



Report Number: ICRR0023271

1. Project Data

Project ID

P131194

Project Name

DJ: Improving Health Sector Performance

Country

Djibouti

Practice Area(Lead)

Health, Nutrition & Population

L/C/TF Number(s)

IDA-52160,IDA-64080,IDA-D4590,TF-19258

Closing Date (Original)

31-Dec-2018

Total Project Cost (USD)

19,019,582.93

Bank Approval Date

02-Apr-2013

Closing Date (Actual)

30-Nov-2021

IBRD/IDA (USD)

Grants (USD)

Original Commitment

7,000,000.00

7,000,000.00

Revised Commitment

19,269,528.88

6,988,011.22

Actual

19,019,582.93

6,988,011.22

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Project ID

P152705

Project Name

DJ HRITF Health AF (P152705)

L/C/TF Number(s)

Closing Date (Original)

Total Project Cost (USD)

0



Bank Approval Date	Closing Date (Actual)	
08-Apr-2015		
	IBRD/IDA (USD)	Grants (USD)
Original Commitment	0.00	0.00
Revised Commitment	0.00	0.00
Actual	0.00	0.00

2. Project Objectives and Components

a. Objectives

The original project development objective (PDO) was “to improve the utilization of quality health care services for maternal and child health and communicable disease control programs (HIV/AIDS, tuberculosis and malaria),” as stated in both the Financing Agreement (FA, p5) and the Project Agreement Document (PAD, p3). The Multi-donor Trust Fund Agreement (May 13, 2015, p5) did not include malaria in the list of communicable disease control programs in parentheses, and on May 13, 2015 an amendment to the project's Financing Agreement revised the project objective, removing the reference to malaria (FA Amendment letter, p1).

The objective was revised again in May 2019 when a second Additional Financing (AF2) was approved, dropping all references to communicable diseases, as follows: “The project development objective is to improve the utilization of quality maternal and child health services” (ICR, p9).

The changes in the PDO and revisions to targets require that a split rating be applied. The first change to the PDO, to drop the reference to malaria, was soon after approval, and US\$1.9 million of the total 19 million (9 percent) had been disbursed. All the other changes were made at the time of the second AF, when US\$11.8 million (62 percent) had been disbursed. Applying two splits, one at AF1 and one at AF2, was considered unwarranted for several reasons: the change to the PDO at AF1 encompassed the early minor change of dropping malaria only, was very early in implementation, would involve only one indicator, and would carry very little weight in the overall rating. A single split is therefore applied at the time of AF2 and the restructuring that dropped all mention of communicable diseases from the PDO.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval



03-May-2019

c. Will a split evaluation be undertaken?

Yes

d. Components

Component 1: Improving health services delivery performance (Appraised: US\$4 million, Actual: US\$12.77 million).

This component would support improvements in child health services including immunization, Integrated Management of Childhood Illnesses (IMCI), treatment of malnutrition; maternal care including prenatal care, family planning, skilled-attended delivery, and emergency obstetric care; and prevention and treatment for HIV/AIDS and other prevalent communicable diseases including Voluntary Counseling and Testing (VCT) for HIV and Directly Observed Treatment (DOTS) for tuberculosis (TB). It would do this through a Results-Based Financing (RBF) mechanism that would pay health providers (at facilities) against specific quantifiable outputs directly linked to health-related Millennium Development Goals. The scheme would have an initial two-year pre-pilot phase in eleven public community health centers in Djibouti City and two rural regions, before being scaled up to all regions in the rural areas. It would target access to and utilization of the following services: a) Maternal and neonatal health services: prenatal care, assisted deliveries by qualified staff in a healthcare facility, post-natal care, family planning, prevention of mother to child transmission of HIV, and emergency obstetric and neonatal care; b) IMCI: treatment of children under 5 years of age according to IMCI guidelines and protocols; c) Nutrition services: treatment of moderate and severe malnutrition among children under five years of age and pregnant women, and nutrition education and practices taught in the centers for recovery and nutrition education of peripheral and secondary health services; d) Expanded Program on Immunization: routine immunization of children under 12 months of age in health facilities and by mobile teams; e) HIV/AIDS prevention and treatment: communication for behavior change, VCT, and antenatal screening of pregnant women; f) Detection and treatment of TB: TB testing, DOTS, and outreach to trace drop-out patients under treatment; and g) Prevention and treatment of malaria: diagnosis using rapid tests and case management in first line health facilities (with results confirmed by microscopy at hospital laboratories).

The component was revised during the AF1 to (i) cover all public health facilities nationally, notably by adding the Arta, Dikhil and Obock regions of Djibouti, which were not included in the first phase of RBF implementation, which would expand RBF coverage from 29 to 54 health facilities, including two recently constructed community health centers (CSCs) in Djibouti City, three Regional Health Centers (CMHs) and 20 Health Posts (PSs); (ii) introduce methodological adjustments to the RBF scheme to further incorporate measures of quality in calculating payments; and (iii) collaborate with the World Bank-financed Social Safety Net Project (P130328) to allow health facilities to subcontract community peer educators called "Mother Counselors" (*Meres Conseilleres*) for community outreach to the poorest and most vulnerable households. The changes to the RBF scheme were to: (i) revise the RBF indicators and payment levels; (ii) introduce a quality adjustment component; (iii) integrate incentives for management in the Project Implementation Unit (PIU); (iv) pilot facility autonomy in managing drug revolving funds to improve drug supply; and (v) improve coaching and accompaniment for health facilities.

The revisions to the component in the AF2 would expand service delivery to include refugees, asylum seekers, displaced peoples, and host communities. Specifically, the changes would scale up the RBF scheme to health facilities in three refugee camps (Holl Holl, Ali-Addeh and Obock) and to the pediatric ward of the Peltier Hospital in Djibouti City; and support the Regional Health Directorates in providing



specialized health services to refugees and host communities in selected remote areas through mobile “Caravan” clinics.

Component 2: Strengthening health system management (Appraised: US\$1.0 million, Actual US\$1.54 million).

This component would support activities to strengthen Ministry of Health (MOH) management capacity and improve health systems performance. Specifically, it would fund medical equipment, office equipment and supplies, capacity building, technical assistance and training, and social mobilization and community outreach to create demand for health services. At the Directorate of Epidemiology and Information Systems, it would strengthen the health information system, including standardizing monthly service reports from the health facilities, harmonize reporting requirements to the different services, and provide for regular reporting, including quarterly reports and annual statistical reports. Support to the Directorate of Health Promotion would focus on strengthening its capacity to provide outreach and communication services to stimulate demand for maternal and child health services and preventive measures, including training of community health agents and conducting outreach campaigns. The project would strengthen the Drug Fund's management and ensure its financial sustainability. At the Directorate of Studies, Planning and International Cooperation, the project would support a health utilization survey and other studies. The project would support capacity building of the Directorate of Health Regions and development of its management systems. The project would also support institutional capacity building at the Directorates of Maternal and Child Health (DSME), Human Resources and Finance (DRHF), Office of the Inspector General (IGSS), Office of Training and Continuing Education, and HIV/AIDS, TB and Malaria control programs.

