposed project is expected to contribute to the sustainability of the stunting reduction efforts by the government of Djibouti by supporting capacity building and training at different levels, behavior change communication, and engaging key actors in different sectors. The project will support the MoH in building the National Nutrition and Food Coordination Authority and its capacity to handle the day to day duties of implementing the project and to serve the coordination and facilitation function for the multi-sectoral national nutrition response. Instead of relying on the project-specific project management unit with staff paid by the project funding, the NNFCA will be responsible for implementing the project and will be integrated within the MoH structure and staffed by civil servants. This Authority will have the mandate of supporting and facilitating the implementation of the National Strategy for the Prevention of All Forms of Malnutrition, to which the proposed project contributes. Furthermore, the project has a major focus on training and behavior change. In order to reduce stunting, concerted efforts in building capacity as well as behavior change communication are crucial. The project will support training of trainers, community health workers and volunteers, mothers and school-age children and using different methods of communication to provide information and influence behaviors. Finally, by supporting the development of nutrition sensitive strategies in sectors outside of health and facilitating coordination among different sectors at different levels, the project aims to help the country build a sustainable environment conducive to effectively prevent, identify and address chronic and acute malnutrition.

D. Role of Partners

68. Various development partners provide support for nutrition in Djibouti, including USAID; UNICEF, and WFP. All five regions in Djibouti benefit from nutrition support (primarily focused on acute malnutrition). UNICEF provides support for the treatment of Severe Acute Malnutrition (SAM) through health facilities and community sites, including access to quality services for the management of children with SAM through USAID/Food for Peace and EU funded projects with nationwide coverage. In addition, UNICEF provides prevention services that are delivered through health facilities that include strengthening and scaling up of the IYCF Program and prevention of micronutrient deficiencies for rural areas and in Balbala through the EU funded project. Meanwhile, WFP provides support for the treatment of moderate acute malnutrition, and people living with HIV/AIDS on antiretroviral treatment and tuberculosis (TB) patients on direct observation treatment are also provided with specialized nutritious foods to support their treatment and recovery. WFP also provides food rations for registered refugees, asylum seekers living in camps and the most food insecure Djiboutian populations, ensuring that they have access to an adequate daily caloric intake. The importance of strong coordination and collaboration cannot be understated in this context. To this end, one of the main priorities of the project will be to strengthen local nutrition governance, and support key health system platforms (i.e., CHW, information systems, etc.) that will be complementary to activities funded by other development partners.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

69. The overall risk rating for the project is considered Substantial given the multi-sectoral nature of the project. The key risks identified include:

70. Political and Governance risk is rated as substantial due to the prevailing political economy challenges including the lack of effective governance. The project's focus on strengthening health and nutrition service delivery requires concerted multi-sectoral action with strong institutions, good governance, and voice and accountability. These areas have been particularly challenging for Djibouti which scores low on both governance and voice and accountability indicators with limited track record in working across sectors to address malnutrition. To mitigate the risks, the Government of Djibouti has demonstrated its commitment to an enhanced national multi-sectoral response through the establishment of the NNFCA and the high-level NCN. It is anticipated that the NCN with ministerial representation will translate the national commitment to joint multi-sectoral action at the community level, and will help address the bottlenecks to working across sectors. In addition, the project will support accountability through improved monitoring and evaluation to ensure effective monitoring of progress towards achievement of the PDO, and the use of an independent verification agency to verify the achievements of the DLIs. A mechanism to encourage citizen engagement will also be introduced through the project to improve voice and accountability including facilitating the beneficiary feedback on the quality and appropriateness of nutrition services delivered at both the community and the health facility levels.

71. Institutional Capacity for Implementation and Sustainability risk is rated as Substantial. The Nutrition Division, which was a team within the MoH Department of Maternal and Child Health, has been upgraded to a NNFCA that will provide the stewardship and coordination needed for a multi-sectoral nutrition program. The Authority will be a platform that will be used for coordinating and managing the national nutrition program, and will manage not just the Bank project but other donor-financed projects. Although the capacity of the Authority has been enhanced by the appointment of key technical staff, it may take some time for project management tasks to be conducted smoothly. To mitigate the institutional capacity risks the project will provide technical assistance on as needed basis. In addition, during project implementation, risks will be mitigated through frequent supervision missions to monitor progress, provision of technical assistance as needed, ensuring that the NNFCA is adequately staffed, and conducting regular workshops on World Bank procedures for procurement, disbursement, and financial management.

72. The fiduciary risk is considered as High.
Procurement. The MoH is implementing a World Bank financed project (PAPSS) using the old procurement and consultant guidelines. For this new project, procurement will be carried out in accordance with the new Procurement Regulations for IPF Borrowers. As required by these regulations, the client has prepared an initial project procurement strategy for development (PPSD) that also gives an overview of contracts already identified to date. Also, the ongoing PAPSS has a large performance based design that requires few and low value contracts, while procurement under this new project would consist of a number of contracts for goods, non-consulting services, consulting services and community driven development. A procurement specialist that will be part of the NNFCA will be appointed by the Government no later than one month from Credit effectiveness. The aforementioned changes, combined with the existing capacity, make the procurement risk high at this stage; the risk will be reassessed and likely be changed to substantial during implementation based on capacity and institutional developments.

Financial Management (FM). The ongoing PAPSS is being executed through a PMU housed at the MoH. For the proposed project, a financial management assessment has been conducted for the MoH to assess the capacity to implement the project. The FM risk is deemed as Substantial based on the following: (i) the MoH has limited human resources with limited experience in implementing Bank financed projects; (ii) the MoH has limited internal control procedures; (iii) the MoH has no accounting software to record the daily transactions and produce the quarterly financial reports; and (iv) the MoH falls under the jurisdiction of the Supreme Audit Institution (SAI), however the SAI has limited capacities and no experience in auditing Bank projects. In order to ensure that the risk is mitigated, specific measures will be applied (refer to Annex 3 on financial management).

73. "Other" risk. There are significant gaps in data and knowledge, reflecting the constraints in the health information system. This is coupled with the lack of timely population based surveys (e.g., Demographic and Health Survey), and nutrition specific surveys, the results of which can be used for planning and for making policy decisions, as well as for accountability purposes. Since regular data collection is critical for monitoring progress towards achieving the project PDO, this is a key area for capacity to be built within the government. A SMART survey is expected to be completed in calendar year 2018, which will provide up to date information on key nutrition indicators (including the stunting and wasting prevalence rates). Depending on the results, the baseline and target values of some indicators may need to be adjusted. To mitigate the risk of not having reliable data periodically, the project will include a specific focus on monitoring and evaluation under Component 3, including the implementation of periodic surveys, assessments, and most importantly strengthening routine data collection as well as the overall health information system. In order to expedite progress in this area, the second DLI "Percentage of health facilities that have annual disaggregated data using DHIS2" is proposed.

VI. APPRAISAL SUMMARY

A. Economic Analysis

74. Reducing childhood stunting has life-long consequences for health, education, employment, and economic growth. In the short term, undernutrition increases the risk of mortality and morbidity. In the longer term, the consequences of stunting extend to adulthood, increasing the risk of impaired cognition that results in poor school performance, poor pregnancy outcomes (including newborns who are small for gestational age), reduced economic productivity and earnings. The future risk for overweight contributes to the rise in non-communicable diseases, such as hypertension and cardiovascular diseases; and increases the potential for intergenerational transmission of stunting and poverty. Though comprehensive economic nutrition analyses in Djibouti are scarce, many studies in low-income countries have estimated the association between malnutrition, education and productivity. In Africa, these consequences add up to 0.2 to 3.6 years less of schooling, and as much as 22 percent loss of yearly income in adulthood.[19] Childhood anemia alone is associated with 2.5 percent drop in adult wages.[20] Furthermore, annual costs associated with child undernutrition in Africa are estimated at 1.9 percent to 16.5 percent of GDP.[21] The costs due to stunting in Djibouti are estimated to be over 10 percent of GDP[22].

[19] Grantham-McGregor, S; Cheung, YB; Cueto, S; Glewwe, P; Richter, L; Strupp, B. 2007. Developmental potential in the first 5 years for children in developing countries. *Lancet* 369 (9555): 60-70

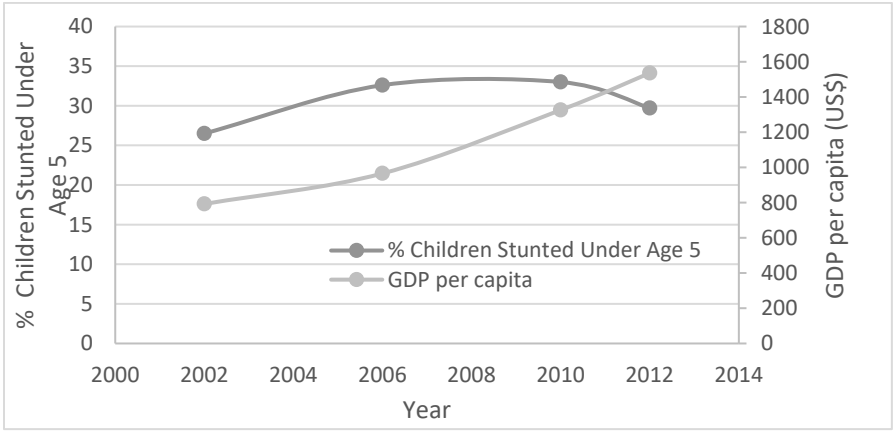
[20] Horton S and Ross J. 2003. The Economics of Iron Deficiency. *Food Policy* 28:517-5

[21] African Union Commission, NEPAD Planning and Coordinating Agency, UN Economic Commission for Africa, and UN World Food Programme. 2014. The Cost of Hunger in Africa: Social and Economic Impact of Child Undernutrition in Egypt, Ethiopia, Swaziland and Uganda. Report. Addis Ababa: UNECA.

