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The World Bank

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IMPLEMENTATION COMPLETION AND RESULTS REPORT  
(IDA-H0420)

ON A

GRANT

IN THE AMOUNT OF SDR 8.8 MILLION

(US\$12 MILLION EQUIVALENT)

TO THE

REPUBLIC OF DJIBOUTI

FOR AN

HIV/AIDS, MALARIA AND TUBERCULOSIS CONTROL PROJECT

May 29, 2009

## CURRENCY EQUIVALENTS

(Exchange Rate Effective May 18, 2009)

Currency Unit = Djibouti Franc (DJF)

US\$1.00 = DJF 177.5

DJF 1 = US\$ 0.0056

SDR 1 = US\$ 0.64

## FISCAL YEAR

January 1 – December 31

## ABBREVIATIONS AND ACRONYMS

AFD	Agence Française de Développement (French Development Agency)
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CBA	Community-Based Association
CCMI	Comité de Coordination Multisectorielle et Inter-partenaire
CPF	Centre Paul Faure
CREDES	Centre de Recherche, d'Etude et de Documentation en Economie de la Santé (Center for Research and Studies in Health)
CRIPEN	Centre de Recherche, d'Information et de Production de l'Education Nationale (National Education Research and Information Production Center)
CSW	Commercial Sex Worker
DASAP	Dispositif d'Appui Social Accéléré aux PVVS (Accelerated Mechanism of Support to Infected and Affected People)
DOTS	Directly Observed Treatment, Short Course
ES	Executive Secretariat
FGM	Female Genital Mutilation
FNP	Forces Nationales de Police (National Police)
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Project
ICR	Implementation Completion Report
IDA	International Development Association
IIBN	Insecticide-impregnated Bed Net
ISR	Implementation Status and Results Report
M&E	Monitoring and Evaluation
MAP	Multisectoral AIDS Project
MDG	Millennium Development Goal
MOH	Ministry Of Health
MTR	Mid-Term Review
NGO	Non-Governmental Organization
PAD	Project Appraisal Document

PDO	Project Development Objectives
PIJ	Point Information Jeunes
PLS	Programme de Lutte Sectoriel
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNLS	Programme National de Lutte contre le SIDA (National Program to Control HIV/AIDS)
QAE	Quality At Entry
QAG	Quality Assurance Group
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

Vice President:	Daniela Gressani
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Sector Manager:	Akiko Maeda
Project Team Leader:	Sameh El-Saharty
ICR Team Leader:	Sameh El-Saharty

**REPUBLIC OF DJIBOUTI**

**Multi-Sectoral HIV/AIDS, Malaria and Tuberculosis Control Project**

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<b>A. Basic Information</b>			
Country:	Djibouti	Project Name:	HIV/AIDS, Malaria and Tuberculosis Control Project
Project ID:	P073603	L/C/TF Number(s):	IDA-H0420
ICR Date:	05/27/2009	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	REPUBLIC OF DJIBOUTI
Original Total Commitment:	XDR 8.8M	Disbursed Amount:	XDR 8.8M
<b>Environmental Category: B</b>			
<b>Implementing Agencies:</b> Executive Secretariat			
<b>Cofinanciers and Other External Partners:</b>			

<b>B. Key Dates</b>				
Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:	04/10/2002	Effectiveness:		12/02/2003
Appraisal:	03/25/2003	Restructuring(s):		
Approval:	05/29/2003	Mid-term Review:	11/30/2006	04/14/2007
		Closing:	09/30/2008	09/30/2008

<b>C. Ratings Summary</b>	
<b>C.1 Performance Rating by ICR</b>	
Outcomes:	Satisfactory
Risk to Development Outcome:	Low
Bank Performance:	Satisfactory
Borrower Performance:	Highly Satisfactory

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

<b>C.3 Quality at Entry and Implementation Performance Indicators</b>			
<b>Implementation Performance</b>	<b>Indicators</b>	<b>QAG Assessments (if any)</b>	<b>Rating</b>
Potential Problem Project at any time (Yes/No):	Yes	Quality at Entry (QEA):	Satisfactory
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	Satisfactory
DO rating before Closing/Inactive status:	Satisfactory		

<b>D. Sector and Theme Codes</b>		
	<b>Original</b>	<b>Actual</b>
<b>Sector Code (as % of total Bank financing)</b>		
Central government administration	10	20
Health	30	30
Other social services	60	50
<b>Theme Code (Primary/Secondary)</b>		
Gender	Primary	Primary
HIV/AIDS	Primary	Primary
Malaria	Primary	Primary
Participation and civic engagement	Primary	Primary
Social analysis and monitoring	Secondary	Secondary

<b>E. Bank Staff</b>		
<b>Positions</b>	<b>At ICR</b>	<b>At Approval</b>
Vice President:	Daniela Gressani	Jean-Louis Sarbib
Country Director:	Emmanuel Mbi	Mahmood Ayub
Sector Manager:	Akiko Maeda	George Schieber
Project Team Leader:	Sameh El-Saharty	Michele Lioy
ICR Team Leader:	Sameh El-Saharty	
ICR Primary Author:	Wendy Ravano/Ilmi Awaleh	

## **F. Results Framework Analysis**

### **Project Development Objectives (from Project Appraisal Document)**

To contribute to the change in behavior of the Djiboutian population in order to contain or reduce the spread of the HIV/AIDS epidemic and to mitigate its impact on infected and affected persons, and to contribute to the control of malaria and tuberculosis.

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

**(a) PDO Indicator(s)**

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
<b>Indicator 1:</b>	Reduced HIV prevalence rate among 15 to 24-year-old pregnant women.			
Value quantitative or qualitative)	2.7%	2.0%	2.2%	2.1%
Date achieved	05/01/2002	09/30/2008	09/30/2008	2007
Comments (incl. % achievement)	According to the sentinel surveillance system, HIV seroprevalence among 15 to 24-year-old pregnant women decreased from 2.7% in 2002 to 2.4% in 2005 to 2.1% in 2007.			
<b>Indicator 2:</b>	Reduced HIV prevalence among sexually transmitted infection (STI) patients			
Value quantitative or qualitative)	22%	10%		9.7%
Date achieved	05/01/2002	09/30/2008		2006
Comments (incl. % achievement)	HIV prevalence among STI patients was reduced to its end-of-project target at the end of 2006.			

**(b) Intermediate Outcome Indicator(s)**

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
<b>Indicator 1:</b>	Percentage of population that have heard HIV/AIDS messages			
Value (quantitative or qualitative)	5%	90%	85%	95%
Date achieved	05/01/2002	09/30/2008	09/30/2008	2007
Comments (incl. % achievement)	The project has exceeded the target of increasing HIV/AIDS awareness.			
<b>Indicator 2:</b>	Percentage of youth that have used a condom during their last extra-marital sexual encounter			
Value (quantitative or qualitative)	5%	50%		38.3%
Date achieved	05/01/2002	09/30/2008		2007
Comments (incl. % achievement)	UNICEF conducted a survey in 2005 that showed 46% of condom use among 15 to 24-year-olds during the last casual sexual intercourse.			

<b>Indicator 3 :</b>	Cumulative number of condoms distributed and cumulative number of condom distribution sites.			
Value (quantitative or qualitative)	0	450 distribution sites 3,500,000 condoms distributed		388 distribution sites, 80 of which in districts 2,385,979 condoms distributed
Date achieved	05/01/2002	09/30/2008		2007
Comments (incl. % achievement)	The cumulative number represents about 86 percent of the target for distribution sites, and 68 percent of the target for distributed condoms in 2007. More recent data on the distribution figures was not available at the time of the ICR.			

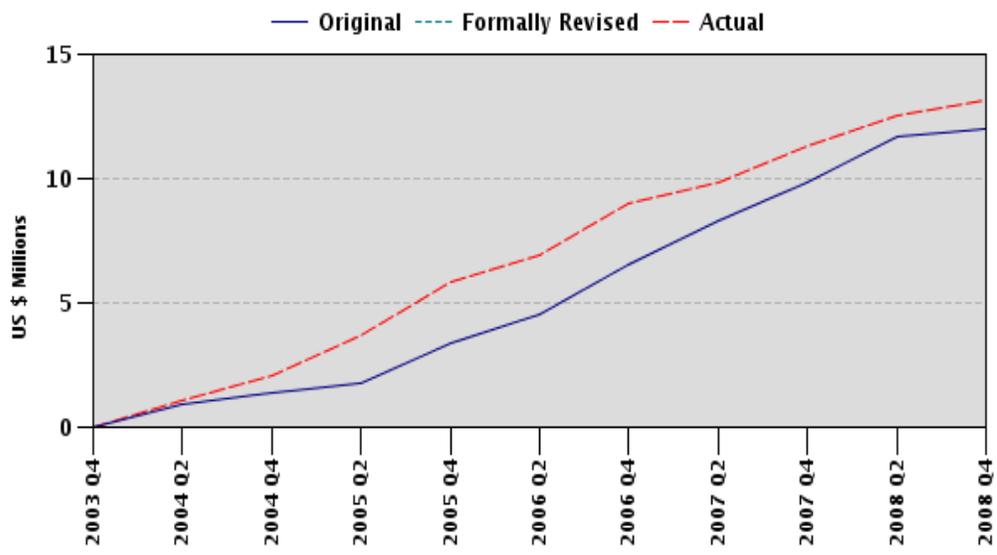
### G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD million)
1	06/11/2003	Satisfactory	Satisfactory	0.00
2	12/11/2003	Satisfactory	Satisfactory	0.52
3	04/14/2004	Satisfactory	Satisfactory	1.65
4	08/02/2004	Satisfactory	Satisfactory	2.08
5	12/03/2004	Satisfactory	Satisfactory	3.33
6	04/22/2005	Satisfactory	Satisfactory	5.38
7	11/30/2005	Satisfactory	Satisfactory	6.84
8	04/07/2006	Satisfactory	Satisfactory	7.94
9	07/28/2006	Satisfactory	Satisfactory	9.02
10	02/18/2007	Satisfactory	Satisfactory	9.88
11	09/27/2007	Highly Satisfactory	Highly Satisfactory	12.16
12	04/01/2008	Satisfactory	Highly Satisfactory	13.01
13	10/18/2008	Satisfactory	Highly Satisfactory	13.13

### H. Restructuring (if any)

Not applicable

## I. Disbursement Profile



# **1. Project Context, Development Objectives, and Design**

## **1.1 Context at Appraisal**

Djibouti is a small desert country with an estimated population of 750,000 at the time of appraisal in 2003. Illiteracy and unemployment are high. Including the rural nomadic population, 60% of Djiboutians live below the poverty line.