The AF2 expanded Component 2 to also: (i) support MOH efforts to improve the routine Health Management Information System (HMIS) through the selection of core indicators, harmonization of data collection tools, and introduction of the District Health Information Software (DHIS2) as data management software; (ii) include surveys on the quality of health services; and (iii) fund installation of small artisanal incinerators at five health facilities in Dikhil, Tadjourah, Obock, and Arta to improve health care waste management.

Component 3: Strengthening project management and monitoring and evaluation capacity (Appraised: US\$2.0 million; Actual: US\$5.69 million).

This component would support the PIU and strengthen monitoring and evaluation of the program, including financing independent quarterly technical audits to validate and verify the achievements reported by health facilities, bi-annual independent health surveys, and health facility and client satisfaction surveys. It would fund office equipment and supplies, technical assistance, PIU operating costs, and PIU staff training.

Component 4: Contingent Emergency Response Component (CERC) (Appraised: \$0, Actual: \$0).



This component was added under the AF2 to meet World Bank requirements for all projects, but it was not used.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project Costs, Financing, and Borrower Contribution: Total program costs were estimated at appraisal at US\$ 7 million, provided as an IDA credit under “blend terms.” AF of a US\$ 7 million grant from the Multi-Donor Health Results Innovation Trust Fund was approved in April 2015. In May 2019 a second AF was approved comprising a US\$5 million IDA grant (IDA-D4590) from the IDA refugee window and a credit of US\$1 million (IDA-64080). No contribution was expected from the Borrower. The ICR (p53) reported actual World Bank disbursements of US\$19.02 million at project closing. The small unspent balance of the total financing of US\$20 million was returned to the Bank.

Dates: The project was approved on April 2, 2013 and became effective on July 11, 2013 (ICR p2). A Mid-Term Review (MTR) was held in May 2016. The project closed on November 30, 2021, a month short of three years after the original closing date, after two extensions. There were four **restructurings**. The **first restructuring on April 14, 2014** (US\$ 1.8 million had been disbursed) accompanied the first AF amount. The PDO was revised to drop malaria, which was deemed unimportant; the scope of the RBF was expanded to include all geographic regions; the RBF payment criteria were expanded to include quality criteria; the monitoring and evaluation (M&E) arrangements were improved, and the Results Framework (RF) was updated to reflect changes in the RBF indicators and updated baseline data. The level 2 **second restructuring on December 17, 2018** (US\$ 11.79 million had been disbursed) extended the closing date by four months to April 30, 2019, to allow time for the second AF to be processed. The AF2 was approved on May 3, 2019, adding a US\$5 million grant from the IDA refugee window and an IDA credit of US\$1 million. It revised the PDO to remove references to communicable diseases; extended the closing date to December 31, 2020; expanded the project scope to include refugees, asylum seekers, and migrants as beneficiaries; introduced a fourth component, the “Contingent Emergency Response Component”; expanded the RBF to health centers in three refugee camps; revised the RF to capture updated and new activities; and changed procurement guidelines to align with new Bank guidelines. The level 2 **third restructuring in December 2020** (US\$ 14.78 million disbursed) extended the IDA grant and credit closing date by another nine months to September 30, 2021 to allow more time for implementing additional activities, and reallocated funds among disbursement categories. The level 2 **fourth restructuring in September 2021** (US\$ 18.23 million disbursed) extended the IDA grant and credit closing date by two months to November 30, 2021 to allow time for completing some of the activities added with the AF2.

3. Relevance of Objectives

Rationale

Original Project Objectives

The project addressed pressing problems: access to and utilization of quality essential health care services, especially with the aim of improving Djibouti’s high infant and child and maternal mortality and improving early child health outcomes, which remained among the worst in the world, despite improvements in the decade preceding the project including reduction in the level of communicable



diseases, especially TB, HIV/AIDS, and Malaria. HIV/AIDS remained the biggest cause of death and of disability and death combined in Djibouti in 2019 (the latest year for which these data are available, Institute for Health Metrics and Evaluation, accessed online on 2/24/23 at healthdata.org). Neonatal disorders and lower respiratory infections (which affect young children particularly) were the second and third highest causes of death in Djibouti both in 2009 and in 2019, and in 2019, they ranked as the top and third causes of death and disability combined, with diarrheal diseases - for which young children bear the brunt - ranking fourth. TB moved from the fourth to sixth highest cause of death between 2009 and 2019 and was the fifth largest cause of death and disability combined in 2019. Malnutrition remains the biggest single risk factor for death and disease in Djibouti. The Systematic Country Diagnostic (SCD, 2018, Report No: 134321-DJ) noted that poor health and nutrition, especially in children, undermined human capital accumulation, which, along with governance and public service delivery, were identified as two of the three main binding constraints to Djibouti's development. Regarding governance and public service delivery, the SCD highlighted the impact of public administration capacity constraints on health, especially limited sector capacity for planning, budget management, information systems, and M&E. It also listed inadequate strategic management of human resources and pharmaceuticals as challenges. The PDO and project activities were fully aligned with this country context.

The project objective and activities aligned with the five strategic priorities of the Government's National Health Development Plan IV for the period 2020-2024: expanding quality care in all regions; integrating promotive, preventive, and curative care; increasing accountability and good governance; strengthening health financing; and strengthening the HMIS.

The project remained consistent with the World Bank's assistance strategy in Djibouti. The PDO aligned well with the Bank's Djibouti Country Partnership Framework FY22-26 (Report No: 147787-DJ), specifically with Objective 3: Strengthen basic service delivery to improve access, quality, and inclusion, while enhancing resilience to climate change and natural disasters, part of Focus Area 2: Strengthening the role and capacity of the state, supporting the government's efforts to strengthen basic service delivery and social inclusion, notably in health, as well as the capacity of public institutions. The PDO focus on improved utilization of maternal health services aligned with the cross-cutting theme of gender parity. The project design strategy of applying an RBF mechanism aligned well with the cross-cutting theme of strengthening transparency to support good governance.

Relevance of Revised Project Objective

The removal of malaria from the PDO in April 2014 on the grounds that it was not an issue in Djibouti was inconsistent with the World Health Organization's Country Strategy note published the following month, which noted that "Djibouti faces an unstable cyclical malaria situation, with malaria epidemics resurfacing in 2013 and 2014 after several years of drought" (WHO Djibouti Country Cooperation Strategy, May 2014), and with World Bank data showing that malaria incidence (per 1000 population at risk) rose from 2.5 in 2013 to around 14 in 2014/15, around 20 in 2016/17, 34 in 2018, 67 in 2019, and 98 in 2020 (World Bank statistics, accessed on-line on 2/20/23).

Comment on Rating.

The original PDO relevance was high. The relevance of the revised PDO is also high, on its own merits. Although the rationale for the revision is questionable and the reduced scope of the PDO seems unwarranted by the situation, it seems reasonable to not downgrade the relevance rating.



Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Improve the utilization of health care services for maternal and child health (original targets)

Rationale

The **theory of change** was that introducing a RBF program that would pay health providers (at facilities) against specific quantifiable outputs directly linked to selected services for maternal and child health (and other services), while also giving autonomy to facilities to manage drug revolving funds to improve drug supply and improving coaching and supportive supervision for providers at health facilities, would improve the availability of essential drugs, commodities, and equipment, improve knowledge, skills, and motivation of health staff, and improve the quality and provision of services, especially those specifically incentivized through the RBF payments. These improvements, together with more community engagement, training of community health agents and outreach, were expected to increase demand and utilization of these services.