[22] Estimation methodology described in the fifth paragraph of this section.

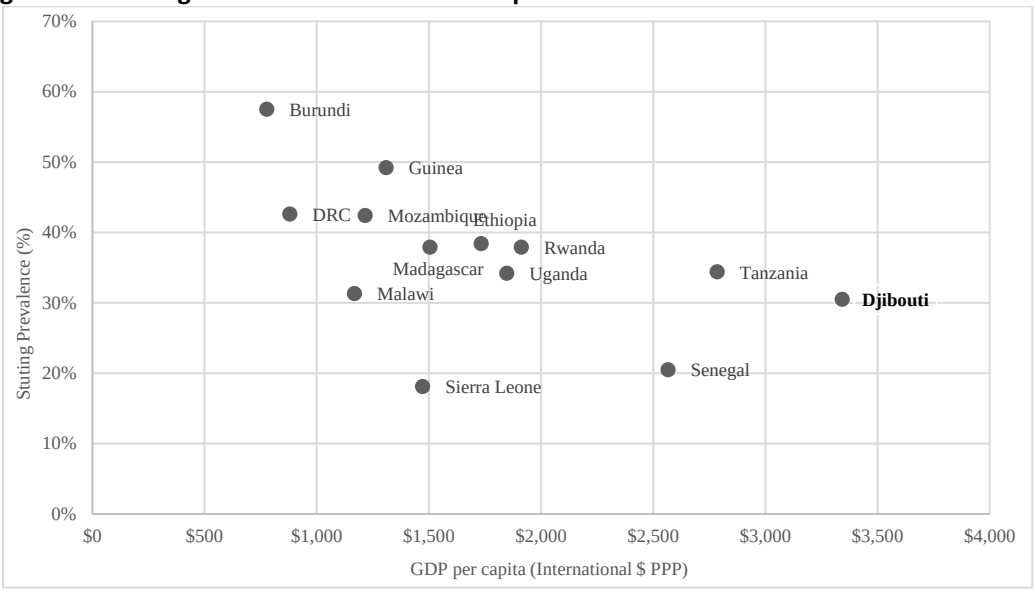
75. While Djibouti has more than doubled its GDP per capita in the last 15 years, the prevalence of stunting has not decreased, and is still alarmingly high. In the near future, economic growth alone cannot be expected to successfully reduce stunting. From 2002 to 2012, Djibouti's GDP per capita almost doubled, however, the prevalence of stunting continued to increase from 26.5 percent in 2002 to 33 percent in 2010, then decreased to 29.7 percent in 2012 (Figure 6). While cross country comparison shows a general negative correlation between stunting prevalence and GDP per capita, Djibouti has a stunting prevalence similar to many African countries with much lower GDP per capita (Figure 7). Public investment and interventions are urgently needed to solve the stunting problem in Djibouti.

Figure 6. Stunting Prevalence and GDP Per Capita in Djibouti, 2002-2012



Source: World Development Indicators, UNICEF

Figure 7. Stunting Prevalence and GDP Per Capita in Low Income Countries in Africa[23]



[23] GDP per capita was expressed in International Dollar Purchasing Power Parity (International $ PPP) to adjust for the purchasing power of different currencies with respect to a standard basket of consumer goods in different countries. In 2015, Djibouti's GDP per capita was US$1,862, equivalent to International $ PPP 3,343.

Source: Excerpt from World Bank's Djibouti Systematic Country Diagnostics

76. By scaling up government prioritized package of high-impact nutrition-specific and nutrition-sensitive interventions, the proposed project aims to contribute to the national goal of stunting reduction to 24 percent in 2023 and have significant health benefits. The estimated current prevalence of stunting under age 5 is 29.7 percent[24]. The historical average annual rate of reduction (AARR) in stunting in Djibouti has been about negative 2.2 percent (2002-2013), With this project, Djibouti is expected to reduce the prevalence of stunting to 24 percent in 2023 (19 percent reduction), equivalent to an average annual rate of reduction (AARR) of 1.43 percent. In 2016, child and maternal undernutrition was the number one risk factor of death and disability-adjusted life years (DALY-a composite metric that incorporates mortality and morbidities) in Djibouti, accounting for 1,046 deaths and 98,408 DALYs[25] (Table 1). Upon achieving the project target, the number of children stunted is expected to decrease by 6,270, and consequently 203 deaths and 18,697 DALYs loss are expected to be prevented.

Table 1. Estimated health benefits of project

	Prevalence of Stunting (percent under age 5)	Estimated number of children stunted (under age 5)	Estimated number of death due to stunting	Estimated number of DALYs due to stunting
Project baseline (Year 2019)[26]	29.7	33,000	1,046	98,408
Project completion (Year 2023)	24	26,730	843	79,710
Program Benefit[27]	5.7	6,270	203	18,697

77. The reduction in stunting prevalence expected for this project converts to significant economic benefits, around US$38 million (2.2 percent of GDP). The economic benefits were estimated using two different approaches: the willingness-to-pay for health approach and the human capital approach; both approaches generated similar estimates of economics cost of stunting in Djibouti. **1) Willingness-to-pay for health approach.** WHO classifies health interventions as very cost-effective if the cost to avoid one DALY is less than a country's GDP per capita. This threshold is commonly used to determine if a specific intervention is a high-value intervention, and some countries consider this as a societal willingness-to-pay standard for better health. If this standard is applied, the willingness-to-pay to avoid death and disability resulting from malnutrition in Djibouti is over US$183 million in 2016[28], approximately 10 percent of Djibouti's GDP[29]. If the project target of reducing stunting prevalence to 24 percent (19 percent reduction from current prevalence) is achieved, the economic benefit of the project will be US$35 million[30] (Table 2). **2) Human capital approach.** The economic costs of stunting can also be quantified by lost productivity. Based on the current employment and market wage statistics[31], If no action is taken, it is estimated that an additional 33,000 children will

[24] Most recent data were from 2013. When more recent data become available, the stunting prevalence at program baseline will be updated.
[25] IHME Global Burden of Diseases in Djibouti
[26] Assume stunting situation in 2019 remains the same as in 2016
[27] Program benefit=different between project completion and status quo.
[28] Total willingness-to-pay to avoid death and disability resulting from malnutrition=DALYs due to malnutrition x GDP per capita.
[29] In 2015, Djibouti's GDP was US$1.727 Billion.
[30] Economic benefit of the project=economic benefit of reducing stunting prevalence by 19%=US$183 million x (0.19).
[31] Djibouti EDAM 2012 household survey showed that around 45 percent of working-age adults were working at the time of survey,

be stunted in Djibouti in the next five years. For this cohort of stunted children, a 22 percent future annual wage reduction will translate to US$11 million loss per year and US$199 million loss in a life-time[32]. If the project target of reducing stunting prevalence to 24 percent is achieved, the economic benefit is estimated to be US$38 million.

Table 2. Estimated Project Economic Return

	Willingness-to-pay approach	Human capital approach	
	Estimated life-time economic cost (million US$)	Estimated annual economic cost (million US$)	Estimated life-time economic cost (million US$)
Project baseline (Year 2019)	183	11	199
Project completion (Year 2023)	148	9	161
Program Benefit	35	2	38

78. Using the human capital approach, with US$15 million investment in this project, the economic return is US$38 million. The return is over $2.5 for every dollar invested. In a very optimistic scenario, where the project outperforms the targets and achieves an annual reduction in stunting rate of 2.86 percent, the return will be $5.1 for every dollar invested in this project (Table 3). In a very pessimistic scenario, where the project cannot achieve the target and only reduces stunting rate by 0.72 percent per year, the return would be $1.3 for every dollar invested. Estimates in other countries also showed good return from nutrition interventions. The benefits of investments to decrease stunting are estimated at $11 for every dollar invested; these benefits translate into improved wages and productivity as adults (Shekar et al., 2016).[33] For the other World Health Assembly global nutrition targets, the returns include $4 for every dollar invested in wasting, and the returns for exclusive breastfeeding are particularly high: $35 for every dollar invested.

Table 3. Estimated Return to Investment and Sensitivity Analysis

	Project investment (million US$)	Economic return (million US$)	Return to investment ratio
Base case scenario (AARR=1.43)	15	38	2.5 : 1
Optimistic scenario (AARR=2.86)		76	5.1 : 1
Pessimistic scenario (AARR=0.72)		19	1.3 : 1

among which 45 percent were working in the public sector. In 2016, the annual wage of an employee in the formal sector averaged around 832,468 Djiboutian Francs (US$4,690), while the average annual wage among these working informally was assumed to be half that of the formal sector wage.

[32] Assumes the effect of future wage increase and inflation cancel out, resulting in no change in purchasing power.