Accurate health statistics were lacking. Overall, life expectancy was under 50 years, general mortality was estimated at 17.7 per 1,000 inhabitants and the infant and child mortality rates were estimated at 114 and 165 deaths per 1,000 live births, respectively. The main causes of death and visits to health facilities were communicable diseases that could be prevented by improved hygiene and behavior change. Specifically, malaria, tuberculosis (TB), and HIV/AIDS had health and economic impacts on households, population and health system (Center for Research and Studies in Health, CREDES, 2003).

The first AIDS cases were reported in Djibouti in 1986. The situation has worsened steadily since, and at the end of 2000, there were 2,179 AIDS cases. Between 1994 and 2000, several surveys showed that prevalence was particularly high in groups such as sex workers, dockers, the police, and the army (“men in uniform”), but data on the general population were unreliable. As the HIV/AIDS prevention strategy would depend on whether the rate was above or below 5 percent (the critical threshold at which the infection reaches its exponential growth rate), a seroprevalence survey was conducted, which estimated HIV seroprevalence at 2.9 percent in the general population. The rate among persons aged 20 to 35 was above 5 percent, confirming that infection is affecting younger age groups, and that the critical threshold affected the most sexually active and economically productive age groups. The survey further revealed that: (i) transmission was mostly heterosexual (95.6 percent of declared cases among women and 91.6 percent among men); (ii) persons aged 15 to 29 represented 47.4 percent of registered AIDS cases, which showed that people were infected at an early age; and (iii) women were infected at a younger age than men: women aged 15 to 29 represented 54.3 percent of declared cases, while men of the same age group represented only 42.7 percent. The AIDS cases were roughly evenly split between men and women, strongly suggesting heterosexual transmission. Risk factors specific to Djibouti include trade, migration, gender inequality, and a high prevalence of TB. With 588 cases of TB per 100,000 inhabitants, Djibouti has the second highest prevalence rate of TB in the world. In addition, the spread of malaria has increased steadily, reaching areas such as the northern districts of Tadjourah and Obock where it was previously nonexistent. Please refer to Annex 9 for more details.

## **1.2 Original Project Development Objectives (PDO) and Key Indicators (as approved)**

The development objectives of the project were to contribute to the change in behavior of the Djiboutian population in order to contain or reduce the spread of the HIV/AIDS epidemic and to mitigate its impact on infected and affected persons, and to contribute to the control of malaria and tuberculosis. Please refer to Annex 9 for more details.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification: Not applicable.

#### 1.4 Main Beneficiaries

The original main beneficiaries include: youth aged 15 to 19 years, truck drivers and dockers, sex workers and women working in bars, men and women in uniform, TB patients, pregnant women and children under 5 years old, and people living with HIV/AIDS (PLWHA). The project had tailored interventions to each of the main target groups.

#### 1.5 Original Components (as approved)

The project was designed to support the implementation of three national strategic plans for the fight against HIV/AIDS, Tuberculosis, and Malaria in Djibouti.

**Component 1: Capacity Building and Policy Development** (US\$4.0 million). This included: (i) Strengthening the Government's capacity to cope with the spread of HIV/AIDS, malaria and tuberculosis, and (ii) Enhancing counseling, voluntary testing, and care and treatment of seropositive persons.

**Component 2: Health Sector Responses to HIV/AIDS/sexually transmitted infections (STI), Malaria and Tuberculosis** (US\$3.8 million). This component aimed to increase access to preventive measures to treatment of STI, opportunistic diseases and Malaria, and to case management, support and treatment of PLWHA.

**Component 3: Multisectoral Response** (US\$3.7 million). The objectives of this component were to: (i) strengthen the management and coordination capacity of the ministries participating in the control of HIV/AIDS; and (ii) support these ministries in implementing essential activities aimed at preventing HIV infection and reducing the impact of AIDS on their own personnel and on the vulnerable groups for which they are responsible.

**Component 4: Support to community interventions** (US\$2.6 million). This component supported the implementation of community subprojects prepared by community-based associations (CBAs) and aimed at: (i) the promotion and distribution of condoms; (ii) targeted information, education, and communication campaigns aiming at changing behaviors related to HIV transmission; (iii) interventions aiming at improving the status and autonomy of women; (iv) psycho-medico-social and economic support and care to people infected with and affected by HIV/AIDS; (v) promotion of voluntary counseling and testing (VCT); (vi) promotion of prevention of mother-to-child transmission; (vii) prevention of malaria; and (viii) continued support to tuberculosis patients. Please see Annex 9 for more details.

1.6 Revised Components: There was no revision of components.

1.7 Other significant changes: None.

## 2. Key Factors Affecting Implementation and Outcomes

Political leadership and commitment led to the creation (and subsequent strengthening) of the Executive Secretariat (ES). The Government's high-level commitment to fight the three major communicable

diseases was manifested by a matching institution having the mandate and capacity to coordinate the multisectoral programs. The project established the ES under the Prime Minister with a mandate to coordinate all prevention and mitigation programs to be implemented by multisectoral and civil society organizations.

This project funded by the International Development Association (IDA) was the first of its kind in Djibouti to receive substantial funding on activities focused on influencing public opinion on “AIDS” as well as to increase the fight against the three major communicable diseases. The project supported the Government in incrementally implementing preventive interventions, and was instrumental in carrying out communication interventions that helped break taboos on AIDS, making it possible for people to talk openly about HIV/AIDS. In 2002, the word “AIDS” elicited strong negative reactions, but by 2008, it had become a household term, while school and university radio stations regularly broadcast programs on HIV/AIDS.

The project design was guided by a strategic plan and several background studies. During project preparation, the Government developed a five-year National Strategy and Plan to fight AIDS, TB, and Malaria, which guided project design and preparation. Several surveys were also conducted to establish the baseline data for the monitoring and evaluation (M&E) system. The institutional arrangements were complex, given Djibouti’s lack of human resources and weak institutional capacity. However, capacity building and technical assistance during implementation were key factors in strengthening program management, including the fiduciary functions. Risk assessment and the mitigating measures were only moderately addressed at the design stage, particularly risks related to procurement and environment, but were adequately managed during implementation. Project implementation was guided by several procedures manuals, detailed guidelines, and protocols that covered all project components and activities. Please see Annex 10 for details on project manuals and guidelines.

A committee and a permanent technical committee ensured strong technical oversight of the various activities. Under the aegis of the ES and the vice chairmanship of the Ministry of Health (MOH), the technical committee coordinated prevention and case management activities to fight the three diseases. The committee reviewed action plans and annual budgets and ensured that the implementation was in conformity with the three national strategic plans. To mitigate the insufficiency of human resources for the program to fight AIDS in the health sector, the MOH in 2006 established a permanent technical committee to reassign staff in order to support the VCT as well as medical case management of HIV/AIDS/STI and related surveillance.

The project had a robust and harmonized M&E system that monitored the program effectively. Championed by IDA and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), the common list of harmonized indicators within one M&E system was adopted by all involved in the fight against the three diseases. Since then, all partners have been expected to use it as a systematic management tool. For example, the good monitoring of the VCT services enabled the other participating programs to plan their services accordingly, i.e., procurement of antiretroviral (ARV) treatment and planning for psycho-social services since most of the enrolled patients were from the lower socio-economic strata.

## 2.1 Project Preparation, Design, and Quality at Entry

The quality of project preparation and design is rated “Satisfactory.”

### 2.1.1. Preparation

Careful use of evidence in extensive national planning and preparation ensured quality at entry. Data were collected, analyzed, discussed, and used as the basis for national plans, to include situation analysis and national response, five-year strategic framework, three-year operational plan, and preparation of a manual of indicators and M&E. Through the planning focal point within the National Program to Control HIV/AIDS (PNLS), several workshops took place in the five districts and in Djibouti-Ville to contribute to the finalization of the HIV/AIDS National Strategic Plan and to discuss the findings of studies on knowledge, attitudes, beliefs, and practices. The HIV/AIDS National Strategic Plan was approved during a second consensus seminar in December 2002 that included all partners. Three national strategic plans to control HIV/AIDS, malaria, and tuberculosis (*Plan stratégique nationale de prévention du VIH/SIDA, Plan stratégique nationale de lutte contre le Paludisme, et Plan stratégique nationale de lutte contre la Tuberculose*) were prepared for the period 2003–2008.

With technical assistance from CREDES during the preparation phase, the main axes for HIV/AIDS, TB, and malaria were identified and reflected in the project: (i) strengthen the coordination of all actors in the fight against HIV/AIDS to achieve a broadened national, regional, and international response to the epidemic; (ii) strengthen the M&E systems; (iii) strengthen the measures to prevent the transmission of HIV and STI; (iv) improve the quality of case management of people living with HIV/AIDS; and (v) reduce the socioeconomic impact of HIV/AIDS on individuals, families, and communities.

The need for community participation was recognized and carefully planned to ensure appropriate use and oversight of community funding. Local communities have a key role to play in the prevention of HIV/AIDS, the care of infected people, and support to affected groups. They also have a role to play in sanitation and in controlling malaria. In addition, the spread of infectious diseases and HIV/AIDS in particular impose a heavy burden on local communities. Appropriate mechanisms had to be put in place to facilitate the provision of support and resources to communities. Therefore, it was decided to have capacity-building activities up front before launching community interventions. In addition, the project intended to select five to ten non-governmental organizations (NGOs) or other institutions with recognized capacities to train, and, on the basis of a competition, to select five of them as supporting organizations. These would have the responsibility of training local NGOs and associations, assisting them with subproject preparation, and supervising and controlling the quality of their activities. This two-tier system was expected to ensure close supervision.