Activities and Outputs

- Medical equipment, supplies, and pharmaceuticals were provided at health facilities.
- Five CSCs were upgraded to polyclinics and equipped to provide 24-hour emergency obstetric services, as well as outpatient care in dentistry, optometry, otolaryngology, and nutrition, with a laboratory and pharmacy, as well as needed equipment and staff training. Providing these enhanced services aimed to increase their availability and reduce congestion at the tertiary level.
- An RBF mechanism was set up in multiple facilities in which providers were incentivized and facilities paid at agreed rates for delivering specific services for maternal and child health. The list of services was expanded during project implementation (made possible by AF).
- Training on the RBF scheme was provided at all levels.
- A robust independent verification system was set up for the RBF using an international consulting agency.
- The RBF scheme was scaled up include to health facilities in three refugee camps (Holl Holl, Ali-Addeh and Obock) and the pediatric ward of the Peltier Hospital in Djibouti-Ville.
- The project funded one round of mobile clinic outreach to refugee camps and other remote areas.
- The project funded training to community-based groups to do community surveys; one round of survey data was collected, and some outreach was done to stimulate demand for health service utilization.



- The project financed a pilot activity (partnering with an ongoing Social Protection Project) in which health facilities subcontracted community peer educators called "Mother counselors" (*Meres Conseilleres*) for community outreach to the poorest and most vulnerable households. The MOH regarded the activity as a Social Protection activity, and did not continue it after the pilot, but the approach was used under a Nutrition Project (email correspondence with Project team member on 1/23/23).

Intermediate Results

- Health facility business plans were drawn up every six months defining priorities for improving the health of the Djiboutian population.
- The RBF payments at the end of each month into the bank account of each contracted health facility enabled facilities to purchase inputs and make infrastructure investments such as renovating and repainting buildings, and construction of emergency rooms.

Outcomes Against Original Targets

(Note: HIV/AIDS services delivered as part of pre-natal care are listed under the objective relating to communicable diseases)

Pre-natal care

The original PDO indicator, "Percentage of pregnant women receiving a prenatal visit before the end of the first trimester of pregnancy" (PAD, baseline 22 percent, target 55 percent), was dropped at AF1/R1, and no data were reported. It was replaced by "Number of women receiving prenatal visits 2-4", edited at AF2 to "Number of women completing two or more prenatal visits." From a baseline of 6,100, the original target of 22,886 was exceeded; the total at completion was 111,987. However, two prenatal visits is a low target; most countries aim for four.

The intermediate results indicator (IRI) for "Percent of pregnant women receiving at least two doses of tetanus toxoid" had an original baseline and target of 29 percent and 60 percent, with the latter exceeded at completion with a result of 62 percent.

Attended births

The original PDO indicator "Percent of women giving birth in a facility assisted by qualified personnel" (baseline 53 percent, target 75 percent) was dropped at AF1/R1, and no data were reported.

Post-natal care

The original indicator "Women receiving two postnatal care visits between 8th and 42nd day after delivery" was dropped at AF1/R1, and no data were reported.



Other reproductive care

The original IRI “Percentage of women of childbearing age visiting the public system to obtain modern family planning (oral contraceptives and injections, intra-uterine devices, or implants)”, with a baseline of 13 percent and target of 25 percent, was changed during AF1/R1, and no data for the original version were reported.

Nutrition services

The original IRI “Number of pregnant/lactating women, adolescent girls, and/or children under age 5 reached by basic nutrition services” (baseline 50,000, target 90,000) was exceeded by the reported achievement of 293,369 women and children reached. Although the revised version has a broader target group, the amount by which the achievement exceeds the original target is so great as to leave little doubt that the target for the original target group would also be exceeded. The enormous difference also calls into question the degree of ambition of the original target.

The IRI “Number of children between age 6 and 59 months receiving vitamin A supplementation (baseline 50,000, target 90,000) was dropped, and no data reported.

Infant and child health care

The PDO Indicator “Percentage of children fully immunized before their first birthday” was originally included with a baseline of 83 percent and a target of 90 percent. The ICR (p28) noted that the indicator “cannot be measured against original target, as the baseline was wrongly calculated and modified at AF1 to 32 percent,” with a modified target of 51.5 percent, which the ICR (incorrectly) lists as the original target. The actual result at completion was 62 percent. The original target is considered not to be met.

An IRI for the percent of children whose growth was monitored at well-baby clinic visits (baseline 5 percent, target 40 percent) was dropped at AF1/R1, and no data were reported.

General measures of health services access/utilization

The IRI for “Number of curative visits per person per year in the public system” had an original baseline of 0.2. The original target of 0.5 was not met, with an achievement of 0.44 at completion.

The original IRI “People with access to a basic package of health, nutrition, or reproductive health services” (baseline 155,000, target 200,500) was dropped, with no data reported.

The PAD included IRIs for the “Number of direct project beneficiaries” (target 300,000) and “Number of female project beneficiaries” (target 210,000), which were “marked for deletion at AF2” (ICR p55), and no data were reported against this indicator. However, new IRIs introduced at AF2 for “People/Females who have received essential health, nutrition, and population services” measure substantially the same thing, and the achievements were reported as 428,925 for all, and 250,673 for women, exceeding the original targets for numbers of direct beneficiaries.

Summary: Six of the original PDO indicators were dropped and no data provided. Targets for tetanus toxoid shots, nutrition services, and total numbers of people served were exceeded by large amounts. The original



immunization target appears not to have been met. The target for average number of curative visits was not met, but the average number more than doubled, a substantial achievement. Data were not available for many of the original indicators, including key MCH activities (such as births attended by a skilled provider and access to modern contraceptives), and the achievement in immunization coverage was low (62 percent). On balance, these results represent substantial achievement, but with moderate shortcomings and data gaps.

Rating

Substantial

OBJECTIVE 1 REVISION 1

Revised Objective

Improve the utilization of health care services for maternal and child health (revised targets)

Revised Rationale

Outcomes Against Revised targets

Prenatal care

For the PDO indicator "Number of women completing two or more prenatal visits," the revised target of 95,700 was exceeded; the total at completion was 111,987. However, as noted above, two visits is a low target; most countries aim for four.

For the IRI "Percent of pregnant women receiving at least two doses of tetanus toxoid," the baseline was revised down to 20 percent, the target was revised down to 45 percent at AF1/R1 and then up to 55 percent at AF2, and was exceeded at completion with a result of 62 percent. However, this is a basic part of prenatal care, and 62 percent coverage is low.

Attended births

The IRI indicator "Number of women giving birth in a contracted facility assisted by qualified personnel" (baseline 1,026, target 7,775) was added at AF1/R1. The target was increased at AF2 to 25,525, but the ICR commented that the indicator was "marked for deletion at AF2," stated that the indicator had been dropped by completion, and did not report any data. A new IRI "Number of deliveries attended by skilled health personnel" (baseline set to 0 per guidelines for corporate indicators, target 35,525) was introduced at AF2, and exceeded by the reported achievement of 67,589 at completion. No information is given as to which facilities or time period the indicator covered. There is also no indication as to the percentage of all births that were attended by qualified personnel, a better indicator of the coverage of this key MCH service.