[33] The benefit/cost ratios calculated range from 3.5:1 (Democratic Republic of the Congo) to 42.7 (Indonesia), for a 5 percent discount rate assuming a final working age of 36. Countries which are growing faster and/or have higher incomes have higher benefit/cost ratios, because the absolute dollar value of the benefits (due to higher wages) are greater, while there is less variation in costs of the nutrition intervention.

79. The proposed program implementation can be further justified in several aspects: 1) Contribute to poverty reduction and improve equity: the poorest population strata are most affected by stunting, and consequently stunting in childhood negatively affects individuals' income as adults, and makes them more likely to stay in poverty. Public investment in stunting prevention is important to break the vicious cycle of poverty, and the intergenerational cycle of malnutrition. The project will directly impact the income generating capacity of the bottom 40 percent in Djibouti to improve equity and promote shared prosperity. **2) Address several types of market failures:** First, there is positive externality of better nutrition to individual children and their families, as well as for society and the economy as a whole. Not only are investments in nutrition one of the best value-for-money development actions, they also lay the groundwork for the success of investments in other sectors (such as education and social protection), and are needed to accelerate national economic growth through enhanced human capital development. Second, there is information asymmetry and supplier-induced demand and other market imperfections hurdling the efficiency of the private market of nutrition. **3) Improve multi-sectorial coordination**: Acceleration of progress in nutrition in Djibouti will require effective, large-scale nutrition-specific programs that address key underlying determinants of nutrition; enhanced coverage and effectiveness of nutrition-specific and -sensitive interventions; sustainable financing and strengthening of the government's stewardship role; and strong monitoring and evaluation of indicators for maternal and child health and nutrition. These require national level planning and coordination by government across sectors such as health, social protection, agriculture and WASH. The Bank's added value in this project will also center around its ability to promote a multi-sectoral approach through its engagement with ministries and agencies in multiple sectors. Specifically, the Bank will ensure a complementarity of services to be provided by the government and other development partners, filling gaps where needed and enabling the convergence of activities across sectors. Furthermore, important lessons from World Bank projects in other countries to address stunting will be considered and applied to the context in Djibouti, as appropriate.

B. Technical

80. The proposed interventions to be funded under the project are in line with global evidence of what works to reduce stunting and consider the context in Djibouti. The Lancet Nutrition series of 2013 estimated that scaling up 10 key nutrition interventions to 90 percent of coverage could result in a 15 percent reduction of under-five mortality, a 20 percent reduction in stunting and a 61 percent reduction in severe wasting. These 10 key interventions are defined as nutrition-specific interventions, meaning that they address the immediate determinants of fetal and child nutrition and development including adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases. Among these 10 key nutrition interventions, the project will support: (i) Peri-conceptual folic acid supplementation; (ii) Multiple micronutrient supplementation in pregnancy; (iii) Promotion of breastfeeding; (iv) Appropriate complementary feeding; (v) Vitamin A supplementation; and (vi) Prevention and management of severe and moderate acute malnutrition. In addition, nutrition-sensitive approaches that address the underlying determinants of fetal and child nutrition and development include: (i) Agriculture and food security; (ii) Early child development; (iii) Women's empowerment; (iv) Schooling; (v) Health and family planning services; (vi) Social safety nets; (vii) Maternal mental health; (viii) Child protection; and (ix) Water, sanitation, and hygiene. To this end, the project aims to scale up best buy nutrition-specific interventions nationwide, targeting children under five (with a focus on those under two) and pregnant and lactating mothers. At the same time, key nutrition sensitive multi-sectoral actions will be implemented, either through the project (i.e., water and sanitation) or through the broader World Bank program (i.e., social protection, community driven development and water and sanitation, education and governance).

C. Financial Management

81. The Republic of Djibouti has a complete and sufficient body of texts to guide sound management of its public finances. The legal framework of Djibouti includes: (i) the Constitution of September 4, 1992; and (ii) the law n°107/AN/00 relating to the finance laws, which fixes the rules relating to the determination of resources and expenses, the preparation and the vote on the annual budget, and the execution and control of the budget.

82. The institutional framework contains the structures necessary for public financial management, and meets the needs with respect to the preparation as well the execution and control of the budget. However, some practices affect the efficiency of the texts. This is particularly the case for the use of the derogatory procedures of public expenditure, as well as a certain lack of budgetary discipline.

83. The Towards Zero Stunting Project will be implemented in Djibouti according to the World Bank guidelines and through the MoH. The ministry has developed a NNFCA that will take the responsibility for project implementation. The project will have multiple categories and types of financing. Disbursement processes are detailed in the disbursement letter. FM details are elaborated in Annex 3.

84. Based on the risks, the following mitigating measures have been agreed upon in order to reduce the FM risk level and have an adequate FM system in place: (i) the MoH will recruit a Financial Officer (FO) no later than one month from Credit effectiveness, who will be a part of the NNFCA, will handle the FM aspects of the project, and the Bank will provide the necessary training to the FO regarding Bank FM procedures; (ii) the MoH will acquire an accounting software specific for the purpose of the project, and will utilize the software to record daily transactions and produce the Interim Un-Audited Financial Reports (IFRs) in the format agreed with the Bank, and will submit them to the Bank no later than 45 days after the end of each quarter; (iii) the MoH will develop an operational manual for the project, which will contain a FM chapter describing FM procedures, including internal controls; and (iv) the MoH will contract an independent external auditor (based on Terms of Reference - ToRs - acceptable to the Bank) to audit the Project Financial Statements (PFS). With the proposed mitigating measures, the project will meet the financial management requirements of OP/BP 10.00, and the FM risk rating would be reduced to Moderate.

D. Procurement

85. All goods, works and 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 and revised in November 2017 (“Procurement Regulations”), and the provisions of the Procurement Plan. The Borrower and the NNFCA 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”).

86. The MoH is currently implementing the World Bank financed PAPSS project under the previous procurement and consultant guidelines. For this operation, procurement will be carried out in accordance with the new Procurement Regulations for IPF Borrowers referenced above. The PAPSS project has a large performance based design that involves few and low value contracts, while procurement under the proposed project would consist of a number of contracts for goods, non-consulting services, consulting services and community driven development. Furthermore, the NNFCA will be responsible for implementing this project. These changes, combined with the existing

capacity of the Ministry, make the procurement risk high. As mitigation measures, the ministry will appoint a procurement officer dedicated to this project, a project implementation manual will be prepared with a clear description of procurement aspects, medical goods/equipment would be acquired through Centrale d'Achat des Médicaments et Matériels Essentiels (CAMME) (and/or UN agencies, as appropriate). The PPSD indicates that there will be no complex or high value contract that would require mandatory high-level Bank review. Similarly, there will be no need for hands-on expanded implementation support, apart from regular training and guidance from the Bank. A detailed procurement plan will be updated, registered in STEP and approved by the Bank before its implementation.

E. Social (including Safeguards)

87. Social Benefits. The proposed project is expected to deliver significant social benefits by reducing stunting among children under five through multi-sectoral interventions. The project will benefit children (girls and boys) from all walks of life, but particularly low-income households, which will have enhanced access to the expanded coverage of multi-sectoral interventions to reduce stunting. Women, who often oversee children's health, are expected to be less worried about their physical progress and instead focus on the positive side of their growth. The social and poverty outcomes of the proposed project will include but not limited to the following: (i) enhanced cognition and educational performance; (ii) normal adult wages; and (iii) a reduced risk for excessive weight gain later in childhood and for nutrition-related chronic diseases in adult life.

88. Consultations and Citizen Engagement. The design of the project has been consultative at several levels. Consultations have included Government Representatives (representing all key sectors involved in the national nutrition response), non-governmental organizations, and international partners (including UNICEF and WHO). Project implementation will likewise be built on engaging local health organizations, neighborhood organizations and households.

89. Social Safeguards: The Project will not support construction or other activities that will lead to involuntary resettlement or land acquisition. OP/BP 4.12 on Involuntary Resettlement is therefore not triggered. Djibouti has no population that would qualify as indigenous people, as defined by OP 4.10; the Indigenous People's policy has therefore not been triggered.

F. Environment (including Safeguards)

90. The project is classified as Category B. The interventions planned under the Subcomponents 1.1 Strengthening of Health and Nutrition Services at the facility level and 1.2 Prevention and Management of Stunting and Wasting at the Community Level have the propensity to generate some Public Environmental, Health and Safety impacts, resulting from the misuse of water treatment procedures or due to the medical waste generation from immunization activities. All other activities will mostly support the delivery and strengthening of health and nutrition services. Some minor renovation of existing buildings is also expected, generating some minor occupational health and safety and environmental impacts essentially related to the management of hazardous solid wastes, generation of noise, fugitive dust and sanitary wastewater discharges. All these impacts are easily remediable and will be easily mitigated.

91. Since the exact localizations of project activities under Components 1.1 and 1.2 are not known, an Environmental and Social Management Framework (ESMF) has been prepared. In addition to detailing the process for screening and implementation arrangements, the ESMF includes: (i) a generic checklist for the environmental management plan for minor renovations/civil works; (ii) hazardous materials management plan; (iii) health care waste

management plan; (iv) health and safety plan for health care beneficiary populations and workers; and (v) equity issues in the social assessment to address potential issues of social exclusion to the services provided. The ESMF has a screening mechanism; activities resulting in Category A-type risks and impacts will be screened out.