Priority vulnerable groups were mapped. Prevention was seen in 2002 as a national priority and the prevalence surveys made it possible to identify the priority vulnerable groups for HIV/AIDS as well as for tuberculosis and malaria, which included youth (aged 15 to 19 years) both in school and out of school, truck drivers and dockers (Ethiopia-Djibouti corridor personnel), commercial sex workers (CSWs) and high HIV-prevalence women who worked in bars and their clients, persons in uniform, PLWHA, people living under the poverty line (vulnerable to TB), TB patients, pregnant women, and children under 5 (vulnerable to malaria).

## 2.1.2 Design

Specific lessons that were learned from international experience and considered in the project design are as follows:

*The importance of political leadership and commitment.* Strong commitment from top political and religious leadership in a country is important for the success of HIV/AIDS efforts. The President of the Republic of Djibouti and several other ministers have demonstrated strong support for the program.

*The need for a selective and well-coordinated multisectoral approach.* Experience in many countries in Africa has shown that HIV/AIDS control activities begin in the health sector but need to be expanded to other sectors. However, experience has also demonstrated difficulties in implementing projects across multiple ministries. The risks inherent in this arrangement would be mitigated by the fact that the project was to be “coordinated” by the ES and the Interministerial Committee placed under the Prime Minister’s Office.

*The importance of stakeholder consultations.* Key stakeholders, particularly those with an important role in implementation, should be involved as early as possible. Project identification was carried out in consultation with line ministries, including the Ministry for Religious Affairs, NGOs (including the NGO “*Oui à la vie*,” which includes PLWHA), UNAIDS and UN agencies, other IDA-financed projects, Social Protection Organization, and donor agencies.

*The need to tailor interventions to social needs.* Experience has shown the importance of conducting social assessments. A qualitative social assessment of the impact of AIDS on people infected and affected by the disease was therefore conducted. The study found nutrition, poor medical and counseling services, and financial constraints to be primary problems. PLWHA were actively involved in the study, and based on the study’s findings, a limited nutritional program was put in place to alleviate the problems and monitor progress during implementation.

*The balance between supply and demand interventions.* The project design included activities to strengthen the service provision, including voluntary counseling and testing, AIDS treatment, and treatment of STIs and opportunistic infections as well as interventions to stimulate demand for those services through multisectoral activities and community interventions.

The overall rating of the quality at entry for project preparation and design was “Satisfactory.”

## 2.2 Implementation

The implementation of Component 1 is rated “Highly Satisfactory.”

Capacity strengthening and policy formulation, the two main subcomponents, were successfully implemented. At the institutional level, the ES was strengthened through training programs in procurement, financial management, planning, communication, and M&E. Likewise, the majority of personnel of vertical programs in the MOH, and AIDS program personnel in the other ministries, benefited from training. At the community level, capacities were strengthened through the “supporting agencies” (*agences d’encadrement*) that provided assistance to the CBAs. The ES effectively managed and coordinated all program components funded by IDA in the amount of US\$12 million. As a result of its increased institutional capacity, the ES successfully prepared and managed three projects financed by

the GF (US\$19 million) in addition to a project by the *Agence Française de Développement* (AFD), of about US\$5 million. At the policy level, the Government developed its second five-year Strategic Plan (2008–2012) to fight against the three diseases, mobilized additional donor funding, engaged several key ministries in the fight, including passing the first law in the MENA region to protect the rights of PLWHA, and allowed space for the NGO movement to grow and actively participate in the program.

A communication strategy that aimed to increase awareness and to change behavior after knowing one's HIV status was successfully implemented. The HIV/AIDS epidemic, considered a national emergency, adopted a communication strategy that was designed in 2004 in collaboration with the program to fight HIV/AIDS at the Ministry of Communication. The strategy provided an approach that built on understanding the “vicious circle of vulnerability,” thus targeting the 14 priority vulnerable groups as defined in the IDA Project Appraisal Document (PAD) and designing well-tailored interventions based on a detailed knowledge of these groups' attitudes and behaviors.

An effective M&E system was designed and implemented. It was established in 2005 with support from the World Health Organization, with a national guideline for M&E. Once the GF program was implemented, the M&E indicators were harmonized for all donors, including IDA and the GF. The M&E Unit prepared harmonized reports for each level of data collection by each executing and coordination body. During the last two years, the M&E Unit developed a calendar of report due dates, which was agreed by all concerned, and reports were submitted in a timely manner according to this calendar.

The implementation of Component 2 is rated “Satisfactory.”

Management of the component had a difficult beginning, including some initial problems in the MOH due to the delay in the recruitment of an accountant who could prepare and submit the financial reports in a timely manner, thereby permitting authorization of subsequent disbursements. This led to delays in the initial procurement of diagnostic and treatment supplies, which negatively affected implementation of the program. The operation of the reference laboratory at Peltier Hospital was similarly affected by delays in the provision of supplies and equipment due to procurement and transportation delays. These issues were addressed through enhanced procurement capacity at the ES in 2005. With regard to the management of medical waste, a good report was prepared by a consultant early in the project, but its recommendations were only implemented in early 2008.

Despite the early delays, implementation was accelerated and most of the expected results were achieved. The project provided inputs to strengthen the capacity of the health unit and investments, including international technical assistance, production and dissemination of normative documents for prevention and case management, training of medical staff on the use of treatment protocols, ARVs, medical supplies, and office and laboratory equipment. Additional funding from the GF provided ARVs, blood test support, cell count machinery, and viral load counters. Training was provided for counselors and laboratory technicians to ensure the effectiveness of the VCT program. A program for the prevention of Mother-to-Child AIDS Transmission was implemented in collaboration with UNICEF. To ensure treatment effectiveness, a “Medical College for ARVs” was established to review the treatment protocols, set the eligibility criteria, and monitor the clinical progress of the program. Implementation was divided in two phases: in Djibouti-Ville and later in districts. Upon successful implementation of the first phase, decentralization of the medical case management was rolled out to the district level. A key innovation under this component was the introduction of “psychosocial supporter” staff (*accompagnateurs psychosociaux*), who are trained aides assigned as part of the case management team to provide psychological and social support to AIDS patients. The project thus successfully implemented an

“integrated and comprehensive case management for HIV/AIDS patients” that included prevention, counseling, testing, treatment, and psychosocial support.

In addition to the program to fight AIDS in the health sector, similar programs contributed to the case management of PLWHA, such as the Social Protection Organization clinic that mostly counseled pregnant women and the clinics for the Police and Armed Forces. Through this coordinated effort, the project rapidly scaled up to achieve high coverage in the provision of VCT from one VCT center to 21 nationwide, in prevention of the transmission from mother to children: since 2005, 80% of pregnant women have agreed to be tested for HIV, and treatment of AIDS cases reached more than the 2,000 treated cases expected by the end of the project.

The implementation of Component 3 is rated “Moderately Satisfactory.”

The implementation of the multisectoral AIDS program varied significantly. Originally, it was planned to phase in the ministries as follows: 5 ministries in 2004, 8 ministries in 2006, and 11 by the end of the project. However, during the first year, the Interministerial Committee decided to start with all 11 ministries to create national multisectoral support and then phase them out gradually. At the beginning, many of the focal points were insufficiently committed and were frequently replaced, as they perceived their role as having additional duties without compensation. Their frequent replacement caused delays in overall implementation, in the submission of action plans, and in the preparation of technical and financial reports, which led to overall delays in implementing this component and subsequent disbursements.

In 2005, the situation improved and activities related to training, increased awareness, and peer education were implemented, but with some delays. As of 2006, support to several ministries started to be phased out as planned. In addition to the increased awareness activities, the National Police, the Defense, and the Organization for Social Protection provided clinical services, including VCT and treatment services (but with modest numbers of users, who preferred to use MOH services to ensure anonymity). Until the end of the project, two ministries were supported as they were having good results, as described below.

The most concerned and relevant Ministries of Education and Youth and Sports implemented all their planned activities and achieved more than 75% of their expected outputs. At the end of the IDA-funded project, many positive results were visible in terms of continuing HIV/AIDS awareness and prevention activities in all secondary schools and at the University. The Ministry of National Education became the champion of the fight against HIV/AIDS by introducing in the curriculum a mandatory training module on HIV/AIDS. School health clubs opened in most establishments. Each year, through the National Education Research and Information Production Center (CRIPEN), the Ministry edits more than 4,000 school agendas for students containing awareness and prevention messages on HIV/AIDS, malaria, and tuberculosis. The CRIPEN school radio is at the vanguard of HIV/AIDS communication: it designs, produces, and disseminates messages, spots, plays and sketches on AIDS, malaria and tuberculosis via Djibouti radio and television.

Similarly, the Ministry of Youth and Sports revamped its community development centers (*centres de développement communautaire*). They are located in each neighborhood of the capital city and in the districts and disseminate information and basic products (e.g., condoms), booths (*points information jeunes* or PIJs) on HIV/AIDS, malaria, and tuberculosis. Since the prevention activities in the community development centers have been attended mainly by young boys, there is a need to design more culturally appropriate venues for young girls.

The implementation of Component 4 is rated “Highly Satisfactory.”

For the first time in Djibouti, there has been considerable growth and capacity building within civil society: the project supported unprecedented civil society engagement and capacity building to plan, implement, and report on behavior change activities and provision of social support for needy groups with the highest HIV prevalence. Prior to IDA project implementation, there were at most a dozen operating NGOs, community groups, and associations, often in name only, without sufficient members, legal status, or a constituted governing body. The project developed the capacity of large NGOs to become supporting agencies that in turn helped build the capacities of CBAs. During the Mid-term Review (MTR, May 2006), it was reported that the CBAs worked on increasing awareness and prevention of AIDS among all vulnerable groups, but were most active among youths 15–24 years of age. Another high risk group, sex workers, was trained using peer education approach under the risk reduction project titled “*Projet Soeur-à-Soeur*.” Community prevention of malaria and tuberculosis was addressed under the project to a lesser degree since other partners (GF and AFD) were already involved. By the end of the project, a total of 170 CBAs were supported by the project in terms of institutional, managerial, and technical capacity building, triple the number originally planned. As a result, the movement within the Djiboutian civil society has grown significantly in size as well as in professionalism. Specifically, the supported associations became capable of designing subprojects, providing technical and financial reports, and improving accountability.