Other reproductive care

The revised IRI "Number of women of childbearing age visiting the public system to obtain modern family planning (oral contraceptives and injections)" with a baseline of 7,304 and target of 35,000, revised up to 130,000 at AF2, was exceeded; the achievement at completion was reported to be 145,850. However, no sense is given of what percentage of women of child-bearing age this covers.



Nutrition services

The revised IRI “Number of women and children who have received basic nutrition services” (baseline revised down from 50,000 to 7,117, and target revised down to 50,000 at AF1/R1 and then up at AF2 to 150,000) was reported to be exceeded, with an actual achieved of 293,369.

Infant and child health care

The PDO Indicator “Percentage of children fully immunized before their first birthday” achieved 62 percent, exceeding the target of 51.5 percent set at AF1/R1, but falling short of the target of 85 percent (as revised in 2019 at AF2). A new IRI, “Number of Children immunized,” introduced at AF2 with a target of 45,000, was reported to be exceeded, with an achievement of 49,711 at completion.

General measures of health services access or utilization

The IRI for “Number of curative visits per person per year in the public system” baseline was revised down at AF1/R1 to 0.15, and the target was revised up at AF2 from 0.5 to 0.65 but was not met, given the achievement of 0.44 at completion.

The PAD included an IRI for the number of direct project beneficiaries (target 300,000) which was “marked for deletion at AF2” (ICR p55), and no data were reported.

The targets for IRIs introduced at AF2 for “People/Females who have received essential health, nutrition and population services” of 250,525/143,025 were exceeded by the achievements reported of 428,925 for all, and 250,673 for females.

For the IRI “Number of female project beneficiaries,” the target was revised at AF2 from an absolute number to a percentage of 65 percent (presumably of all project beneficiaries), but also “Marked for deletion at AF2” and reported in the ICR as “Dropped” in the column for “Achieved at Completion” (Annex 7, p56). However, females are 58.4 percent of the total number of people who received essential HNP services (reported above), a shortfall from the 65 percent target.

A new IRI, “Number of displaced persons (refugees, asylum seekers and migrants) receiving services at health facilities,” was introduced at AF2 with a baseline of 0 and target of 35,734. It was substantially achieved, with 33,394 displaced persons served by the end of the project. It would have been helpful to know (even approximately) what proportion of all displaced people had access to health services.

Summary: Revised targets for six indicators were exceeded and two were substantially achieved. One of the two immunization indicators (absolute number of children) was achieved, but the other (percentage of children) was not achieved. The target for the average number of curative visits was not met, but the increase over the baseline was large. Overall, this appears to be a substantial achievement, although few of the indicators describe the coverage - i.e. percent of the relevant population reached, which is a better measure of achievement.



Revised Rating

Substantial

OBJECTIVE 2

Objective

Improve the utilization of health care services for communicable disease control programs

Rationale

The theory of change for Objective 1 applies also to objective 2, but for services related to prevention and treatment of communicable diseases.

Outputs

The outputs reported for PDO 1 apply here also.

Intermediate Results

The intermediate results reported for PDO 1 apply here also.

Outcomes

Malaria

As noted earlier, malaria was dropped from the PDO in AF-1 after less than one year of implementation. The only indicator for malaria, the IRI "Percentage of suspected malaria cases that are tested and confirmed," was dropped at AF1/R1, and no data on malaria detection or treatment were collected or reported in the ICR.

HIV/AIDS

The PDO indicator "Percentage of HIV positive pregnant women receiving treatment according to protocol" (baseline 12 percent, target 55 percent) was revised from a percentage to a total number at AF1, and no data were reported for the original indicator. At AF2, the indicator was "demoted" to an IRI. The revised indicator baseline was 63 and target was 300; the reported number at completion of 443 exceeded the target.

The original IRI for the percentage all persons tested for HIV who received their test results (baseline 70 percent, target 87 percent) was dropped at AF1/R1, and no data were reported.

TB

For the IRI "Number of people receiving TB treatment in accordance with the World Health Organization-recommended DOTS" (baseline 300), the initial target of 500 was increased at AF2 to 2,800, and greatly exceeded by the reported total of 4,724 at project completion.



Summary: Although the revised indicator targets were exceeded, very few data were provided, and no information was provided by which to judge the extent to which coverage (a measure of total need) was increased. Achievement of this objective is therefore rated Modest.

Rating
Modest

OBJECTIVE 2 REVISION 1

Revised Objective

This objective was dropped from the PDO in the project restructuring at the time of AF2.

Revised Rationale

No comment or rating needed because this objective was dropped from the PDO.

Revised Rating

Not Rated/Not Applicable

OBJECTIVE 3

Objective

Improve the utilization of QUALITY health care services for maternal and child health

Rationale

The **theory of change** described for Objective 1 applies to this objective as well. In addition, the quality of services was expected to be further enhanced as a result of improved MOH management capacity, specifically through a stronger health information system with better data verification and supervision of data management, better management of the Drug Fund that would improve the availability of essential medicines in health facilities, a health utilization survey and other studies, and capacity building at the DSME, DRHF, IGSS, Office of Training and Continuing Education, and HIV/AIDS, TB, and Malaria control programs.

Activities/Outputs

- DHIS-2 software was acquired, the database set up, and 306 staff trained in its use.
- Consultants (national and international) were hired, and logistical support was financed (including purchase of a vehicle), to enable the MOH to monitor data collection.
- The HMIS system that had been developed by other donors and implemented in hospitals was extended to the University Hospital and down to the first and second levels. The project financed training and supervision/logistic support to ensure that data were collected and collated. The TTL did



not remember whether the project also paid to hire additional staff to work on the HMIS. PIU staff were trained on the system.

- Five mini-incinerators were installed at health facilities and staff trained in their use. Personal Protective Equipment (PPE) for waste management was procured (for two facilities) and staff trained on waste segregation.
- Training was provided for MOH and PIU staff on fiduciary management and procurement; and how to develop budgets, business plans, and procurement plans.
- Quarterly assessments of the quality of care provided by health facilities were conducted.
- One community survey was done, and the results shared with contracted facilities.
- The MOH provided regular training to improve skills of facility staff. The project helped improve the quality of coaching and supportive supervision provided to staff at health facilities. The Borrower's ICR noted "weak support for capacity building of healthcare providers in drug management, contraceptive techniques, IMCI, and Comprehensive Emergency Obstetric and Newborn Care services" (ICR p50).

Intermediate Results

- RBF increased the financial autonomy of health facilities and availability of budgets that could be used for timely purchase of needed supplies. Up to 30 percent of each RBF transfer to a health facility could be used for staff bonuses; the rest was to be used for operating costs and/or procurement of materials and goods. Health facility committees were set up with oversight over the funds.

Outcomes

The original RF had no PDO indicators for quality but did include two IRIs to measure quality.

The IRI "Percentage of established and functioning Health Management Committees in CSCs and CMHs" had a baseline of 15 percent and target of 100 percent, but the indicator was dropped at AF1/R1 and no data were reported.

A new IRI for the "Number of health care providers trained on the DHIS2" was added at AF2; the target of 312 was substantially achieved, with 306 people trained.