92. The ESMF will be a part of the POM, and will be included in project management and regular project monitoring. The preliminary version of the ESMF was consulted with all stakeholders. Copies of the final version of the ESMF are available in locations that are easily accessible to project affected persons. The final version in French, taking in account all comments, has been disclosed on the MoH website and on the Bank's external website on May 7, 2018.

G. Climate Change Adaptation by Improved Nutrition Outcomes for Women and Children

93. Climate change and its impact jeopardizes the World Bank's mission in Djibouti and thus directly affects the efforts made under this project (and any others envisaged for the country). The country 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. Djibouti's agricultural sector will experience volatile swings in rainfall, which could endanger food security. Natural capital, including the forests that cover 0.2 percent of the country (2015), will be at risk too. Low income populations, especially the 23 percent of Djiboutians who live below the national poverty line (2014), are also 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 MENA region, suffers from water insecurity. As highlighted in Beyond Scarcity, water shortages will reduce MENA 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.

94. Djibouti's *Intended Nationally Determined Contribution (2015)*, which became its *Nationally Determined Contribution* (2016), recognizes the challenge of climate change and calls for an ambitious response, including $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.

95. This operation has been screened for short- and long-term climate change and disaster risks, and extreme temperature and drought have been identified as having high potential for impact on project implementation. Such climate change effects will negatively impact food security and nutrition outcomes especially for women and children living in poverty. People's livelihoods and lifestyles are affected through different pathways. With only 0.1 percent of the land being arable, farmers and nomads are already facing more challenges due to changing weather patterns, such as increased frequency of droughts and floods. 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. Building disaster risk management capacity increases a country's ability to deal with future climate-induced natural disasters; in this case, creating databases of vulnerable populations enables government to respond to extreme weather when it happens. In the longer term, climate change affects the availability of natural resources and food, as well as access to food.

96. Climate change is a potential 'hunger-risk multiplier' that can exacerbate malnutrition 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 combat Climate Change. Poor health and malnutrition in turn further weaken

people's resilience to, and ability to, adapt to climatic shocks. In summary, climate change can worsen the crisis of malnutrition, including stunting, through three main causal pathways: (i) Impacts on household access to sufficient, safe, and adequate food; (ii) Impacts on care and feeding practices; (iii) Impacts on environmental health and access to health services.

97. The project contributes directly to reducing risks to nutrition outcomes due to climate change through several interventions. The CHWs, with the use of technology for monitoring and tracking women and children, deliver micronutrients and provide screening, which helps to quickly identify malnourished (or at-risk of being malnourished) children or women and refer them to the appropriate level of care. Assisting poor people through this intervention increases a nation's resilience to climate-induced extreme weather because they are the most vulnerable and least equipped to handle the impacts of climate change, e.g., lower food security from drought. This technology could also be used to identify individuals who may be affected by the effects of sea level rise, e.g., flooding of coastal areas. By strengthening community engagement and communication campaign outreach, households are empowered to adopt better nutrition practices at home. By facilitating the convergence of nutrition sensitive programs on beneficiaries, their access to services (such as safe drinking water, which could include water harvesting, sanitation and hygiene) contributes to sustained improvement of nutrition outcomes. By strengthening the district health information system, any increase or change in a disease pattern related to climate change (e.g., increase in heat exhaustion, change in malaria cases) will be detected at an early stage for the government to respond in a timely manner.

H. World Bank Grievance Redress

98. 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/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

Project Development Objective(s)

The project development objective is to reduce stunting among children under five in Djibouti.

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets				End Target
					1	2	3	4	
To reduce stunting among children under five.									
Percentage of infants 0-5 months exclusively breastfed			Percentage	12.40	15.00	18.00	24.00	30.00	36.00
Percentage of children 6-23 months consuming a minimum acceptable diet/diverse diet			Percentage	0.00	20.00	30.00	40.00	60.00	75.00
Women who attended at least four antenatal care visits during their most recent pregnancy			Percentage	23.00					50.00
Percentage of children 6-59 months who are stunted			Percentage	29.70	28.50	27.50	26.00	25.00	24.00
Women referred by CHWs and registered at the health facility within 4 months of pregnancy (DLI 1A)	DLI 1		Text	0.00	(a) revitalized CHW strategy developed including	2,500.00	3,000.00	3,500.00	4,000.00

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets				End Target
					1	2	3	4	
					training plan, accountability mechanism and motivation strategy; (b) training for CHWs rolled out.				
Women referred by CHWs, who completed at least 3 antenatal visits at the health facility (DLI 1B)	DLI 2		Text	0.00	0.00	2,500.00	3,000.00	3,500.00	4,000.00
Women referred by CHWs, who completed at least 2 postnatal visits at the health facility (DLI 1C)	DLI 3		Text	0.00	0.00	2,500.00	3,000.00	3,500.00	4,000.00

Intermediate Results Indicators by Components	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets				End Target
					1	2	3	4	
High-impact Health and Nutrition Services to Reduce Stunting									
Percentage of children fully immunized before their first birthday			Percentage	67.98	70.00	72.00	74.00	78.00	80.00
Percentage of 15-19 year-old girls supplemented with iron and folic acid			Percentage	0.00	10.00	20.00	40.00	60.00	80.00
Percentage of pregnant and lactating women counselled on infant and young child feeding			Percentage	0.00	10.00	20.00	40.00	60.00	80.00
Percentage of children 6-23 months having received micronutrient powder supplement			Percentage	32.00	40.00	50.00	60.00	70.00	80.00
People who have received essential health, nutrition, and population (HNP) services		Yes	Number	0.00	25,000.00	50,000.00	75,000.00	100,000.00	150,000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Yes	Number	0.00	15,000.00	25,000.00	50,000.00	75,000.00	100,000.00
Number of women and children who have received basic nutrition services		Yes	Number	0.00	25,000.00	50,000.00	75,000.00	100,000.00	150,000.00
Strengthening Multi-sectoral Interventions for Stunting Reduction									
A multi-sectoral nutrition coordinating mechanism that meets at least twice a year			Yes/No	N	Y	Y	Y	Y	Y
Households that have a handwashing facility with soap			Percentage	0.00	10.00	20.00	30.00	50.00	75.00
Strengthening Coordination, Project Management and Monitoring and Evaluation									
Beneficiaries that feel services provided satisfy their needs			Percentage	0.00	10.00	20.00	30.00	50.00	75.00

Percentage of health facilities that have annual disaggregated data using DHIS2 (DLI 2)	DLI 4		Text	0.00	(a) Design for DHIS 2 completed; (b) plan for roll-out of DHIS 2 finalized; (c) DHIS2 rolled-out to health facilities	0.25	0.50	0.75	0.80

Monitoring & Evaluation Plan: PDO Indicators	
Indicator Name	Percentage of infants 0-5 months exclusively breastfed
Definition/Description	The percentage of infants less than 6 months old who receive no food or fluid but breast milk.
Frequency	Every 2 years
Data Source	SMART survey, DHS, KAP survey
Methodology for Data Collection	
Responsibility for Data Collection	DIS, DISED, NNFCA
Indicator Name	Percentage of children 6-23 months consuming a minimum acceptable diet/diverse diet
Definition/Description	Baseline data not yet available. The percentage of children aged 6-23 months of age (breastfed or non-breastfed) who received the minimum dietary diversity and the minimum meal frequency during the previous day.
Frequency	Annual
Data Source	KAP survey
Methodology for Data Collection	
Responsibility for Data Collection	DIS, DPS, NNFCA

Indicator Name	Women who attended at least four antenatal care visits during their most recent pregnancy
Definition/Description	The percentage of women aged 15 to 49 with a live birth in a given time period that received antenatal care provided by skilled health personnel at least 4 times during their most recent pregnancy.
Frequency	Annual
Data Source	SIS
Methodology for Data Collection	
Responsibility for Data Collection	DIS

Indicator Name	Percentage of children 6-59 months who are stunted
Definition/Description	The percentage of children aged 6-59 months below minus two standard deviations from median height for age.
Frequency	Every 2 years
Data Source	SMART survey, DHS
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA, DPS, DISED

Indicator Name	Women referred by CHWs and registered at the health facility within 4 months of pregnancy (DLI 1A)
Definition/Description	The number of women who were referred by the CHWs to and registered at the health facilities during the first 4 months of pregnancy; it excludes pregnant women who went to the health facilities without being referred by CHWs.
Frequency	Annual
Data Source	Routine administrative data. Existing Health Management Information System data.
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA, DPS, DIS
Indicator Name	Women referred by CHWs, who completed at least 3 antenatal visits at the health facility (DLI 1B)
Definition/Description	The number of women who were referred by CHWs and completed at least 3 antenatal care at the health facility; it excludes women who sought antenatal care at health facilities without being referred by CHWs.
Frequency	Annual
Data Source	Routine administrative data. Existing Health Management Information System.
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA, DPS, DIS

Indicator Name	Women referred by CHWs, who completed at least 2 postnatal visits at the health facility (DLI 1C)
Definition/Description	The number of women who were referred by the CHWs and completed at least 2 postnatal visits at the health facilities; it excludes women who go to the health facilities for postnatal care without being referred by CHWs.
Frequency	Annual
Data Source	Routine administrative data. Existing Health Management Information System.
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA, DPS, DIS