In addition to management capacity, civil society in Djibouti increased the scope of its support. During the early stages of project implementation, the approaches favored by the CBAs focused on communication: peer education, advocacy by influential leaders, and focus group discussions on various themes. Later, the project introduced a program for the Accelerated Mechanism of Support to Infected and Affected People (DASAP) in which the CBAs provided a social package for needy people living with HIV and needy people affected by AIDS. DASAP was later expanded with funding from the GF to 15 communities, thus moving the community-based activities toward a more comprehensive social support program.

IDA funding was instrumental in the institutionalization of social marketing in Djibouti. A Social Marketing Unit was established within the ES to manage the promotion and distribution of condoms. Condoms were purchased through UNFPA. With funding from the GF, the distribution was further expanded through condom distributors such as Total, Coubèche, or parastatal organizations, e.g., the Social Protection Organization placed in major business outlets. As of December 2007, condoms were distributed in the capital and five districts, for a total of 388 distribution points, 80 of which are in districts. The Social Marketing Unit works closely with the ES communication unit to train the people in charge of distribution points, and assist them in organizing behavior change sessions.

### 2.3 M&E Design, Implementation, and Utilization

The overall rating of the M&E system is “Satisfactory.” The project established a robust M&E system, including the conduct of baseline surveys and setting baseline data for most indicators. During 2004, the M&E was mostly measuring process indicators. When the GF support started its support in 2005, a concerted effort was made to implement the “Three Ones” policy of “one framework, one coordination entity, and one monitoring and evaluation system.” As a result, a common list of harmonized indicators with one M&E system was adopted by the ES and all donors.

The M&E enabled the ES and donors to continuously monitor the progress of the different project components and adjust interventions accordingly. For example, the quarterly utilization rate of VCT services has allowed a better average forecast of the VCT kits needed; knowing the number of HIV positive persons has allowed prediction of the need for psychosocial services and a better sense of the need for ARV drugs. The M&E system of the *Programme de Lutte Sectoriel* (PLS) at the MOH that dealt with the prevention and treatment of the three diseases was also supported by technical assistance from the World Health Organization. During the first two years of the project, the M&E measured mainly output indicators and the ES postponed the MTR to late 2006 to allow the project interventions to demonstrate outcome results. The MTR and its related surveys were therefore conducted in late 2006 and the results obtained in early 2007. The end-of-project surveys, which were intended to be conducted in April–May 2008 (before the beginning of the summer months and the project end in September 2008), were not conducted as not enough time had elapsed since the MTR surveys to demonstrate measurable trends, and because project funds were almost fully disbursed. It was then agreed with the ES to carry out these surveys in the fall of 2009 with financing from the GF.

#### 2.4 Safeguard and Fiduciary Compliance

Financial management is rated “Satisfactory”. The project’s financial management arrangements were adequate. Accounting books and records were properly maintained using an accounting and reporting system. Required financial monitoring reports were produced on time and were reviewed by an external auditor. The project's accounts were regularly audited and the Bank has received the audit report covering calendar year 2008, with an unqualified statement. The project disbursed 100% of the grant's total amount of SDR8.8 million in less than four years, as shown in the Implementation Status and Results Report (ISR). However, expenditures of US\$114,404 still need to be justified by the ES. This amount had been advanced to some ministries and regional health centers involved in project implementation.

Procurement management is rated “Satisfactory.” Initial low capacity of the ES caused delays, but technical assistance and training for ES staff strengthened procurement capacity considerably. In general, the ES procurement functions were carried out effectively and, with the provision of technical assistance, all procurement activities were carried out in accordance with the provisions of the Bank’s Procurement and Consultant Guidelines. This is a notable achievement, given the low capacity and poor track record in procurement in other sectors of the country. The GF and the AFD have chosen to use the well-established managerial and fiduciary (financial management and procurement) arrangements under the ES in implementing their projects, which confirms the confidence shown by other donors in the capacity developed under the ES.

Environmental management is rated “Moderately Unsatisfactory.” The project environmental rating was assessed as B. A detailed environmental management plan was developed under the project, including a medical waste management plan, and an Environmental Committee was established under the ES for waste management. However, the environmental management plan was not produced until the last year of the project due to an early disagreement between the Bank and the ES on the implementation plan (later resolved). However, implementation of the medical waste management plan was not initiated under the project and it was agreed with the MOH to implement the plan under the Health Sector Development Project, which received additional financing until 2012. The MOH worked closely with the Ministry of Environment in the last year of the project to institutionalize the medical waste management plan.

The social aspects are rated “Highly Satisfactory.” The project achieved its key social development outcomes of: (i) ensuring access to HIV/AIDS-related information, prevention, treatment, and

psychosocial support; (ii) reducing the taboos surrounding AIDS and the stigmatization of PLWHA so that those individuals with AIDS may seek treatment and reduce cross-infection; (iii) ensuring that communities are better able to protect themselves from HIV infection and to care for those among them who are affected by AIDS; (iv) reducing the rate of increase of AIDS infection among the general population; (v) improving life expectancy and productivity of PLWHA and ensuring better livelihood prospects for AIDS orphans, widows, or other dependents; and (vi) improving the knowledge and understanding of opinion leaders. The participatory approach ensured that community initiatives were identified and selected in a transparent manner by establishing clear criteria for participation and the establishment of a broad-based selection committee. The project provided tools and guidelines (such as counseling and peer education guidelines) to harmonize all communication messages related to HIV/AIDS. The project strengthened CBAs and expanded the engagement of stakeholders in community subproject preparation and implementation.

Focus group discussions were conducted with vulnerable groups such as CSWs and dockers to identify attitudes and practices exposing them to infection. Funds were provided to NGOs and CBAs using simple contractual agreements to implement community subprojects, and included the following activities: (i) providing care and support for PLWHA and their dependents (e.g., nutrition for AIDS patients, income-generating activities); and (ii) information and communication for behavior change activities for prevention and de-stigmatization of PLWHA. As a result of the CBAs' social work, 2,550 persons received dry rations, 300 HIV-positive women benefited from psychosocial support, and 600 orphans and other vulnerable persons received psychosocial support, nutrition, school supplies and school fees and financing of income-generating activities for their guardians. (For more details on results, see section 3.2 and Annex 2).

## 2.5 Post-completion Operation/Next Phase

The ES has developed adequate plans and mobilized resources to sustain the program. First, the ES developed the second five-year strategic plan (2008–2012) to fight HIV/AIDS, TB, and Malaria to guide its next phase of program implementation. The project attracted funding from other donors with effective coordination and complementarity. As a result of the activities undertaken through the IDA-financed project, the Government in 2005 was able to demonstrate its commitment to HIV/AIDS and fulfilled the eligibility conditions for the Global Fund rounds 4 and 6 that financed the purchase of ARV, condoms, and the continuation of DASAP. The GF will provide an additional US\$11.9 million for AIDS, US\$3.4 million for TB, and US\$3.7 million for malaria. AFD is providing US\$5 million for HIV/AIDS and tuberculosis through technical support to the national reference *Centre Paul Faure* (CPF) and for related decentralized activities.

In addition, IDA is providing about US\$1.5 million in support of the three diseases under the additional financing of the Health Sector Development Project. In sum, the program has mobilized adequate financial and technical resources to support its activities for at least the next five years. Program institutional capacity is increasingly being strengthened and is likely to be sustained, particularly the program management capacity of the ES and its units. Similarly, the capacity of the NGO supporting agencies and the many CBAs that developed under the program will continue to provide their community interventions with the newly mobilized funds, not only for HIV/AIDS but also for TB and malaria. These NGOs and CBAs should be able to survive beyond the planned support period by diversifying their scope of work to include other social services. For example, under the planned IDA additional financing for the Health Sector Development Project, these NGOs and CBAs would be used to promote health services such as family planning and behavior change such as against Female Genital Mutilation (FGM). In

addition, the Social Marketing Unit was in the process of transforming into an independent entity and becoming the “Djiboutian Association of Social Marketing” (*Association de Marketing Social Djiboutienne*, AMASOD) that will sell its own brand of condoms “Prudence” at a subsidized price.

Most of the program results are likely to be sustained. The gains achieved in the project are likely to be sustained, particularly with regard to increased awareness and behavior change among the young population and high-risk groups as these continue to be supported by the GF and IDA. The increased knowledge about the modes of AIDS transmission among the general population is likely to be sustained and expanded through the continued support of donors. Moreover, the knowledge of methods to protect against AIDS transmission and the increased use of condoms, particularly among high-risk groups, will likely observe a positive trend. On the other hand, the program will face a key challenge in financing the ARVs beyond 2012 and transforming the social marketing unit responsible for condom promotion and distribution into an independent non-profit organization.

### **3. Assessment of Outcomes**

#### **3.1 Relevance of Objectives, Design, and Implementation**

The project objectives and design are more relevant today than when the project began in 2002. The three diseases continue to pose a high burden on the health sector and the gains achieved in this project need to be sustained. In January 2007, the Government launched the National Initiative for Social Development (*Initiative Nationale pour le Développement Social - INDS*), a reference framework that provides a comprehensive vision for economic growth and poverty reduction and replaces the former Poverty Reduction Strategy Paper process. This new strategy is based on four main pillars, one of which seeks to develop human resources and improve access to basic services, notably for women and youth. Also in 2007, the ES finalized the second five-year strategic plan to fight against HIV/AIDS, TB, and malaria. Similarly, the country assistance strategy for the period 2009–2012 proposes to “support access to basic social services and human development; improve health access and quality” (country assistance strategy outcome 2.2). The Bank will help the Government improve access to and quality of health services in a sustainable manner in order to contribute to the achievement of the health-related Millennium Development Goals (MDGs) of reducing malnutrition, child and maternal mortality, and combating communicable diseases through a US\$7 million program, of which about US\$1.5 million will be allocated for the three communicable diseases. In addition, the program is supported by the GF and the AFD. This support reflects the relevance of AIDS control to the current development challenges facing Djibouti.

#### **3.2 Achievement of Project Development Objectives**

##### **3.2.1 HIV/AIDS**

The project achieved its overall objectives in slowing the progress of HIV/AIDS, raising awareness among the population, and establishing the basic institutional and technical capacities as well as community-based programs. The GF project followed in late 2005 with an initial focus on treatment and complementing the Bank’s project until late 2007 when the GF expanded its interventions as IDA funds were depleted, thereby ensuring a smooth transition.