The original IRI "Average score on the quality checklist" had a baseline of 45 and end target of 75 in the PAD. At AF1/R1, the IRI for quality was "promoted" to a PDO indicator "Average facility quality," with a baseline of 29 and target of 60, which was revised upward to 65 at AF2. (The ICR Annex 1 showed the AF1/R1 baseline of 29 and AF1/R1 target of 60, which it incorrectly called the original target). The average facility scores shown in the ICR (Figure 2, p12) rose sharply from 29 at the start of the project to a high of 59 in 2018 and 2019, and then fell in the final two years of the project, consistently failing to reach the target; the ICR reported the actual achieved at completion as 45. However, it appears that the summary indicator for all facilities obscures the extent of improvements in quality in larger facilities. The ICR explained that average facility quality was measured each quarter using a composite indicator tailored for each type of facility. (The quality score earned the facility a bonus of up to 25 percent, so long as the score was at least 50% of the maximum.) The ICR showed annual average quality scores for each region, separating health posts, regional



facilities, and, in Djibouti-Ville, separating community health centers, polycliniques and hospitals. Most facilities achieved improvements in quality scores over most years. For health posts, the highest scores were in 2019. Most regional facilities scored highest in the final assessment (2021). No health posts achieved the target in any year, but hospitals and polyclinics in Djibouti-Ville, and Regional Health Facilities in most regions, met or exceeded the targets fairly consistently after 2018, including at completion, as shown in the graphs in Figure 2 on p13 of the ICR.

A new IRI, "Percentage of beneficiaries satisfied with health services," was added at AF2 with a target of 60 percent. The ICR reported the achievement at completion as 50 percent, partially achieving the target. The ICR noted that score increased during project implementation, but that the inclusion of public satisfaction in the overall facility score was not consistent over time and across health facilities. One of the responsibilities of the Health Facility Management Committees set up under the project was getting feedback from communities; the ICR reported that "performance varied" in this.

A new IRI, "Community survey conducted and results shared with contracted facilities" (yes/no measure) was added at AF2, and reported in the ICR as having been achieved, although the ICR provided no details on how many surveys were done (they were supposed to be done annually). The TTL explained that community-based organizations were contracted and completed one survey, but were unwilling to repeat the survey the following year (conversation with TTL on 1/31/23). As this survey was intended to be done each year, one survey does not meet the target.

The Borrower's ICR noted that an evaluation conducted by an independent firm called SADEV found "satisfactory results... in terms of the quality of services" (ICR p46) but noted "differences between the scores assigned by the verification team and the AVEI" [Independent verification agency hired to assess a sample of facilities each quarter]. It also stated that "implementation of the project has made it possible to improve the technical capacity of the health facilities, the relative availability of drugs, the regularity and quality of reports to the health information system, and patient and provider comfort. However, bottlenecks still persist, mainly at the level of the supply chain and drug management, and the effective empowerment of health facilities and community involvement in the management of these facilities" (ICR p46). It noted that "motivation of healthcare and service providers in health facilities is low, especially at the level of PSs" (ICR p47).

Summary: The training target was substantially achieved; facility quality score targets were partially met; assessment of beneficiary satisfaction was not consistently done; and available data are inadequate to assess satisfaction. Achievement is therefore rated Modest.

Rating
Modest

OBJECTIVE 4

Objective

Improve the utilization of QUALITY health care services for communicable disease control programs

Rationale



The description of the theory of change for Objective 3 applies to this objective as well.

The information provided for Objective 3 on activities and outputs also applies to communicable diseases.

The qualifiers "in accordance with the WHO recommended DOTS" in the IRI for the "Number of people receiving TB treatment in accordance with the WHO recommended DOTS," and "according to protocol" in the IRI "Percentage of HIV positive pregnant women receiving treatment according to protocol," introduced a quality element into these indicators, but there are no explicit, specific measures of improvements in the quality of services for communicable diseases.

Rating
 Modest

OBJECTIVE 4 REVISION 1

Revised Objective

This objective was dropped from the PDO in the project restructuring at the time of AF2.

Revised Rationale

No comment or rating needed because this objective was dropped from the PDO.

Revised Rating
 Not Rated/Not Applicable

OVERALL EFFICACY

Rationale

Overall efficacy under the original PDO and outcome targets is rated modest (modest for three objectives and substantial for one objective).

Overall Efficacy Rating
 Modest

Primary Reason
 Low achievement

OVERALL EFFICACY REVISION 1

Overall Efficacy Revision 1 Rationale

Overall efficacy under the revised objectives and outcome targets is substantial, but barely so, based on substantial achievement of improved utilization of health care services for maternal and child health, but mixed achievement (aggregating at modest) of improved quality of services for maternal and child health.



Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

Ex-Ante Assessment of Efficiency

The PAD (p14) stated that the project design was technically sound, reflected Djibouti's particular circumstances, and incorporated lessons learned from the implementation of the previous IDA-financed health project in Djibouti and RBF pilots in other countries. It said that the interventions financed were cost-effective and were expected to have a significant positive impact on child mortality, maternal mortality, and the control of communicable diseases. It reported that RBF experience in other countries had found that at least US\$2.50 needed to be spent per inhabitant per year to significantly improve provision of health services, and that the project budget provided for spending above this threshold. No detailed economic analysis was done, although the PAD reported a Marginal Budgeting for Bottlenecks estimate of relative cost efficiency of US\$7.40 if the project were to save 932 lives in total, and US\$6.90 if 999 lives were saved, without any additional details or explanations for these projections.

Ex-post Assessment of Efficiency

A cost-benefit analysis done ex-post for the ICR concluded that the project economic benefits were positive: the Net Present Value (NPV) was estimated at between US\$54 million and US\$93 million (average NPV of US\$71 million), the economic Internal Rate of Return (IRR) at between 82 and 117 percent (average IRR of 99 percent), and the Cost-Benefit Ratio (CBR) range at 4.3 to 6.8 (average CBR of 5.4). The project was assumed to reduce Disability-Adjusted Life-Years (DALYs) caused by maternal deaths by 20 percent, childhood mortality by 10 percent, and DALYs related to HIV/AIDS, TB and malaria all by 10 percent. The ICR reported that sensitivity analysis to test the robustness of the estimates confirmed that the NPV, IRR, and CBR remained positive when the maternal mortality attribution was reduced to 15 percent or increased to 30 percent. Each DALY was valued at the GDP per capita, costs were discounted at an inflation rate of 2 percent, and DALY values were discounted at 3 percent.

The ICR considered that the project's focus on targeted interventions for mothers and children (for whom mortality rates were high) and people in the regions and remote areas was an efficient way of trying to improve utilization of maternal and child health services. The ICR opined that the RBF principles of providing incentive payments for delivering a defined package of high priority selected health services, adjusting the payment amounts by a facility quality score, and independently verifying the RBF data, together with the training provided to enhance the capacity of the MOH and PIU to oversee the program, and some limited efforts to stimulate demand for services, "improved the project's overall efficiency" (ICR p14). However, more recent analysis of RBF (see Risk to Development Outcome section) questions whether the contingent payments and the verification required are a more efficient way to achieve results than simply providing non-contingent additional discretionary budget allocations to facilities.

The ICR judged preparation and implementation of the project to have been efficient. Preparation stages (times between the benchmark events of concept note, approval, effectiveness, and first disbursement) were



significantly faster than World Bank averages (ICR p43). The project disbursed at a high rate, including the AFs provided to fund increases in the project coverage.