Monitoring & Evaluation Plan: Intermediate Results Indicators	
Indicator Name	Percentage of children fully immunized before their first birthday
Definition/Description	The percentage of children who were fully immunized against six diseases (tuberculosis, poliomyelitis, diphtheria, pertussis, tetanus and measles) by their first birthday.
Frequency	Annual
Data Source	DIS, DHS
Methodology for Data Collection	
Responsibility for Data Collection	DIS

Indicator Name	Percentage of 15-19 year-old girls supplemented with iron and folic acid
Definition/Description	The percentage of girls aged 15-19 years, who received iron and folic acid supplementation
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	
Responsibility for Data Collection	DIS, NNFCA

Indicator Name	Percentage of pregnant and lactating women counselled on infant and young child feeding
Definition/Description	The percentage of pregnant and lactating women who received infant and young child feeding counselling
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	
Responsibility for Data Collection	DPS, DIS, NNFCA

Indicator Name	Percentage of children 6-23 months having received micronutrient powder supplement
Definition/Description	The percentage of children aged 6-23 months who have received micronutrient powder supplement
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	
Responsibility for Data Collection	DIS, NNFCA

Indicator Name	People who have received essential health, nutrition, and population (HNP) services
Definition/Description	
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	This corporate result indicator is the sum of 3 indicators: (i) the number of women and children who have received basic nutrition services; (ii) the number of children immunized; and (iii) the number of deliveries attended by skilled health personnel. This project only includes the indicator (i) on nutrition.
Responsibility for Data Collection	DIS, NNFCA

Indicator Name	People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)
Definition/Description	
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	
Responsibility for Data Collection	DIS, NNFCA

Indicator Name	Number of women and children who have received basic nutrition services
Definition/Description	
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	
Responsibility for Data Collection	DIS, NNFCA

Indicator Name	A multi-sectoral nutrition coordinating mechanism that meets at least twice a year
Definition/Description	The presence and functioning of a multi-sectoral nutrition coordinating mechanism that meets at least twice a year
Frequency	Every 6 months
Data Source	NNFCA
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA

Indicator Name	Households that have a handwashing facility with soap
Definition/Description	The percentage of households that have a specific place for handwashing with soap
Frequency	Annual
Data Source	Survey
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA, DPS, DIS

Indicator Name	Beneficiaries that feel services provided satisfy their needs
Definition/Description	The percentage of patients who visited health facilities and/or those who benefited from community level interventions, that feel that the services provided satisfy their needs.
Frequency	Annual
Data Source	Survey
Methodology for Data Collection	
Responsibility for Data Collection	NNFCA, DPS, DIS

Indicator Name	Percentage of health facilities that have annual disaggregated data using DHIS2 (DLI 2)
Definition/Description	The percentage of health facilities that have annual disaggregated data using DHIS2 (DLI 2)
Frequency	Annual
Data Source	DIS
Methodology for Data Collection	
Responsibility for Data Collection	DIS

Disbursement Linked Indicators Matrix				
DLI 1	Women referred by CHWs and registered at the health facility within 4 months of pregnancy (DLI 1A)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	800,000.00	0.04
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Year 1	(a) revitalized CHW strategy developed including training plan, accountability mechanism and motivation strategy; (b) training for CHWs rolled out.		345,000.00	If (a) is completed, $200,000. If (b) is completed, $145,000
Year 2	2,500.00		87,500.00	Number of women in this category x $35
Year 3	3,000.00		105,000.00	Number of women in this category x $35
Year 4	3,500.00		122,500.00	Number of women in this category x $35
Year 5	4,000.00		140,000.00	Number of women in this category x $35
DLI 2	Women referred by CHWs, who completed at least 3 antenatal visits at the health facility (DLI 1B)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**

Outcome	Yes	Text	325,000.00	0.02
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Year 1	0.00		0.00	n/a
Year 2	2,500.00		62,500.00	Number of women in this category x $25
Year 3	3,000.00		75,000.00	Number of women in this category x $25
Year 4	3,500.00		87,500.00	Number of women in this category x $25
Year 5	4,000.00		100,000.00	Number of women in this category x $25
DLI 3	Women referred by CHWs, who completed at least 2 postnatal visits at the health facility (DLI 1C)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	325,000.00	0.02
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Year 1	0.00		0.00	n/a
Year 2	2,500.00		62,500.00	Number of women in this category x $25

Year 3	3,000.00	75,000.00	Number of women in this category x $25
Year 4	3,500.00	87,500.00	Number of women in this category x $25
Year 5	4,000.00	100,000.00	Number of women in this category x $25

DLI 4	Percentage of health facilities that have annual disaggregated data using DHIS2 (DLI 2)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	500,000.00	0.03
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Year 1	(a) Design for DHIS 2 completed (year 1), (b) plan for roll-out of DHIS 2 finalized (year 1), and (c) DHIS2 rolled-out to health facilities		200,000.00	$50,000 for (a), $100,000 for (b), and $50,000 for (c)
Year 2	0.25		93,750.00	$300,000/80% x (Xn - Xn-1)
Year 3	0.50		93,750.00	$300,000/80% x (Xn - Xn-1)
Year 4	0.75		93,750.00	$300,000/80% x (Xn - Xn-1)
Year 5	0.80		18,750.00	$300,000/80% x (Xn - Xn-1)

ANNEX 1: Key Positions for the National Nutrition and Food Coordination Authority and Recruitment Method

COUNTRY : Djibouti
Towards Zero Stunting in Djibouti

Staff	Recruitment	Timeline
Program Director/Project Coordinator (MoH)	Serve as project coordinator for the project. To be selected and funded by the MoH (civil servant).	Already appointed
Procurement staff (MoH)	Selected and funded by the MoH (civil servant)	To be appointed no later than 1 month from effectiveness
Financial management staff (MoH)	Selected and funded by the MoH (civil servant)	To be appointed no later than 1 month from effectiveness
M&E Staff (MoH)	Selected and funded by the MoH (civil servant)	Already appointed
Communication and social mobilization staff (MoH)	Selected and funded by the MoH (civil servant)	Already appointed
Environment and Social Focal Point	Selected by the relevant MoH service and will work part-time on the project	To be appointed no later than 1 month from effectiveness
Temporary Consultants as needed to serve specific time-limited functions	Competitive selection	To be financed by the project and recruited as needed during project implementation

ANNEX 2: DISBURSEMENT-LINKED INDICATORS MATRIX AND VERIFICATION PROTOCOL

COUNTRY : Djibouti
Towards Zero Stunting in Djibouti

DLIs	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
1A. Number of women referred by community health workers and registered at the health facility within the first 4 months of pregnancy ***DLI Value = $0.8 million***	0	DLI Target 1A.1 • (a) revitalized CHW strategy developed including training plan, accountability mechanism and motivation strategy; (b) training for CHWs rolled out. ***US$ 345,000*** *(US$200,000 for (a); US$145,000 for (b))*	DLI Target 1A.2 2500 ***DLI Value= US$87,500***	DLI Target 1A.3 3000 ***DLI Value= US$105,000***	DLI Target 1A.4 3500 ***DLI Value= US$122,500***	DLI Target 1A.5 4000 ***DLI Value= US$140,000***
1B. Number of women referred by community health workers who completed at least 3 antenatal visits at the health facility ***DLI Value = US$0.325 million***	0	***n/a***	DLI Target 1B.2 2500 ***DLI Value= US$62,500***	DLI Target 1B.3 3000 ***DLI Value= US$75,000***	DLI Target 1B.4 3500 ***DLI Value= US$87,500***	DLI Target 1B.5 4000 ***DLI Value= US$100,000***
1C. Number of women referred by community health workers who completed at least 2 postnatal visits at the health facility ***DLI Value = US$0.325***	0	***n/a***	DLI Target 1C.2 2500 ***DLI Value= US$62,500***	DLI Target 1C.3 3000 ***DLI Value= US$75,000***	DLI Target 1C.4 3500 ***DLI Value= US$87,500***	DLI Target 1C.5 4000 ***DLI Value= US$100,000***

million						
Total DLI #1 Value = US$1.45 million			***US$212,500***	***US$255,000***	***US$297,500***	***US$340,000***
2. Percentage of health facilities that have annual disaggregated data using District Health Information System (DHIS2)	0%	DLI Target 2.1 • (a) Design for DHIS 2 completed; (b) plan for roll-out of DHIS 2 finalized; (c) DHIS2 rolled-out to health facilities	DLI Target 2.2 • Disaggregated DHIS2 reports available for 25% of health facilities	DLI Target 2.3 • Disaggregated DHIS2 reports available for 50% of health facilities	DLI Target 2.4 • Disaggregated DHIS2 reports available for all facilities for 75% of health facilities	DLI Target 2.5 • Disaggregated DHIS2 reports available for all facilities for 80% of health facilities
Total DLI #2 Value = US$0.5 million		***US$ 200,000*** *(US$50,000 for (a); US$100,000 for (b) and US$ 50,000 for (c))*	***US$93,750***	***US$93,750***	***US$93,750***	***US$18,750***

Verification Protocol

DLI #	***Definition/ Description of achievement***	**Disbursement Linked Results (DLR) as applicable**	***Scalability of Disbursements (Yes/No)***	***Protocol to evaluate achievement of the DLRs and data/results verification***		
				Data source/ agency	***Verification Entity***	***Procedure***
# 1A	Under Subcomponent 1.2 (b) of the project: Number of women referred by community health workers and registered at the health facility within the first 4 months of pregnancy	DLR #1.A.1: a) Revitalized CHW strategy developed including training plan, accountability mechanism and motivation strategy (year 1); and b) Training for CHWs rolled out (year 1)	No	a) NNFCA b) NNFCA	Independent Verification Agency (IVA)	DLR #1.A.1: a) NNFCA to submit the validated CHW strategy to the World Bank. US$200,000 disbursed when the strategy is deemed satisfactory and complete by the World Bank b) NNFCA to submit the CHW training plan, list of trainers and trainees, detailed account on the timing and location of training sessions to the World Bank. US$145,000 disbursed when the training is deemed rolled out by the World Bank.