The first part of the project development objectives is: “to contribute to the change in behavior of the Djiboutian population”. One goal was to increase the percent of the population that had heard HIV/AIDS

messages from 5% in 2002 to 85% in 2008. By early 2007, HIV/AIDS awareness among the general population reached 95%, thus exceeding the target almost 18 months before project closing. Moreover, 60% of the population had heard a message about STIs. Similarly, a 2005 survey showed that among 15–24-year-old respondents, 45% of males and 50% of females were able to correctly cite three prevention methods. A majority of respondents (60%) mentioned prayers, fasting, and good Muslim behavior as methods to protect against HIV/AIDS. This is an elaborate reflection of the choice of “abstinence”, as a risk reduction strategy chosen among the three strategies known as “A-B-C” or “Abstinence – Being Faithful – Condom use.” Awareness about modes of transmission and methods of protection against HIV/AIDS resulted in a significant change in behavior reflected by the increase in condom distribution and reported use of condoms (detailed below).

By the end of 2007, the project had distributed about 2.4 million condoms, representing about 68% of the end-of-project target of 3.5 million. At the time of ICR preparation, the cumulative figure for the end of 2008 was not available but the trend suggests that the end-of-project target (December 2008) is likely to be achieved, based on the expansion of distribution sites.

The reported use of condoms, at 27% in the general population, represents a dramatic increase from the extremely low level reported in 2002 surveys. It was due to the lifting of opposition, taboos, and rumors against the use of condoms, following the endorsement of the fight against HIV/AIDS by religious leaders, which was a key intermediate result. The most remarkable project outcome following two international conferences and a series of in-country awareness workshops was the unanimous declaration by the country’s religious leaders that the use of condoms was one of the means to prevent HIV/AIDS.

The proliferation of community interventions and high-quality peer education activities were key intermediate outcomes. Regarding the community interventions for behavior change, the project focused on the quality capacity building from supporting agencies to CBA peer educators. It resulted in long-term improvements in the organizations representing civil society. The emphasis on quality strengthening, along with the increase in the sheer number of enrolled CBAs, resulted in increased demand for VCT services and condom use among the priority vulnerable groups. A tracing system has recently been introduced to further track the number of persons referred by the CBAs to receive VCT services.

The second part of the PDO contains: “to contain or reduce the spread of HIV/AIDS epidemic.” The major project impact is the reduction of HIV/AIDS prevalence among young people and the “marker” group of STI patients—proxy measures for new infections, in the absence of actual data on incidence. According to the sentinel surveillance system, HIV seroprevalence among 15–24-year-old pregnant women decreased from 2.7% in 2002 to 2.1% in 2007. Similarly, HIV prevalence among STI patients was reduced from 22 percent to 9.7 percent in 2006, a trend suggesting a reduction of HIV incidence, since STI patients are at high risk for transmission.

The achievement of the project HIV/AIDS outcomes related to prevention was directly linked to the increase in condom use and VCT services utilization, and the mitigation of the impact was related to the increase in access to ARV treatment, and social services, nutrition support, and legal protection of persons infected and those affected by the HIV/AIDS. See Annex 2 for a detailed account of the project output indicators.

### 3.2.2 Tuberculosis

The target of lost cases among TB patients under treatment, including trans-border patients, amounting to 15%, has been met. However, the existence of transborder patients increases the risk of multidrug-resistant strains of TB bacillus. The HIV seroprevalence among screened TB patients was reduced from 13.8% in 2006 to 12% in 2007, which is consistent with the coinfection rate in countries with an epidemic of medium magnitude. Project funds were used to strengthen the capacities of CPF with equipment and drugs. As of 2008, more than 1,200 patients were treated with a success rate of 81%. According to a 2008 survey, the detection rate was at 76%. The project has also provided nutritional support to 210 TB inpatients at CPF. The GF and AFD are funding other aspects of the TB program such as the rehabilitation of CPF, the expansion of the decentralization of service delivery, and strengthening of the community component.

### 3.2.3 Malaria

During project implementation (2003–2008), the anti-malaria program received insecticide-impregnated bed nets (IIBNs) from various donors: 90,000 from the GF; 20,000 from UNICEF; and 8,000 from the African Development Bank, of which 19,070 remain to be distributed. These IIBNs were distributed either during anti-malaria campaigns, at antenatal care clinics, or during child health–Integrated Management of Childhood Illness visits. The project funded the purchase and distribution of 42,000 IIBNs in high-prevalence areas of Tadjourah; Dikhil; Balbala; Ambouli; and Quartier Sept of Djibouti-Ville. Additionally, 25 community projects were funded to conduct training on utilization, impregnation and re-impregnation of bed nets.

Project funds were also used to procure three much-needed vector-control spraying machines. The IIBN coverage survey of July 2007 showed that 25% of sampled households had IIBNs and 18.9%–29.1% of vulnerable groups (pregnant women and children under the age of five) slept under IIBNs the night preceding the survey. The utilization of bed nets might have been underestimated because the survey was done after a dry spell, and in a month when rain was 20-50% below normal (implying relatively few mosquitoes). The project strengthened the capacities of the Epidemiology and Hygiene Services with equipment, drugs, bed nets, and household treatment products.

### 3.3 Efficiency

The initial economic and financial analysis (PAD) predicted that the present value (over the period of 2002 and 2028) of the accumulated total costs of the epidemic, including treatment costs (excluding ARV), foregone income and funeral, and years of life lost to premature deaths, was estimated about 13% of GDP of 2002.

The ICR analysis also finds a consistent estimate that the present value of total cost (over the period of 2002 and 2025) of not addressing this epidemic is about 11.8% of GDP in 2002. However, with the intervention and use of three quantitative indicators, the current analysis finds that the present value of total costs would be reduced to 3.8% of GDP in 2002. Given that GDP of Djibouti in 2002 is about US\$658 million, the costs saved through the intervention are about US\$52 million. Since the ICR reports US\$13 million disbursed for the total costs of this intervention, the cost benefit ratio is almost 4.0 even under a conservative scenario. (See Annex 3 for more details.)

### 3.4 Justification of Overall Outcome Rating

The overall outcome rating is “Satisfactory.” By the end of the project, outcomes were achieved and most of the intermediate indicators were achieved and some even exceeded the end-of-project targets. The continued high burden of the three diseases makes the project interventions relevant and they are featured prominently in the Government plans and donor support programs.

Compared to similar MAP projects in other African countries, this project in Djibouti is clearly one of the best performing, particularly when looking retrospectively and considering the complexity of the multisectoral design. At the end of the project, the law protecting the PLWHA and affected persons was voted through by the Parliament and enacted by decree, and the ES was created and made operational by effectively coordinating funding from three major donors. The Ministry of Public Health, taking the lead on technical aspects in the Interministerial Committee as well as the Inter-partner Technical Committee, developed and issued strategies for VCT services, for prevention and protocols for comprehensive case management and psychosocial support, for syndromic approach of STI, and a protocol for accidental exposure to blood. The project enabled religious leaders to better understand the dynamics and programming of HIV/AIDS so that they no longer opposed the HIV/AIDS program, and the religious leaders have helped in advocacy for prevention. Further, the religious leaders no longer openly oppose the use of condoms when circumstances dictate (e.g., discordant couples). Djibouti is leading the way in the Arab world in the fight against HIV/AIDS, and its civil society involvement and grassroots behavior change communication program is an adaptable model for the region.

### 3.5 Overarching Themes, Other Outcomes and Impacts

#### 3.5.1 Poverty Impacts, Gender Aspects, and Social Development

*Gender aspects: Prevention of Mother-to-Child Transmission (PMTCT).* The project fully funded the national expansion of the PMTCT program. Further, while recognizing the scientific and biological fact of HIV transmission that occurs between mother and child, the project collaborated with the Djibouti partners to address the gender aspects by contributing to the lessening of stigmatization of, and violence against women, and endorsing the more inclusive national program name which is: “Prevention of Parent-to-Child Transmission” (*Prévention de la Transmission de Parent à Enfant*).

*Soeur-à-Soeur Project: Peer education for risk reduction among commercial sex workers.* The project provided the ES with the resources to assist the hard-to-reach and most vulnerable and priority group—CSWs. CSWs are predominantly unskilled, low-income, destitute women, mostly from neighboring countries and often single mothers with young children. With assistance from the Ministry of Social Affairs and Women Promotion, some of the CSWs were trained to acquire various vocational skills and generate income.

#### 3.5.2 Institutional Change/Strengthening

The ES created under the impetus of the project is continuing and has attracted funding from the GF and other multilateral and bilateral agencies, including the AFD. At the community level, qualified supporting agencies and strengthened CBAs will likely continue their activities to fight the three diseases.

3.5.3 Other Unintended Outcomes and Impacts (positive or negative): Not applicable.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops: Not applicable.

#### **4. Assessment of Risk to Development Outcome**

The risk to development outcome is rated “Low.” The key development outcome of this operation is the reduction of HIV/AIDS prevalence in young pregnant women aged 15 to 24 years from 2.7 percent in 2002 to 2.1 percent in 2007, which exceeded the end-of-project target of 2.2 percent adopted at the MTR. The gains made in increasing the general population’s awareness of the methods of transmission and protection from HIV/AIDS; the behavior change among the young population and high-risk groups; the increase in the distribution and use of condoms, particularly among high-risk groups; the steady increase in VCT; the increased access to treatment; and the increased management capacity are all technical and institutional factors that would sustain the achieved development outcomes beyond the project.

Moreover, the continued support from the GF to the program as well as the Additional Financing to the Health Sector Development Project (P107395), which includes a component to support HIV/AIDS prevention and treatment interventions; likely sustained program institutional capacity; and continued NGO and CBA support are factors that would contribute financially and economically to sustaining the development outcome. Also, the Minister of Health of Djibouti has been a very active member of the GF board, which reflects government commitment to the HIV/AIDS program.

#### **5. Assessment of Bank and Borrower Performance**

##### **5.1 Bank Performance**

##### **5.1.1 Bank Performance in Ensuring Quality at Entry**

Bank performance in ensuring quality at entry is rated “Satisfactory.” The Bank successfully identified the HIV/AIDS risk factors and their potential impact in Djibouti, taking into consideration the strategic relevance of the epidemic and the cost of inaction on socioeconomic development. During preparation, the Bank mobilized a team of experts in the field with an adequate skill mix to provide sound technical guidance to the Government, including developing a strategic plan for HIV/AIDS, conducting baseline surveys, suggesting sound institutional arrangements, ensuring adequacy of fiduciary and safeguard requirements, and proposing a robust M&E framework.