Turnover among key counterpart staff improved substantially towards the second half of the project lifecycle, and was described as “stable” for the PIU and MOH management “except during a short phase of political disturbance,” with many PIU staff remaining in post or in other roles in the MOH throughout the project (ICR p42). The Bank team had four TTLs during the project, and the ICR described transitions as “smooth,” despite the fact that one handover occurred in 2016 during a time when the MOH was refusing all missions.

The ICR explained that the institutional context and capacity constraints in Djibouti lengthened the time it took for the RBF mechanism to be absorbed. In particular, low-level facilities often lacked the human resources needed for the decision-making and accountability for financial management, data management, and reporting, and governance and management of resources required by RBF. However, the ICR noted that the time it took was consistent with experience in other countries and that the longer implementation period was used to introduce other important improvements in the health system and had the benefit of stable partner engagement.

Several factors are likely to have reduced project efficiency. (1) Only limited planned activities to stimulate demand were planned, and not fully implemented. On p13, the ICR refers to the pilot efforts to improve community-level engagement with mothers and to target women in poor households for outreach in collaboration with the Bank-funded social safety net project as “nascent,” but that they “showed potential to improve outcomes for women who are most vulnerable and at risk.” (2) The abrupt suspension of project activities and communication between the Bank and MOH for a period of 6-8 months from mid-2016 after a change in MOH’s political leadership (ICR p18) would likely have impacted the efficiency of implementation. (3) The failure in project design to take into account the failed earlier effort to build decentralized capacity to manage service delivery (described in the ICR on p17) by allowing more time to build capacity, especially by starting with a pilot of smaller scope, and allowing more time for the initial steps, was a shortcoming. The ICR noted that the risk assessment had highlighted the lack of governance and management mechanisms at the health facilities, which were not autonomous, had no experience with financial management and disbursement, and lacked fiduciary personnel, training, or financial management tools. In addition, the assessment at the time of preparation found that the PIU also was not well equipped to handle fiduciary management and did not have adequate procedures and internal audits to handle the complexity and decentralization aspects of the RBF. The PIU also was responsible for other projects and donors in addition to the new project. The ICR noted the mitigation measures included in the project (hiring additional qualified staff, internal and external auditors, setting up health management committees at each participating health facility, providing trainings, providing management tools to health facilities, and setting up management teams within health facilities), but also noted that “the time frame to implement these mitigation measures was short” (ICR p17). The ICR also noted that “a smaller pilot would have allowed the RBF mechanism to be fully tested in a more contained and manageable way. In addition, it would have enabled the PIU and other stakeholders to fully understand and enact their roles and responsibilities, for instance in relation to the verification and cross-verification process or fiduciary management before a progressive scale-up. Finally, additional time for the initial pilot could have been used to put in place tools required to facilitate the decentralized planning, decision-making, monitoring, and reporting for health facilities such as the digital PBF portal that would have enabled the PIU to consolidate information for better management and oversight at the PIU level. The client and PIU’s readiness for implementing such an ambitious project with a nationally planned scale-up within two years was insufficient” (ICR p17). Notwithstanding these moderate shortcomings, overall efficiency is rated Substantial.

Efficiency Rating



Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	99.00	0 <input checked="" type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Overall Outcome Ratings

Rating Dimension	Original PDO	Revised PDO
Relevance		High
Efficacy		
Obj. 1: Improve utilization of Maternal and Child Health Services	Substantial	Substantial
Obj. 2: Improve utilization of services for communicable diseases	Modest	N/A
Obj. 3: Improve quality of MCH services	Modest	Modest
Obj. 4: Improve quality of Communicable Diseases services	Modest	N/A
Efficacy Overall	Modest	Substantial
Efficiency		Substantial
Outcome Rating	Moderately Unsatisfactory	Satisfactory
Outcome Rating Value	3	5
Amount Disbursed (US \$ million)	11.9	6.9
Disbursement %	62%	38%
Weight Value	$3 * 0.62 = 1.86$	$5 * 0.38 = 1.9$
Total Weights	$1.86 + 1.9 = 3.76$	
Overall Outcome Rating	Moderately Satisfactory	

a. Outcome Rating



Moderately Satisfactory

7. Risk to Development Outcome

The ICR did not explicitly identify risks to the project outcomes, but explained why the project outcomes were likely to be sustained (ICR p25). It noted that the government had signaled its commitment to sustaining the project achievements by announcing the inclusion of a line in the national budget for RBF, although COVID-related budgetary stress prevented this from being done. The ICR commented that the MOH requires “substantial support” due to the “low-capacity setting,” but that continued financial and technical support was being provided through a follow-on IDA financed project (Djibouti Health System Strengthening Project, P178033) approved on May 26, 2022 that was providing an IDA credit of US\$14.5 million and an IDA grant of US\$5 million to support continued RBF support for reproductive, maternal, neonatal, child, and adolescent health and nutrition services and further reforms to improve service delivery and quality, citizen engagement, and project management. The project design includes testing direct facility financing (DFF), an alternative financing scheme under which, as with RBF, facilities are provided with additional funds and spending autonomy and have similar reporting requirements, but without tying the funds to specific results or quantity or quality performance. New research has found similar results between DFF and RBF, but that DFF is more cost-effective and procedurally less onerous because it does not include verification or counter-verification (Khanna, M., Loevinsohn, B., Pradhan, E. *et al.* 2021, Decentralized facility financing versus performance-based payments in primary health care: a large-scale randomized controlled trial in Nigeria. *BMC Med* 19, 224).

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was prepared relatively quickly (11.6 months from concept note to approval). The objective was fully relevant to Djibouti’s development priorities, population healthcare needs, and health sector issues. The arrangements for implementation gave primary responsibility to the MOH, with support and oversight from the PIU, which had a decade of experience with Bank-financed projects. The ICR noted that the feedback from reviewers during the concept note review were mostly addressed at appraisal (ICR p24). The risk assessment was thorough, and thoughtful measures were described to mitigate most risks. However, the PAD noted lack of familiarity with RBF as a risk, but said only that this would be mitigated by development and use of a detailed RBF manual and training, without details, which suggests inadequate appreciation of and planning for the effort and time required to introduce RBF in the Djibouti context.

The project design relied almost completely on RBF to achieve the objectives of increasing utilization and quality of health services, but the PAD does not provide adequate justification for this. The PAD noted that “it was agreed by all concerned parties that the supply of services will be prioritized... experience has shown that demand should not be vigorously stimulated until the supply of services is fully functional and readily available to satisfy it.” This implies that the supply of services was not fully functional and readily available to meet an increase in demand. However, the PAD noted that “during the past five years, there has been considerable improvement in the provision of health services. Various interventions undertaken



by the projects and programs of the MOH have notably reduced the number of constraints that hindered access to health care services” (PAD p14). There was no discussion of supply constraints in the PAD aside from references to the inadequate budget for drugs. The only provision in the project to enhance the supply or quality of services was the RBF program. Regarding stimulating demand, Component 2 included an unspecified amount of funding to strengthen the capacity of the “Directorate of Health Promotion ...to provide outreach and communication services to stimulate demand for maternal and child health services and preventive measures. These activities will include training of community health agents and conducting outreach campaigns” (PAD p6). No additional details were provided. The inference is that the RBF program was expected to make supply “fully functional and readily available,” with ambivalence about whether efforts to enhance demand would be needed for the project to reach its targets. The PAD needed to be clearer about these central considerations.