		DLR #1.A.2 –2500 women referred by community health workers and registered at the health facility within the first 4 months of pregnancy (year 2) DLR #1.A.3 –3000 women referred by community health workers and registered at the health facility within the first 4 months of pregnancy (year 3) DLR #1.A.4 –3500 women referred by community health workers and registered at the health facility within the first 4 months of pregnancy (year 4) DLR #1.A.5 – 4000 women referred by community health workers and registered at the health facility within the first 4 months of pregnancy (year 5)	Yes	Existing Health Management Information System (Système National d'Information Sanitaire -SNIS)	IVA	DLR #1.A.2-#1.A.5: A verification will be carried out by an Independent Verification Agency at the request of the MoH once the DLI achievement reaches at least the minimum threshold amount for disbursement. The verification will be based on a review of the reports and documentation submitted by the MoH on a quarterly basis, and on-site verification done in a representative sample of areas targeted by the project. The IVA submits the report to the MoH for review and validation. The MoH submits final report to the World Bank for review, validation and disbursement. DLR #1.A.2-1.A.5: For each woman referred by community health workers and registered at the health facility within the first 4 months of pregnancy, US$35 may be available for withdrawal by the Recipient upon verification up to US$455,000, with a minimum threshold payment of US$52,500 (1,500 women).

DLI #	*Definition/ Description of achievement*	**Disbursement Linked Results (DLR) as applicable**	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLRs and data/results verification*		
				Data source/ agency	*Verification Entity*	*Procedure*
#1B	Number of women referred by community health workers who completed at least 3 antenatal visits at the health facility	DLR #1.B.2 – 2500 women referred by community health workers who completed at least 3 antenatal visits at the health facility (year 2) DLR #1.B.3 – 3000 women referred by community health workers who completed at least 3 antenatal visits at the health facility (year 3) DLR #1.B.4 - 3500 women referred by community health workers who completed at least 3 antenatal visits at the health facility (year 4) DLR #1.B.5 – 4000 women referred by community health workers who completed at least 3 antenatal visits at the health facility (year 5)	Yes	Existing Health Management Information System (Système National d'Information Sanitaire -SNIS)	IVA	DLR #1.B.2-#1.B.5: A verification will be carried out by an Independent Verification Agency at the request of the MoH once the DLI achievement reaches at least the minimum threshold amount for disbursement. The verification will be based on a review of the reports and documentation submitted by the MoH on a quarterly basis, and on-site verification done in a representative sample of areas targeted by the project. The IVA submits the report to the MoH for review and validation. The MoH submits final report to the World Bank for review, validation and disbursement. DLR #1.B.2-1.B.5: For each woman referred by community health workers who completed at least 3 antenatal visits at the health facility, US$25 may be available for withdrawal by the Recipient upon verification up to US$325,000, with a minimum threshold payment of US$37,500 (1,500 women).

DLI #	*Definition/ Description of achievement*	**Disbursement Linked Results (DLR) as applicable**	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLRs and data/results verification*		
				Data source/ agency	*Verification Entity*	*Procedure*
#1C	Number of women referred by community health workers who completed at least 2 postnatal visits at the health facility	DLR #1.C.2 – 2500 women referred by community health workers who completed at least 2 postnatal visits at the health facility (year 2) DLR #1.C.3 – 3000 women referred by community health workers who completed at least 2 postnatal visits at the health facility (year 3) DLR #1.C.4 – 3500 women referred by community health workers who completed at least 2 postnatal visits at the health facility (year 4) DLR #1.C.5 – 4000 women referred by community health workers who completed at least 2 postnatal visits at the health facility (year 5)	Yes	Existing Health Management Information System (Système National d'Information Sanitaire -SNIS)	IVA	DLR #1.C.2-#1.C.5: A verification will be carried out by an Independent Verification Agency at the request of the MoH once the DLI achievement reaches at least the minimum threshold amount for disbursement. The verification will be based on a review of the reports and documentation submitted by the MoH on a quarterly basis, and on-site verification done in a representative sample of areas targeted by the project. The IVA submits the report to the MoH for review and validation. The MoH submits final report to the World Bank for review, validation and disbursement. DLR #1.C.2-1.C.5: For each woman referred by community health workers who completed at least 2 postnatal visits at the health facility, US$25 may be available for withdrawal by the Recipient upon verification up to US$325,000, with a minimum threshold payment of US$37,500 (1,500 women).

DLI #	*Definition/ Description of achievement*	**Disbursement Linked Results (DLR) as applicable**	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLRs and data/results verification*		
				Data source/ agency	*Verification Entity*	*Procedure*
#2	Under Subcomponent 3.2 of the project: Percentage of health facilities that have annual disaggregated data using District Health Information System (DHIS2)	DLR #2.1: a) Design for DHIS 2 completed (year 1); b) plan for roll-out of DHIS 2 finalized (year 1); and c) DHIS2 rolled-out to health facilities (year 1)	No	Existing Health Management Information System (Système National d'Information Sanitaire -SNIS)	IVA	DLR #2.1 a) Department of Health Information to notify the World Bank that the design of DHIS2 is completed and share the design documents; US$50,000 disbursed when the design is deemed satisfactory by the World Bank b) Department of Health Information to share the DHIS2 roll out plan with the World Bank; US$100,000 disbursed when the plan is deemed satisfactory and complete by the World Bank c) Department of Health Information to notify the World Bank that DHIS2 has been rolled out at the facility level and share a list of facilities and focal points at each facility; US$50,000 is disbursed when the IVA verifies the roll out.
		DLR # 2.2: Disaggregated DHIS2 reports available for 25% of health facilities (year 2)	Yes	Existing Health Management Information System (Système	IVA	DLRs 2.2-2.5: A verification will be carried out by an Independent Verification Agency at the request of the MoH once the DLI achievement reaches

DLI #	*Definition/ Description of achievement*	**Disbursement Linked Results (DLR) as applicable**	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLRs and data/results verification*		
				Data source/ agency	*Verification Entity*	*Procedure*
		DLR #2.3: Disaggregated DHIS2 reports available for 50% of health facilities (year 3) DLR #2.4: Disaggregated DHIS2 reports available for 75% of health facilities (year 4) DLR# 2.5: Disaggregated DHIS2 reports available for 80% of health facilities (year 5)		National d'Information Sanitaire -SNIS)		at least the minimum threshold amount for disbursement. The verification will be based on a review of the DHIS reports and documentation submitted by the MoH on a quarterly basis, and on-site verification done in a representative sample of areas targeted by the project. The IVA submits the report to the MoH for review and validation. The MoH submits final report to the World Bank for review, validation and disbursement. DLR #2.2: For each 1% increase in the number of health facilities with disaggregated DHIS2 reports, US$3,750 may be available for withdrawal by the Recipient upon verification, up to US$300,000, with a minimum threshold payment of US$75,000 (20% of health facilities). DLR #2.3 For each additional 1% increase in the number of health facilities with disaggregated DHIS2 reports over year 2 value, US$3,750 may be

DLI #	*Definition/ Description of achievement*	**Disbursement Linked Results (DLR) as applicable**	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLRs and data/results verification*		
				Data source/ agency	*Verification Entity*	*Procedure*
						available for withdrawal by the Recipient upon verification, up to US$300,000, with a minimum threshold payment of US$75,000 (20% more health facilities). DLR #2.4 For each additional 1% increase in the number of health facilities with disaggregated DHIS2 reports over year 3 value, US$3,750 may be available for withdrawal by the Recipient upon verification, up to US$300,000, with a minimum threshold payment of US$75,000 (20% more health facilities). DLR #2.5 For each additional 1% increase in the number of health facilities with disaggregated DHIS2 reports over year 4 value, US$3,750 may be available for withdrawal by the Recipient upon verification, up to US$300,000, with a minimum threshold payment of US$75,000 (20% more health facilities).

ANNEX 3: FINANCIAL MANAGEMENT

COUNTRY : Djibouti
Towards Zero Stunting in Djibouti

1. The Republic of Djibouti has a complete and sufficient body of texts to guide sound management of its public finances. The legal framework of Djibouti includes notably: (i) the Constitution of September 4, 1992; and (ii) the law n°107/AN/00 relating to the finance laws which fixes the rules relating to the determination of the resources and expenses, the preparation and the vote on the annual budget, and the execution and control of the budget.