Project preparation was led by a skilled task team leader from the Africa region with strong experience in preparing and supervising AIDS projects. Bank management provided adequate financial resources and support to the task team. During appraisal, the Bank team adequately assessed the institutional capacity of the ES and a sound decision was made to delegate the procurement management to the health project until ES capacity was further developed. Also, the team ensured that the project had a comprehensive set of interventions that covered all aspects of the epidemic from prevention to treatment and social support, and devised a multisectoral approach and strong community interventions with an adequate balance between demand- and supply-side interventions.

The Quality Assurance Group (QAG) conducted an assessment of this operation and QAE was rated “Satisfactory.”

#### 5.1.2 Quality of Supervision (including of fiduciary and safeguards policies)

Bank performance in quality of supervision is rated “Satisfactory.” The Bank team throughout implementation conducted extensive supervision missions, particularly in the first two years of the project. The Bank team insisted that the ES prepare all the procedures manuals, guidelines, and protocols and spent considerable time reviewing them to facilitate the implementation of complex interventions such as the community interventions, treatment protocols, and eligibility criteria for social support. The Bank team also focused on the activities directly related to achieving the PDO and related indicators. The mission aide-mémoires were very detailed and provided an assessment on the progress of each project component, including technical annexes in addition to a detailed list of actions that were followed at each supervision mission.

There was exemplary coordination with the GF and other development partners to ensure synergy and a harmonized list of indicators or utilizing the same set of indicators whenever possible, even if this meant sharing the results, because all the inputs to programs, regardless of funding sources, are provided to achieve the same results set by the Government. Almost all supervision missions in 2006 and onward were conducted jointly with the GF, including the MTR. This joint collaboration was a key factor in ensuring effective implementation and achievement of the project results. Internally, the team reported to management through the ISRs on the issues facing implementation, including the delays in implementing the environmental management plan. Management comments in the ISRs provided guidance to the team on actions to be taken. The team supervised adequately the fiduciary and safeguards aspects and took necessary actions to mitigate any problems, including the delay in implementing the environmental management plan and the lack of documentation supporting an amount expended under the multisectoral component identified during the annual external audit. Actual disbursements exceeded the planned disbursement schedule and total funds were fully expended without the need for a project extension. The team also properly phased out Bank support in many components during the last year of the project in a well-coordinated manner with the GF. The project’s achievements were featured at the XIV International AIDS Conference in Mexico City in August 2008.

The QAG assessed the overall quality of supervision of this project in September 2006 and rated it “Satisfactory” and found several aspects “Highly Satisfactory.” QAG noted that the team: (i) did an excellent job in supporting the development of a national program with a strong M&E system that allowed other donors to equally support the government; and (ii) made a major contribution in putting the “Three Ones” concept into action.

#### 5.1.3 Justification of Rating for Overall Bank Performance

Overall Bank performance is rated “Satisfactory.” It was satisfactory during preparation and supervision as judged by the successful implementation of the project, the achievement of the PDO and most outcome and output indicators, as well as the disbursement of all project funds in a timely manner without the need for project extension. In addition, the Bank demonstrated exemplary coordination with the GF and other development partners to sustain the gains achieved in the project.

## 5.2 Borrower Performance

### 5.2.1 Government Performance

Government performance is rated “Satisfactory.” The Government was highly committed to the project from inception. The creation of the project Intersectoral Committee chaired by the Prime Minister, which was later transformed into the CCMI, chaired by an active Minister of Health, helped coordinate the multisectoral activities and donor support. Despite the weak progress in implementing the awareness-raising activities in some sectors, key ministries achieved their targets. There were regular meetings at the beginning of the project, but these became less frequent, and this point was raised in the MTR. Subsequently, the meetings of the CCMI were resumed on a regular basis.

Government commitment was also reflected in its initiative for the preparation of the second five-year HIV/AIDS strategic plan (2008–2012) with technical assistance from donors, including the Bank. Moreover, the Government issued many of the decrees required to implement the program, such as the Presidential Decree establishing the Interministerial Committee and the ES to implement the program, the decree establishing the Medical College for HIV/AIDS to manage the clinical aspect of the program, and the issuance of the first law in the MENA region to protect the rights of PLWHA. In addition, the Government provided adequate authority to the ES in implementing the program and recruiting the necessary staff.

### 5.2.2 Implementing Agency or Agencies Performance

The performance of the implementing agencies is rated “Highly Satisfactory.” The ES and its units, created and mainly strengthened under the IDA project, implemented all the project components in a timely manner, disbursed all the project funds, and ensured sustained coordination of actors while keeping the Interministerial Committee informed of progress. As a result of IDA’s support, the GF and AFD used the ES as well to implement their programs, which reflects the confidence in ES institutional and management capacity. The sectoral programs to fight the three diseases (PLS) were generally effective despite the frequent replacement of focal points and early difficulties. The surveys conducted by UNICEF and during the MTR demonstrated that the PLS in the different ministries greatly contributed to the achievement of project development objectives, particularly the PLS of the health sector.

The ES through its Community Interventions Support Unit and Communication Unit provided excellent and outstanding support to community interventions, particularly the development of the procedures manuals and guidelines that facilitated the implementation of this component. A key success factor was the recruitment of the supporting agencies, which were instrumental in building capacity, training and supervising the 170 CBAs that implemented community interventions and awareness campaigns to specific vulnerable and high-risk groups in the regions, which was done based on a competitive selection process under the IDA project. In addition to coordinating the above activities, the ES implemented the social marketing component and the communications strategy, which was not in its original mandate. As a result, the distribution of condoms and awareness of the general public significantly increased. The ES successfully completed all planned activities, disbursed all project funds, and achieved the PDO and most of the outcome and output indicators with some exceeding the end-of-project targets.

### 5.2.3 Justification of Rating for Overall Borrower Performance

Overall borrower performance is rated “Highly Satisfactory.” The project components and interventions were completely new to the Borrower and had never been implemented before. During identification, the Borrower did not have the capacity to implement the program and no institutional framework was in place. During preparation and almost one year into project implementation, the Borrower developed institutional and management capacity. The Borrower successfully implemented a complex program across 11 ministries and 170 community projects, coordinating and managing funds from different donors, and managing the control of three communicable diseases. The achievement of the PDO and disbursement of all the project funds in a timely manner attest to the outstanding overall performance of the Borrower.

## 6. Lessons Learned

**Political and social/religious leadership and commitment matter.** Getting the support at the highest political level made a huge difference in implementation. The creation of the Interministerial Committee, later transformed into the CCMI, succeeded in mobilizing the multisectoral and community-based activities and donor support. Moreover, it was important to engage religious leaders. Trained religious leaders and imams were often called on to conduct advocacy and question and answer sessions.

**Institutional and management capacity building takes time but it pays off.** The early delays in implementation were caused by the focus on strengthening the management capacity and qualified staffing of the newly established ES and on the development of detailed guidelines and procedures (14 manuals). However, later on, this investment accelerated the implementation guided by the protocols and procedures manuals.

**Harmonization of donors’ inputs and focus on results facilitated implementation.** The fight against HIV/AIDS is a long-haul emergency that requires the effective coordination of all stakeholders, particularly donors. The key donors—the Bank and GF—worked together with the ES to implement the “Three Ones” policy. Developing a rigorous list of indicators that was periodically revised and harmonized was a critical lesson. Activities were adjusted depending on results.

**In combating HIV/AIDS, access to ARV treatment is equally important as prevention.** Although prevention of HIV/AIDS, including VCT, remains the most cost-effective weapon in the fight against the epidemic compared to ARV treatment, insight and closer consideration of epidemiologic and cultural aspects led to the conclusion that prevention (particularly VCT services) would fail unless ARV treatment was simultaneously offered. As a result, the project introduced and scaled up ARV treatment until the GF took over. It was later shown in service statistics that VCT utilization increased, particularly among the young and educated, when they were assured of access to affordable treatment.

**The provision of an integrated package of medical and social services proved to be very effective.** It was found that lack of treatment compliance of many PLWHA, despite free provision, was due to psychological, social, and financial factors. The innovative DASAP was therefore introduced and implemented using NGOs to link the treatment with nutritional, social, and psychological care.

## **7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners**

### **(a) Borrower/implementing agencies**

This completion report reflects the reality of its implementation during the period 2003-2008 in a complete and satisfactory manner, which is in line with our view as the project implementing agency.

At the outset, we commend the Bank's team on the notes and conclusions reached as the rating of the ES and its collaborating partners were rightly justified. We would also like to attest that the World Bank was a partner in the successful implementation of the project would deserve the same performance rating of the Government, i.e. "Highly Satisfactory".

Despite being a young institution, the ES was able to meet at least two major challenges: to strengthen its organizational and management capacity and to propel various aspects of the national response. After five years of operations, considerable progress was noted particularly with regard to the community response. HIV/AIDS awareness has increased among the public in general and the young people in particular through various information channels. An equally successful combat against TB and Malaria was also carried out and it was adequately noted in the report.

These extremely encouraging results could not be obtained without the political leadership at the highest level. On the ground, it is necessary to commend the dynamism, the engagement and the determination of all the teams from the sectoral ministries that worked in "new" and "complex" areas. This work increasingly required greater coordination of the stakeholders, which resulted in the adherence to the "Three Ones" principle since 2003.

The relevance of this project to the development challenges and the poverty reduction strategy in Djibouti is real and it deserves to be continued by an additional financing from the World Bank in order to support the national strategic plan and to scale up the interventions.

The challenges however remain enormous and several recommendations need to be considered in order to enrich the report. First, particular attention should be given to reorganizing the Communication Unit at the ES. Second, the "gender" dimension was incorporated in the implementation of all the programs and interventions but was not adequately noted in the report. Lastly, we should in the future recruit persons living with HIV/AIDS in decision-making jobs in order to reverse their marginalization and stigmatization and promote their social acceptability.

Finally, we would like to end this note by asking the decision makers at the World Bank to promote the "best practice" of Djibouti in combating HIV/AIDS and allowing the program managers to share their experience in the Arab and Islamic countries.