The ICR noted that the PAD did not mention earlier unsuccessful efforts in Djibouti to set up decentralized regional health committees to coordinate activities for HIV/AIDS and TB interventions, and underestimated the time required to build the basic local level capacity needed for implementing RBF. A smaller pilot, with more time between phases, “would have allowed the RBF mechanism to be fully tested in a more contained and manageable way. In addition, it would have enabled the PIU and other stakeholders to fully understand and enact their roles and responsibilities, for instance in relation to the verification and cross-verification process or fiduciary management before a progressive scale-up. Finally, additional time for the initial pilot could have been used to put in place tools required to facilitate the decentralized planning, decision-making, monitoring, and reporting for health facilities, such as the digital PBF portal that would have enabled the PIU to consolidate information for better management and oversight at the PIU level. The client and PIU’s readiness for implementing such an ambitious project with a nationally planned scale-up within two years was insufficient” (ICR, pp17-18). There were also notable shortcomings in the project’s RF, which are discussed in the section on Monitoring and Evaluation (M&E) design.

In summary, the project relied very heavily on RBF, without giving enough time and attention to be able to learn from a well-evaluated RBF pilot.

Quality-at-Entry Rating Moderately Unsatisfactory

b. Quality of supervision

The project team was relatively stable during the project lifecycle, although Task Team Leaders (TTLs) changed four times. Most transfers of responsibilities between TTLs occurred smoothly, but the transition in 2016 was impacted by the political changes in country and MOH disengagement, and no handover mission was possible. The Bank team continued supervision during COVID through regular virtual meetings.

The quality of supervision and reporting improved during implementation. Initial Implementation Status and Results Reports (ISRs) did not contain adequate details of implementation progress or challenges. From 2015, reporting and documentation were stronger, more candid, and more comprehensive. The section below on Safeguards notes that the Bank team (and MOH) gave inadequate attention to environmental issues before the mid-term review (MTR).



The ICR said that the Bank team was proactive in identifying and addressing challenges to achieving the project objectives and provided strong technical support overall. The team provided appropriate advice and support to the PIU regarding project management and implementation, and on several restructurings and two AFs to expand the project's scope and coverage, do more to improve medical waste management, and better enable the health sector to meet the health care needs of large numbers of refugees and seasonal and economic migrants. The RF was reviewed and revised in response to new data, restructurings, and the AFs, and to the changing requirements for corporate indicators.

The removal of malaria from the PDO in April 2014 was questionable given the data cited above on the rise in malaria cases, that continued throughout the project (HNPstats data).

The team diplomatically handled a politically sensitive situation. In mid-2016, a change in MOH's political leadership resulted in an abrupt halt in project activities and communication with the Bank and all other partners for 6-8 months. The Bank team renegotiated some project activities to ensure overall continuity of the project, including support for upgrading five CSCs to secondary level polyclinics with emergency obstetric services in Djibouti-Ville and reinstating performance incentives for health workers (which had been removed). The Bank team was able to navigate this delicate situation and took on a lead role in donor coordination as communication between the MOH and larger group of development partners remained strained. This period of disengagement impacted outcome indicators such as immunization rates, which depended heavily on donor support, particularly from GAVI. The team made concerted efforts to improve direct and regular communication with the PIU.

Quality of Supervision Rating

Moderately Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The PDO was fairly specific and well-focused on priority health conditions and gave appropriate recognition to service quality. A manageable number of indicators were chosen to track key project results that met most of the "SMART" criteria. However, no indicators were included to track activities under Component 2. Many of the indicators and targets were set as absolute numbers, and although this makes it easier to collect data, and perhaps is a clear way to measure increases in service delivery, it gives no sense of the coverage (i.e the percent of the eligible or target population served), which is a very important aspect of increased utilization, and a better measure of the degree of ambition of the project relative to need. The results framework included baselines and target values for each year of the project for all indicators, and listed data sources and collection frequency. However, indicators were not all clearly defined, and responsibility for data collection was given as "MOH" for most indicators, which could have been more specific. RBF programs rely heavily on sound data reporting and verification, and the project included internal verification of data by the MOH and also funding to hire an independent third-party firm to do quarterly verification of activities reported in the health facility registers including through random samples



of households. In addition, independent financial auditors were to be hired to examine health facility bank accounts and ensure proper use of funds.

The PAD reported that a baseline survey had been conducted for the RBF and that “an assessment of the RBF interventions [would] be carried out at the mid-term review of the Project and lessons learned ... considered in the RBF expansion during the remaining project duration. An end of project survey [would] be carried out by the Pan Arab Project for Family Health at the conclusion of the RBF intervention” (PAD p10). In addition, the PAD reported that “independent health facility and household surveys [would] be carried out to ensure that there [was] overall progress in strengthening the quantity and quality of health services and that the RBF [did not have] unintended consequences and to confirm the data contained in the health information system” (PAD p10).

The M&E design did not take account appropriately of the weak M&E capacity noted in the PAD, and the limited data availability in Djibouti which was exacerbated by the difficulty of getting access to it.

b. M&E Implementation

Efforts were made during implementation to address the design shortcomings of the RF, including clarifying indicator formulations and definitions, revising baselines found to be inaccurate and revising targets, and adding a PDO indicator for quality. (The first round of PBF verification enabled estimates to be made of some baselines that had been “guesstimates” in the absence of survey or administrative data.) The PDO Indicator for prenatal care during the first trimester was dropped, as were several IRIs that remained relevant to the project objectives but for which data were not readily available. All PDO indicators and two of the four IRIs relating to HIV and TB were dropped when these diseases were removed from the PDO. The ICR commented that although “the RF was changed several times during implementation to reflect the changes in project activities, the overall M&E remained weak” (ICR p19).

Implementation of the M&E system for the RBF scheme improved over the course of implementation, but delays were slow to be overcome. The MTR in May 2016, nearly three years into implementation, noted that an information technology consultant had not yet been hired to put in place an RBF portal, and that the contract for the independent verification agency had not been signed. The verification contract was given priority after the MTR. It took until 2018 for community-based associations to be contracted to carry out user satisfaction surveys, initially in Djibouti-Ville. However, only three associations were willing to carry out a second round of surveys, because of difficulties in identifying households from the manual register data of the health centers, and delayed remuneration. This meant that user satisfaction was not able to be used in the quality score as planned. Towards the end of the project, a study was done on the quality of health facilities using secondary PIU data and structured and semi-structured stakeholder interviews. However, the evaluation did not include surveys of facilities or of households, limiting the assessment to the data provided by the PIU.