2. The institutional framework contains the structures necessary for public financial management. The institutional framework meets the needs with respect to the preparation as well the execution and control of the budget. However, some practices affect the efficiency of the texts. This is particularly the case for the use of the derogatory procedures of public expenditure, as well as a certain lack of budgetary discipline.

3. The Towards Zero Stunting Project will be implemented in Djibouti according to the World Bank guidelines and through the Ministry of Health (MoH). The ministry will be assigning the National Nutrition and Food Coordination Authority (NNFCA) to take the responsibility for project implementation. The project will have multiple categories and type of financing. The disbursements and control arrangements are detailed below.

Financial Management Assessment

4. The FM team reviewed the financial management arrangements at MoH. Currently MoH is implementing a Result Based Financing health project financed by the Bank through a PMU. The FM performance of the PMU is satisfactory. For the proposed project, MoH will assign the NNFCA to implement the project. The Authority will report directly to the Minister of Health.

5. Based on the results of the assessment, the FM risk, as a component of the fiduciary risk, is rated as Substantial. With the proposed mitigating measures, the MoH will have the proper financial management requirements as per OP/BP 10.00 and the FM risk rating would be reduced to Moderate.

6. In view of the risks identified and the weaknesses observed, the overall financial management risk is deemed to be Substantial. The following risks are identified: (i) the MoH has no accounting software to record the daily transactions and produce the required financial information; (ii) complex project with several types of financing, numerous intersectoral public agencies involved and activities dispersed throughout multiple communities; (iii) the MoH has limited human resource capacities; (iv) the MoH has limited internal controls; and (v) the MoH falls under the audit purview of the Supreme Audit Institution (SAI). The SAI has a limited role in auditing public institutions and has no experience in auditing Bank-financed projects. The SAI may not specifically audit the project as part of the MoH's operations, which would give limited assurance about the project's use of funds.

7. Based on the risks, the following mitigating measures have been agreed upon in order to reduce the FM risk level and have an adequate FM system in place: (i) the MoH will recruit a Financial Officer (FO) who will be part of the Authority and will be handling the FM aspects of the project. The Bank will provide the necessary training to the FO regarding Bank FM procedures; (ii) the MoH will acquire an accounting software for the purpose of the project, and will utilize the software to record the daily transactions and produce the Interim Un-Audited Financial Reports (IFRs).

The format of the IFRs will be agreed upon with the Bank. The IFRs will be submitted to the Bank no later than 45 days after the end of each quarter; (iii) the MoH will recruit an independent verification agent to validate the results of the DLIs. The terms of reference of the agent will be expanded to include the verification of other activities under the project; (iv) for the purpose of the project, the MoH will develop an operational manual which will contain a FM chapter describing in detail the FM procedures, including internal controls; and (v) the MoH will get into a contract with an independent external auditor using a Terms of Reference (ToRs) acceptable to the Bank to audit the Project Financial Statements (PFS). The auditor will prepare an audit report and management letter. The project will submit the annual audit report and management letter to the Bank no later than six (6) months after the end of each fiscal year.

Financial Management and Disbursement Arrangements

8. *Staffing*: The NNFCA that will be created to implement the project will be established within the MoH and will report directly to the minister. The team will be comprised of a project director, a financial officer and a procurement specialist. The FO will be handling the FM aspects of the project and will be reporting to the project director. The Bank will provide the necessary training to the FO regarding Bank FM procedures.

9. *Budgeting*: The MoH prepares its budget on an annual basis and it forms part of the overall national budget. The consolidated budget of the MoH is prepared after receiving inputs from the various departments/units. The MoH will be preparing a separate annual budget and disbursement plan for the purpose of the project. The budget will be prepared on an annual basis and submitted to the Bank in November/December of each year covering the subsequent year. The disbursement plan will cover each fiscal year and will be divided by quarter and submitted with the quarterly Interim Un-Audited Financial Reports (IFRs). The MoH will monitor the variances in the disbursement plan and provide justification for any major divergence(s).

10. *Project accounting system*: The MoH will acquire an accounting software for the purpose of the project. the software will be installed at the NNFCA and will be utilized to record daily transactions and produce the Interim Un-Audited Financial Reports (IFRs) for all categories. The project Financial Officer will be responsible for preparing the IFRs before their transmission to the Project Coordinator for approval. Periodic reconciliation between accounting statements and the IFRs will also be done by the Financial Officer.

11. The general accounting principles for the project are as follows: (i) project accounting will cover all sources and uses of project funds, including payments made and expenses incurred; (ii) the International Public-Sector Accounting Standards (IPSAS) cash basis will be followed; and (iii) all transactions related to the project will be entered into the accounting system.

12. For category 1 of the project, disbursements will be made from the project Designated Account (DA) and will also be entered into the project accounting system. Project transactions and activities will be separated from other activities undertaken by the MoH. The IFRs summarizing the commitments, receipts, and expenditures made under the project will be produced quarterly using the templates established for this purpose. The project chart of accounts will be in compliance with the classification of expenditures and sources of funds indicated in the project cost tables, as well as with 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, subcomponent and category.

13. For category 2 of the project, a verification protocol will be applied and for category 4 special procedures will be applied to trigger disbursement (refer to section flow of funds).

14. Project financial reporting will cover all categories and will includes quarterly IFRs and yearly Project Financial Statements (PFS). IFRs should include data on the financial situation of the project, including:

1) A 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) a Reconciliation Statement for the balance of the Project's Designated Account, (iii) a Statement of Cash payments made using Statements of Expenditures (SOE), iv) a budget analysis statement indicating forecasts and discrepancies relative to the actual budget, and (v) a comprehensive list of all fixed assets.

15. The project IFRs should be produced by the MoH every quarter and sent to the Bank within 45 days from the end of each quarter. The PFS should be produced annually. The PFS should include: (i) a cash flow statement; (ii) a closing statement of financial position; (iii) a statement of ongoing commitments; (iv) an analysis of payments and withdrawals from the project's account; (v) a statement of cash receipts and payments by category and component; (vi) a reconciliation statement for the balance of the Project's Designated Account; (vii) a statement of cash payments made using the Statements of Expenditures (SOE) basis; and (viii) the yearly inventory of fixed assets acquired under the project.

16. *Internal control*: For the purpose of this project, The MoH will prepare a Project Operational Manual (POM), which will define the roles, functions and responsibilities for the implementing agency. The POM will contain a separate FM chapter detailing the FM and accounting procedures and will also include internal controls procedures.

17. *Flow of funds:* Payment shall require three signatures: The Secretary General of the MoH, the Director of the External Financing Department at the MoF and the Director of the Debt Department at the Ministry of Budget. For category 1 of the project, funds will be transferred from the Bank based on Withdrawal Applications submitted by the project. The funds will be channeled from the Bank through the single segregated Designated Account (DA) in US$ opened at a commercial bank in Djibouti acceptable to the World Bank. Advances from the IDA account will be disbursed to the designed account and used for project expenditures.

Categories 2 of the project

18. The DLIs form part of expenditures for an ongoing program financed by the MoH. The program includes activities within eight directorates at the ministry: Department of Mother and Child; Department of Health Promotion; Department of Health Regions Djibouti; Department of Health Regions Arta; Department of Health Regions Ali Sabieh; Department of Health Regions Dikhil; Department of Health Regions Tadjourah; and Department of Health Regions Obock. The total amount of the program will be around US$4.3 million over 5 years. The DLIs will cover US$1.95 million.

19. The budget for these directorates for fiscal year 2017 and 2018 is presented as follows:

	Description	Allocated Budget FY17	Allocated Budget FY18

MoH Budget Line		DJF	US$	DJF	US$
14-02-06	Department of Mother and Child	7,550,000	42,482	10,550,000	59,363
14-02-08	Department of Health Promotion	5,150,000	28,973	5,150,000	28,973
14-02-09	Department of Health Regions - Djibouti	27,800,000	156,426	35,050,000	197,220
14-02-10	Department of Health Regions - Arta	18,200,000	102,408	20,450,000	115,069
14-02-11	Department of Health Regions - Ali Sabieh	20,450,000	115,069	20,450,000	115,069
14-02-12	Department of Health Regions - Dikhil	18,200,000	102,408	20,450,000	115,069
14-02-13	Department of Health Regions - Tadjourah	20,450,000	115,069	20,450,000	115,069
14-02-14	Department of Health Regions - Obock	18,200,000	102,408	20,450,000	115,069
		136,000,000	**765,243**	**153,000,000**	**860,901**

Exchange rate: US$/DJF=177.72

20. The budget foresees an increase of around US$480K for these directorates over five years (taking fiscal year 2017 as the base year).

21. The project will be financing the achievement of the DLIs to cover the expenditures of these directorates and the expected increase in the budget. The Bank will provide a first advance to the DLIs based on an expenditures projection of 6 months. The project is expected to disburse an amount of around US$500K related to the DLIs in the first year. Once the advance is justified (based on the verification protocol), the MoH can request another amount based on a six-month expenditures forecast.