### **(b) Co-financiers**

Please see comments received from the Global Fund in Annex 8.

### **(c) Other partners and stakeholders**

Not applicable.

## Annex 1. Project Costs and Financing

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

Components	Appraisal Estimate (USD million)	Actual/Latest Estimate (USD million)	Percentage of Appraisal
CAPACITY BUILDING AND POLICY DEVELOPMENT	4.6	4.90	33%
PUBLIC HEALTH SECTOR RESPONSE TO HIV/AIDS/STI, MALARIA AND TUBERCULOSIS	2.3	3.80	25%
MULTI-SECTOR RESPONSES FOR HIV/AIDS PREVENTION AND CARE	2.6	3.70	25%
SUPPORT TO COMMUNITY-BASED INITIATIVES	2.5	2.60	17%
<b>Total Project Costs</b>	12.0	15.00	100%

### (b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD million)	Actual/Latest Estimate (USD million)	Percentage of Appraisal
Borrower		0.72	0.00	0.00
IDA GRANT FOR HIV/AIDS		12.00	15.00	125%

## Annex 2. Outputs by Component

The achievement of the project HIV/AIDS outcomes related to prevention was directly linked to the increase in condom use and VCT services utilization and the mitigation of the impact was related to the increase in access to ARV treatment, and social services, nutrition support, and legal protection of persons infected and those affected by the HIV/AIDS. The following related output indicators were achieved:

- The share of 15–24-year-olds reporting the use of condom during last casual sexual intercourse increased from 5% in 2002 to 38.3% by the end of 2006. Given continued increase in condom marketing and distribution and indication of growing acceptability of condom use, it is possible that the project target of 50% use will have been achieved by the end of 2008, although it will need to be confirmed by a survey planned by the ES with the GF in late 2009. Condom use among CSWs reached 94% in 2007. Of the 300 CSWs in the “Soeur à Soeur” project, just 80 accepted to be tested for HIV of whom 42 (52.5%) were found to be HIV-positive. This shows where continuing work is needed.
- Condom use remained low among other high-risk groups: 13% among men in uniform and dockers, revealing where additional work is needed.
- The number of persons tested for HIV in VCT services increased from 1,574 in 2004 to 5,321 in 2006, to 2,156 for the first quarter of 2008 and 1,765 for the second quarter of 2008.
- More than 80% of pregnant women attending antenatal care services have accepted VCT for HIV, well above the 50% project target.
- The STI prevalence rate among pregnant women was not systematically recorded or notified at the antenatal clinics. Despite this, the national service statistics recorded total STIs of 5,047 in 2007 and 2,804 in the first six months of 2008, males and females. The dominant pathology among females in 2007 was vaginal discharge.
- More than 2,000 PLWHA were registered for HIV/AIDS case management. Among them, 1,541 were under ARV treatment (in ARV active file).
- Treatment of HIV-infected children started with nine children in 2005 and increased to 24 in early 2007.
- 2,550 persons benefited from dry rations provided by the World Food Program and distributed to home-bound patients by CBAs.
- 610 hospitalized HIV patients received three hot meals per day.
- 300 HIV-positive women benefited from psychosocial support from CBAs.
- 600 orphans and other vulnerable persons received psychosocial support, nutrition, school supplies and school fees, and financing of income-generating activities for their guardians.
- The survival rate of PLWHA under ARV treatment increased from 75% in 2005 to 88% in 2007.
- Djibouti is the first country in the region to adopt a law protecting the rights of PLWHA and their families against any form of discrimination, and gave them assistance to lawyers in case of litigation.



			in 10 antenatal clinics of Djibouti City
(b) Development of VCT protocols and intensification of VCT activities and follow up	12–14 centers with antenatal care are offering VCT services	17 VCT service centers were established	VCT protocols were completed in 2005 and first utilized at CYT, the national reference center. The extension of VCT services in Djibouti City and CMH started in 2006 and completed during the third quarter of 2007. By the end of the project, there are 17 VCT service points. Following the initial training and supervision, refresher courses for VCT counselors and laboratory technicians were carried out.
(c) Strengthening the health system for the treatment of HIV/AIDS, STI and other opportunistic infections, particularly Tuberculosis (TB)	<p>- Health centers are treating STI</p> <p>- PLWHA use the VCT and case management services according to the established protocols</p> <p>- Case management of TB outside of the reference center Paul Faure</p>	<p>- 100% of health centers are treating STI</p> <p>17 VCT services (5CMH and 12 centers) are operational</p> <p>- More than 2000 PLWHA are registered for HIV/AIDS case management. Among them, 1541 are under ARV treatment (in ARV active file)</p>	<p>- STI case management started in 2003 in 10 health centers of Djibouti City with revisions of guides in 2006 and in 2008.</p> <p>- All VCT services were operational in mid-2007. Case management of PLWHA benefited from project investments made at Peltier laboratory (Civil work and cell count machines) Periodic supply of reagents was contributed from other donors. Following the institutional and technical strengthening - - training of ARV prescribing physicians and their supervisor, establishment of ARV College, the first ARV prescription was made in February 2004. As of the end of 2007, 40% of the country is covered with facilities provided with resources to treat PLWHAs. Five of the 21 facilities that offer ARV therapy are in districts. However, only 4 of the 21 facilities are treating 80% of the patients: 32% treated at Younis Toussaint; 23% at Peltier Hospital; 17% at Paul Faure and; 8% at Bouffard (Army Hospital). This pattern of utilization of facilities equipped for ARV therapy is driven by both fear of stigma from neighbors and by former care seeking preferences.</p> <p>Extension of case management of TB (DOTS and DOTCS) outside Paul Faure was completed in 2007</p>
(d) Purchase of condoms and		Since project start-up in 2003, more	Social Marketing strategy was completed in 2006, including the

intensification of their distribution, as per the designed strategy		than 2.4 million condoms were distributed. The distribution was intensified in 2006 and beyond	creation of a social marketing NGO. As of December 2007, condoms are distributed in the capital and five (5) districts from a total of 388 distribution points, 80 of which are in districts.
<b>Component 3: Multisectoral response for the prevention and care of HIV/AIDS</b>			
Sectors have formulated their action plans in response to the HIV/AIDS	End of 2004: 5 plans End of 2006: 8 plans	11 actions plans were started at project start-up Two sectoral ministries (Education and Youth) were most active	- At project start-up, the 11 sectors were fully mobilized and since then have submitted and implemented their action plans with mixed results.  - Ministry of Justice formulated laws to protect PLWHA.
<b>Component 4: Support to community interventions</b>			
(a) Strengthening the behavior change communication	150 peer educators trained per year  Djiboutians of targeted groups have heard at least 14 messages on HIV/AIDS, malaria and TB that are broadcasted on the radio ever week	95%	Targets are largely exceeded for peer educators  Behavior change communication used multimedia as well as interpersonal approaches. Key messages were tested and communication channels were radio, TV, newspapers but also national artists and mostly peer educators for community activities. Selection of peer educators was conducted by recruited supporting agencies and as per the processes in the component manual. A generic guide for peer educator was adapted for every targeted group. There were 200 trained peer educators per association. Supporting agencies ensured quality of activities by using observation checklists during their monthly or quarterly supervisions. Numerous activities were carried out around the World AIDS Day to a point that it became "National Week for the Fight against AIDS.
(b) Mechanisms to convey funds to communities	Disbursements end of 2005: 50%  60% of households living with registered PLWHA that are treated receive psychosocial support	End of 2007: 85% of disbursement	For the sake of convenience and to be able to manage 30 -50 associations per year and up to 110 at the end of the project, the project recruited on a competitive basis the supporting agencies. Six supporting agencies were selected to be in charge of strengthening the technical and financial capabilities of community-based associations, including responsibility to convey the funds according to pre-established transparent processes. Supporting agencies were

			<p>operating as per their geographical location, areas of action and priority vulnerable groups: UNFD covers Quartier 6, Q7 and Q7bis and Arta Region; ADPEF covers Ambouli, Hayable and Dikhil ; CCFIS covers part of Hayable and Ali Sabieh region; CCAF covers Q1 and Q2, Einguela and Tadjourah region; UDC covers Q3 et Q4, Arhiba and the Obock region; CCAB covers solely Balbala, 4th quarter and PK12.</p> <p>About 100 psychosocial support and therapeutic extension workers were trained and supervised by prescribing physicians to assist PLWHA and their families. The DASAP was established by the project to provide an economic and social support after review by an independent committee. About 500 persons benefited from this support that was later continued under Global Fund.</p>
(c) Communities master the means to fight HIV/AIDS	<p>End 2004: 30 communities implement action plans to prevent HIV/AIDS and case management</p> <p>Ten resting stops for truckers benefit from HIV prevention</p>	<p>Target was exceeded: 30–50 associations or communities per year, a total of 170 CBAs were active by the end of the project</p> <p>The 10 resting stops were taken care under other funding by another donor</p>	<p>Associations representing communities benefited of institutional, technical and financial strengthening that made them able to design and implement sub-projects for prevention using peer education approach to include awareness sessions, advocacy and to a lesser degree individual one-to-one sessions</p> <p>Activities at resting stops were carried out in cafes and restaurants around PK12. Sporadic awareness sessions and condoms distribution took place amidst the urban taxi drivers.</p>
(d) Communities master the means to fight Malaria	Fight against Malaria is integrated in community sub-projects	20 community sub-projects carried out under the national program fighting malaria ( <i>PNLP</i> )	Sub-projects were made to distribute IIBNs in the framework of social mobilization in hyper endemic malaria areas at the height of seasonal transmission

### **Annex 3. Economic and Financial Analysis**

#### **Summary of the Initial Economic and Financial Analysis at Appraisal:**

The benefits of the intervention to reduce the transmission and prevalence of the HIV/AIDS mainly come from (i) saving the costs of treatment, (ii) reducing the foregone revenue and funeral costs, and (iii) reducing the number of deaths due to the HIV/AIDS. The direct costs of intervention include (i) distribution of condoms and (ii) awareness raising campaigns.