In summary, the persistent shortcomings in the implementation of monitoring plans included delays in operationalizing the RBF portal, failure to computerize most RBF indicator data, failure to repeat the community survey, delays in operationalizing the DHIS-2 HMIS system, and low capacity at the facility level to collect data.



c. M&E Utilization

The use of the RBF data – as the basis for calculating payment amounts and disbursing funds to health facilities – was accomplished, and was “robust, especially once the verification and counter-verification processes were being implemented smoothly” (ICR, p22). Additional use of the RBF data was hampered by a failure to computerize these data; inadequate functionality of the RBF portal; and issues with routine data entry in the DHIS-2 system and analysis of incoming data. No examples of utilization of M&E data were provided in the ICR.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

Environmental and social safeguards: The project was categorized as “B” under the Bank’s Environmental Assessment Policy (OP 4.01). The Environmental and Social Impact Assessment (ESIA) identified the main project impact as the generation of additional biomedical waste and noted that biomedical waste management capacity was weak. A Biomedical Waste Management Plan was prepared and disclosed on MOH and World Bank websites in December 2012. The project included funding for training in waste management and purchase of PPE. The 2016 Aide-Memoire noted that PPE for waste sorting were procured for only two health centers and that no training of medical staff on waste segregation and disposal had been done (ICR, p22).

The 2012 ESIA had noted that biomedical waste management in Djibouti was poor, with ad hoc waste segregation and only a couple of operating hospital-grade incinerators in in Djibouti-Ville and none in the regions. AF2 included funding to strengthen biomedical waste management through the construction of five artisanal incinerators in the four regions (Arta, Tadjourah, Obock et Dikhil). An ESIA specific to AF2 was approved and disclosed on March 1, 2019. The PIU changed the planned site for the incinerator in Arta region, to move it away from residences. An Environmental and Sanitation Management Plan specific to the new location was approved and disclosed on July 1, 2021 on the World Bank website and MOH websites, in compliance with disclosure requirements.

Project performance on safeguard mitigation was assessed as Moderately Satisfactory throughout implementation. The ICR noted that only three ISRs/aide-memoires (AMs) reported on implementation of safeguards: May 2016 (MTR), June 2017 and June 2021. The June 2017 AM noted that recommendations of the MTR in May 2016 regarding biomedical waste management had not been implemented. Greater attention was paid to Environmental and Social safeguards from 2020: the PIU submitted safeguard implementation reports to the Bank in 2020 and 2021, and the Bank hired a national environmental and social short-term consultant in 2021 to guide and assist the PIU in implementing the safeguards.

b. Fiduciary Compliance



Fiduciary. The Financial Management (FM) rating was Moderately Satisfactory for most of the project. The PIU had a decade of experience with Bank-financed projects and a dedicated team for FM aspects whose overall performance was regarded as satisfactory. The ICR reported that Internal control for the project was “strong,” with implementation procedures documented in a Project Operations Manual. There was also an RBF manual, a condition for RBF disbursement. The main issue during implementation was delays in the submission of quarterly interim un-audited financial reports and internal audit reports. To address the delays in the latter, an internal auditor was recruited, and quarterly audit reports were prepared. Any concerns raised in internal audit reports were addressed by the PIU with adequate follow-up. The annual external audit reports were submitted on time with an unqualified “clean” auditor’s opinion.

Procurement. Procurement performance was rated Satisfactory throughout implementation. Procurement conformed to World Bank regulations. Procurement arrangements were updated during AF2 to adhere to the August 2018 revision of “WB Procurement Regulations for Borrowers under Investment Project Financing.” The PIU had a dedicated procurement specialist. Djibouti already had an acceptable legal framework and regulations for procurement. Commitments were subject to local procurement procedures through the National Procurement Committee for any amount exceeding the threshold fixed by local regulations. The only procurement issue noted in the ICR was some occasional delays in timely documenting of procurement activities in Systematic Tracking of Exchanges in Procurement (STEP) (ICR p23).

c. Unintended impacts (Positive or Negative)

None noted.

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Moderately Satisfactory	This ICR Review separates quality and utilization of MCH and of communicable disease services into four separate evaluable objectives, and rates efficacy for the "quality" dimension of the objective as Modest.
Bank Performance	Moderately Satisfactory	Moderately Satisfactory	
Quality of M&E	Modest	Modest	
Quality of ICR	---	Modest	



12. Lessons

These lessons are drawn from the ICR, pp. 25-26, and restated by IEG.

RBF should not be attempted unless robust and reliable M&E and HMIS are assured. Strong M&E and HMIS are essential for the functioning of RBF, which requires effective measurement and performance reporting as the basis for payments. Mechanisms are also needed to enable facility staff to understand and address factors that hinder their success. The lack of data and data systems, and reluctance of the government in Djibouti to release data, made the decision to introduce RBF highly risky, perhaps questionable.

In a country with a large population of refugees, migrants, and/or displaced people, unifying health service provision for these groups and the host communities supports improvements in equity. Having parallel service delivery in refugee camps/settings can be inefficient and inequitable. When there are large population influxes, unless the capacity of the health system to supply quality services is bolstered, access by the host population and new arrivals and the quality of care are likely to be compromised.

Strengthening institutional capacity – especially to implement new health programs or reforms - requires sustained effort. Health reforms that require new mechanisms, information flows, and behavioral responses take time and sustained support and institutional capacity building. Even with strong MOH commitment, new skills and behaviors take time to acquire and hone with practice. Staff mobility and turnover must also be taken into account and may require repeated training and sustained support for skill-building.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a concise, and mostly clear description of the project. The assessment of implementation performance was balanced and candid about shortcomings. The four restructurings and two AFs were well summarized. Useful analysis of data on facility quality scores was presented. Considerable effort was put into the efficiency analysis. The lessons and recommendations were thoughtfully selected. The Annexes are helpful (notably Annex 7 which traced the numerous changes made to the RF), and Annex 1B and Annex 3 were correctly completed (unlike many ICRs).

No theory of change was provided other than a results chain, which was not specific enough about what activities were financed by the project and how they were expected to improve utilization and quality. The decision to drop malaria on the grounds that “the incidence was low” (PAD p10), and then later, HIV/AIDS and TB, was accepted without question and without checking against data trends during project implementation, which in fact showed a rapid rise in malaria cases, as noted above. The ICR limited itself to data reported for



the project. There was no assessment of the validity or reliability of the reported data or validity of the indicators, and no effort to consider any project counterfactual. Some contributions to project outcomes made by other donors were noted (for example, the important contributions by GAVI to immunization services).

The ICR correctly noted that a split rating was required but divided implementation into three sub-periods and separately rated each sub-period, instead of assessing the final outcomes against both the original indicators and targets, and against the revised indicators and targets. The ICR's assessment of efficiency gave scant attention to the factors that undermined the efficiency of the project (although they were described elsewhere in the ICR).

Some assessments in the ICR were not expressed clearly. For example, the leading sentence in paragraph 53 (p18) is: "The project's ambitious design did not necessarily account for prior experience in decentralizing service delivery or the institutional capacity, that remained weak." Although not entirely clear, the statement seem to indicate that the project design was over-ambitious given the weak institutional capacity, and a prior failed effort to decentralize service delivery.

The section on project efficacy and Annex 1B used different sub-objectives. The main text broke the PDO into two sub-objectives: 1: to improve the utilization of quality health care services for maternal and child health and PDO 2: to improve the utilization of quality healthcare services for communicable disease control programs (HIV/AIDS, tuberculosis, and malaria). Annex 1B omitted any mention of communicable diseases, and separated out improvements in utilization and in quality, listing Objective/Outcomes 1 as: Improve utilization of healthcare services for maternal and child health, and Objective/Outcome 2 as: Improve quality of services delivered.

a. Quality of ICR Rating
Modest