22. The list of indicative expenditures under the DLIs will include:

- Non-salary recurrent expenditures allocated through the MoH's budget for the NNFCA (the nutrition Division is currently under the Department of Maternal and Child Health, and will be upgraded to a national authority) that is responsible for managing the national nutrition program. Expenditures include payments incurred by the NNFCA for maintenance, office supplies, travel and non-consulting services.
- Non-salary recurrent expenditures allocated through the MoH's budget for the DHP that is responsible for all health promotion activities at the community level including the work of CHWs. Expenditures include payments incurred by the DHP for maintenance, office supplies, health education, travel and non-consulting services.
- Non-salary recurrent expenditures allocated through the MoH's budget for the DHRs (for Djiboutiville and each of the five health regions) that is responsible for planning and monitoring and evaluation of all health activities. Expenditures include payments incurred by the DHRs for maintenance, printing of registers for community health centers, Nutrition recuperation Center, food, transport costs, office supplies, and mobile clinics.
- Non-salary expenditures allocated through the MoH's budget for the Department of Health Information. Expenditures include payments incurred by the Department of Health Information on supervision, support for data collection, operating costs, and training of staff.

23. *Disbursement Linked Indicators (DLIs):* the two DLIs are for a total amount of US$1,950,000 under category 2 of the project. The DLIs are distributed as follows:

DLI #1 (US$1,450,000):

- 1A-Number of women referred by community health workers and **registered** at the health facility within the first 4 months of pregnancy;
- 1B-Number of women referred by community health workers who **completed at least 3 antenatal visits** at the health facility; and

- 1C-Number of women referred by community health workers who **completed at least 2 postnatal visits** at the health facility
- DLI #2: Percentage of health facilities that have annual disaggregated data using District Health Information System (DHIS2) (US$500,000)

24. Both DLIs comprise scalable and non-scalable DLRs and are included in a separate category of expenditures. An independent verification agent will be recruited to verify the results for the DLIs. The verification process for the DLIs will be the following:

- The MoH achieves results linked to the DLIs, at least the level equivalent to the minimum threshold amount eligible for disbursement, and verifies internally and issue report
- Independent verification agent verifies the results at the request of the MoH and counter verifies and submits report to the MoH.
- The MoH reviews and accept/request revision of report.
- Final report submitted by MoH to the World Bank for review.
- World Bank validates the results based on the report and releases the related funds.

25. Funds will be transferred from the Bank to the MoH bank account opened for the purpose of this category. The detailed activities, procedures and processes related to these DLIs will be elaborated in the project operational manual.

Category 3 of the project

26. This category which is linked to component 4, has been introduced to account for any case of emergency that may arise during project implementation. Funds will be re-allocated to this category based the preparation of an Emergency Response Operational Manual (EROM). Funds will be transferred to a separate designated account opened specifically for this category based on criteria to be detailed in the manual. Payments will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery.

27. For control purposes, all envisaged expenditures under this activity will be appraised, reviewed, and accepted by the World Bank before any disbursement is made. This category will be implemented following Bank guidelines for emergency situation OP 8.00.

28. The task team will work with the Bank disbursement department to ensure that funds are readily available for withdrawal once the above criteria are met. All funds utilized under this category will be audited by the external auditor.

29. *Audit of the project financial statements*: An annual external audit of the project financial statements will cover the financial transactions of all categories, internal controls and financial management systems. It will also include a comprehensive review of statements of expenditures (SOEs).

30. An external auditor will be appointed according to a Terms of Reference acceptable to the Bank. The audit should be conducted in accordance with international auditing standards. The auditor should produce: (i) an annual audit report including his/her opinion on the project's annual financial statements; (ii) a management letter on the project internal controls; and (iii) a limited review opinion of the IFRs on a yearly basis. 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 Bank along with the yearly audit report. The MoH will ensure that the recruitment of the external auditor will be done no later than 6 months from Credit effectiveness. This will enable the auditor to start field work early so to deliver the audit report and management letter within the deadlines, thereby avoiding any delays in this regard.

31. Flow of information: The MoH will be responsible for preparing periodic reports on project implementation progress, as well as 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. The MoH will maintain the project bookkeeping and will produce an annual PFS and quarterly IFRs.

Summary of Actions to be Taken

Actions	Deadline
Recruit a Project Financial Officer as part of the NNFCA	No later than 1 month from effectiveness
Recruit an independent verification agent	No later than 3 months from effectiveness
Prepare a FM chapter as part of the POM detailing the FM and accounting procedures	No later than 3 months from effectiveness
Acquire accounting software	No later than 3 months from effectiveness
Hire an external auditor with ToRs acceptable to the Bank	No later than 6 months from effectiveness

Disbursements

32. The IDA funds will be disbursed according to the World Bank guidelines and should be used to finance project activities. The project will include 4 types of categories: (i) category 1: standard IPF financing with four disbursement methods: advance, reimbursement, direct payment and special commitments; (ii) category 2 eligible expenditures under disbursement linked indicators whereas the disbursement will be based on a set of results achieved and a verification protocol; and (iii) category 3 which is a contingent category related to an emergency situation under component 4.

Allocation of the Credit Proceeds

Category	Amount of the Credit Allocated	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Works, goods, non-consulting services, consulting services, training and workshops, incremental operating costs and audits under	US$13,050,000	100%

Part A (a), (b) (i), Part B (a), (b), (c) and Part C (a) of the project		
(2) Payments for EEPs under Part A (b) (ii) and Part C (b) of the Project	US$1,950,000	100%
(3) Emergency Expenditures under Part D of the Project	0	100%
Total	US$15,000,000	

Category 1 of the project

Designated Account

33. For category 1 of the project and on behalf of the MoH, the Department of External Financing will open a segregated DA in a Commercial Bank in Djibouti acceptable to the World Bank in US Dollars related to category 1 of the project to finance its share of eligible project expenditures. The ceiling of the DA will be US$650,000 of the Credit's amount. The MOH will be responsible for submitting monthly replenishment applications with appropriate supporting documentation. The proceeds under this category of the project will be disbursed in accordance with the traditional disbursement procedures of the Bank and will be used to finance activities through the disbursement procedures currently used, including: Advances, Direct Payments, and Reimbursements accompanied by appropriate supporting documentation (records and/or Statement of Expenditures (SOEs)) in accordance with the procedures described in the Disbursement Letter and the Bank's "Disbursement Guidelines". The ceiling of the project Designated Account (DA) is set at US$650,000. The IFRs and the PFS will be used as financial reporting mechanisms, and not for disbursement purposes. The minimum application size for direct payment and reimbursement will be equal to 20 percent of the ceiling advance.

Statement of Expenditures (SOEs):

34. For requests for Reimbursements and for reporting eligible expenditures paid from the Designated Account:

- Statement of Expenditures (attachment 2 of the DFIL)
- Bank reconciliation statement (attachment 3 of the DFIL)

35. For requests for direct payments: records evidencing eligible expenditures, for example, copies of receipts, and copies of suppliers' invoices above the minimum application size.

Category 2 of the project

36. On behalf of the MoH, the Department of External Financing will open a segregated DA in a Commercial Bank in Djibouti acceptable to the World Bank in US Dollars related to category 2 of the project to receive the funds and finance its share of eligible project expenditures. No proceeds shall be withdrawn under these categories until and

unless the Recipient has furnished evidence, verified according to protocols set forth in the Verification Protocol and detailed in the Project Operational Manual. An advance will be granted to the project based on a 6 months expenditures projection. The MoH will use the advance to achieve results over a period of 6 months and then will justify the advance (based on the verification protocol). The subsequent amounts to be withdrawn will be based on a 6 months expenditures projection. IFR will be used when requesting the subsequent advances and will be based on a six months expenditures projection. The IFR format is added in the DFIL. The Bank will provide the necessary support and guidance when preparing the IFR. The POM will need to be adopted and is satisfactory to the Bank prior to any withdrawal. The MoH will be responsible for sending withdrawal applications for replenishment of the DA based on the results achieved and the verification protocol.

37. For advances and reimbursements made from the DA for this category the following documents will be required:
- Summarized Statement of Payment in the format provided in Attachment 4 of DFIL
- Bank notification confirming that (i) one or more DLIs/DLRs (as referred to under the Annex to Schedule 2 of the Financing Agreement) have been achieved and, (ii) indicating the amounts payable for such DLIs/DLRs.

38. Disbursement conditions:

The following are the conditions for disbursing under each DLIs. The MoH will need to ensure that a minimum number of results are achieved before getting reimbursed for each DLR.

DLI 1: Number of women referred by community health workers:
- For DLR 1.A.1: 100% achieved.
- For DLRs 1.A.2; 1.A.3; 1.A.4; 1.A.5; 1.B; and 1.C: minimum of 1500 women referred.

DLI 2: Percentage of health facilities that have annual disaggregated data:
- For DLR 2.1: 100% achieved.
- For DLRs 2.1; 2.2; 2.3; 2.4: minimum of 20% of health facilities should have disaggregated DHIS2 reports available.

Category 3 of the project

39. An "Emergency Response Operational Manual" (EROM) will be prepared as a condition of disbursement under this category. Triggers for this component will be clearly outlined in the EROM acceptable to the World Bank. 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. This category will be implemented following Bank guidelines for emergency situation OP 8.00. Once the set of criteria enumerated above are fulfilled, the Bank will reallocate funds to this category.

Governance and Anti-corruption

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

Supervision Plan: 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: All supporting documentation will be obtained to support the conclusions recorded in the FM Assessment.