The initial analysis assumes two channels through which diffusion of the epidemic in Djibouti: (i) sexual intercourse and (ii) mother-to-infant transmission. The probability and speed of the transmission would then be highly dependent on the assumptions on this transmission process and probability. Despite the limited availability of data, in order to make a reasonably realistic model, the following assumptions are made. The population of interest consists of four groups including 0-14 year old children, 15-49 year old male and female, and sex workers. The average number of sex partners and sexual intercourse per year per partner among the adult male, female and sex workers are assumed based on Rehle et al. (1998). The transmission probability depending on the prevalence of condom use, the prevalence and presence of STI, and the direction of transmission are also assumed. Given the population age structure, fertility and mortality rates, and initial prevalence rates by age and gender, the HIV/AIDS prevalence rates and the costs of the epidemic are projected.

The findings illustrates that the costs of the epidemic can be substantial without intervention. For example, the costs of treatment and foregone revenue could be up to six percent of GDP by year 2010 without intervention. If the costs of the years of life lost due to premature deaths due to the HIV/AIDS, the present value of accumulated costs would be about 13% of today's GDP even at a conservative scenario. In addition, if the undermining effects of the HIV/AIDS on human capital accumulation are added, the costs of not addressing the epidemic would become even greater than projected.

The analysis identified three major areas of intervention by this program, and showed the effectiveness of the interventions. Given that a slight changes in sexual behavior and prevalence of STI has a substantial impact on the transmission probability and prevalence rates, the analysis focus on changing the rates of condom use, the number of visits to sex workers, and the prevalence rates of STI through intervention. The findings suggest that the increase in condom use when it is combined with reduction in commercial sex and STI prevalence rates, the internal rate of return would be above 30% by the year 2025.

#### **End of Project Economic and Financial Prospects:**

##### *Assumptions and simulation*

The model of HIV/AIDS transmission and assumptions regarding major parameters remain the same from the original analysis. In order to quantify the expected benefits of the intervention using the model, post intervention data on three major areas of intervention are needed: (i) prevalence of condom use, (ii) STI prevalence rate, and (iii) behavioral change in sexual activity. Among these, prevalence of condom use and STI are obtained from PDO indicators. Parameters regarding the behavioral change in sexual activity, however, should be inferred due to lack of data. Thus, the strategy to quantify the effect of the intervention is to use the observable indicators (e.g., condom use) and adjust unobserved outcomes (e.g.,

average number of visits to sex workers) so that the predicted outcomes from the model to capture the actual outcomes (e.g., prevalence rates).

For this purpose, three quantitative PDO indicators are chosen: (i) prevalence rate among pregnant women; (ii) prevalence rate among STI patients; and (iii) prevalence of condom use among general public and sex workers. According to the completion report, the prevalence rate among 15-24 year old pregnant women is reduced from 2.7% in 2002 to 2.1% in 2007. Assuming that the prevalence rate among pregnant women linearly declines and continues declining between 2007 and 2008, and the rate of reduction is the same for adult female, the overall prevalence rate among adult female is assumed to decline from 3.4% (CREDES data) in 2002 to 2.4% in 2008. The prevalence rate among STI patients should have important implication given that the probability of transmission is assumed to be more than 20 times higher among STI patients than non-STI population. Given that STI population and sex workers are similar in the sense that they are high risk groups vulnerable to HIV/AIDS, the reduction in prevalence among STI's may imply the reduction in prevalence among sex workers. It is assumed that prevalence rate among sex workers is reduced from 10.0% in 2002 to 4.5% in 2008. Then the overall prevalence rate among adults is 3.3% in 2002 and 2.5% in 2008.

Finally, according to 2006 data, the condom use among general public and sex workers have greatly improved, and the rate of condom use in 2008 is assumed to be 45% and 97% for non-sex workers and sex workers respectively. Given these numbers, it is assumed that average number of partners per sex worker is assumed to be reduced from 8 to 6, and STI prevalence is reduced from 10 to 6% for the model to match the overall prevalence rate, sex workers' prevalence rate, and adult females' prevalence rate in 2008 to be at 2.5%, 4.5%, and 2.4%, respectively.

Table 4.1. Summary of Indicators Used for Simulation

PDO Indicators/Additional Assumption	2002 (PAD data)	2007 (ICR data)	2008 (assumed)
1. Prevalence among pregnant women	2.7%	2.1%	2.0%
Overall prevalence rate (adult female)	3.4%	-	2.4%
2. Prevalence among STI's	22.0%	9.7%	9.7%
Prevalence rate among sex workers	10.0%	-	4.5%
Overall prevalence rate (adult)	3.3%	-	2.5%
3. Condom use			
Among 15-24 public	5%	38.3% (2006)	45%
Among sex workers	7.5%	94%	97%
4. Average number partners per sex worker	8		6
5. STI Prevalence rate	10%		6%

Source: Author's calculation based on PAD and ICR data

### Results and Discussion

Without intervention, the prevalence rate of HIV/AIDS rapidly increases mainly due to the limited usage of condom. Especially after 2010 when the rate is over 5%, the infection rates exponentially rise. Total number of the infected at time  $t$  ( $Tot_t$ ) is the previous period's total ( $Tot_{t-1}$ ) added by the number of the newly infected ( $New_t$ ) less of the number of deaths due to AIDS ( $Death_t$ ):  $Tot_t = Tot_{t-1} + New_t - Death_t$ . Then the total number of the infected among each group (children, adult male and female, and sex workers) determines prevalence rates for each group. The prevalence rate affects, in turn, the transmission probability of HIV. Since the data on the number of deaths due to AIDS

is limited, it is assumed that about 5% of the infected from the previous period die due to AIDS. Given this law of motion and the parameters from Table 4.1, the prevalence rates without and with intervention are calculated (Table 4.2). Without intervention, the adult prevalence could have been up to 5.3% in 2008. However, due to the intervention, the prevalence is as low as 2.5 in 2008. If the impacts of this intervention persist, the prevalence rates would decline further to remain low.

Table. 4.2. Impact of Interventions on Prevalence rates and Deaths due to AIDS

Year	2002	2005	2008	2010	2015	2020	2025
<u>Without Intervention</u>							
Overall Prevalence rate	2.0	2.7	3.4	4.2	6.6	10.5	16.8
Adult Prevalence rate	3.3	4.4	5.3	6.5	10	15.8	24.9
Deaths due to AIDS*	620	975	1,196	1,470	2,478	4,231	7,221
<u>With Intervention</u>							
Overall Prevalence rate	2.0	1.9	1.7	1.6	1.3	1.0	0.8
Adult Prevalence rate	3.3	3.1	2.5	2.3	1.8	1.4	1.1
Deaths due to AIDS*	620	703	663	633	556	483	415

\*UNAIDS-WHO estimates the number of deaths due to AIDS is 550 and 690 in 2001 and 2003, respectively.

Without the intervention, the initial analysis (PAD) predicts that the present value (over the period of 2002 and 2028) of the accumulated total costs of the epidemic including treatment costs (excluding ARV), foregone income, and years of life lost to premature deaths was estimated about 12% of GDP of 2002.<sup>1</sup> Current analysis also finds a consistent estimate that the present value of total cost (over the period of 2002 and 2025) of not addressing this epidemic is about 11.8% of GDP in 2002.<sup>2</sup> With the intervention, however, if the prevalence rates declines as suggested in Table 4.2, the present value of total costs would be reduced to 3.8% of GDP in 2002. Given that GDP of Djibouti in 2002 is about USD 658 million, the costs saved through the intervention are about USD 52 million. Since the ICR reports USD 13 million disbursements for the total costs of this intervention, the cost benefit ratio is almost 4.0.

If the costs of treatment and foregone revenue per year and person were larger, the benefits from the intervention would be greater (Table 4.3). Depending on the assumptions of STI prevalence rate, condom use among general public (non sex workers), and the average number of sex partners for sex workers, the net benefits of the intervention slightly vary. In particular, if the condom use rate had achieved the original target (50%) set at PAD, it would have made difference by 0.1% of GDP. However, it is clear that the intervention has saved huge costs that might have occurred with rising HIV/AIDS prevalence.

<sup>1</sup> The baseline line scenario assumes treatment costs, foregone revenue and funeral, and value of life at USD 100, 50, and 860 (GDP per capita) per year and person, respectively, as in PAD. However, the funeral costs of households could be someone else's revenue in the society, it is not appropriate to include them as social costs. Given that funeral costs are negligible compared to treatment costs and foregone revenue, they are not considered in the analysis here.

<sup>2</sup> The major difference between the analysis in PAD and ICR includes (i) the assumptions on the number of deaths due to AIDS and (ii) population age structure, which leads to the different level of prevalence rate in each group and the number of newly infected in each year.

Table. 4.3. Present Value of Costs of HIV/AIDS by Cost Scenarios and Intervention Outcomes

Costs (treatment+foregone revenue) per year/person	\$150	\$250	\$350	\$450	\$550	\$650	\$750
Present Value of (Costs+YOL) as a percentage of GDP in 2002							
<u>Without Intervention</u>							
(STI prevalence, condom use, number of partners for sex workers)							
10%, 2.5%, 8	11.8%	18.0%	24.1%	30.2%	36.4%	42.5%	48.7%
<u>With Intervention</u>							
(STI prevalence, condom use, number of partners for sex workers)							
6%, 45%, 6	3.8%	5.8%	7.8%	9.8%	11.8%	13.8%	15.8%
3%, 45%, 8	3.5%	5.3%	7.1%	8.9%	10.7%	12.6%	14.4%
6%, 50%, 6	3.7%	5.6%	7.5%	9.4%	11.3%	13.2%	15.1%

\*Assumptions on costs of treatment, foregone revenue and funeral are discussed in the PAD .

Note: Grey column indicates the baseline (most conservative) estimates of the impacts of the intervention.

The stabilization and potential reversal of the HIV/AIDS epidemic would reduce the future fiscal burden due to HIV/AIDS as described above. However, this projection is based on the assumption that the impact of the intervention persists, namely the use of condom remains high and the prevalence of STI is kept low. In addition, the distribution of ARV is not discussed here due to the high costs of ARV. Thus, it is recommended that the new Health Sector Improvement Project make effort to (i) regularly monitor the prevalence rates of HIV/AIDS and STI and the practice of condom use, and (ii) ensure condom distribution, and (iii) identify areas of further improvement.

### **Technical Notes for the Analysis:**

#### *Transmission through sexual intercourse*

The probability that an individual  $i$  gets infected from  $j$  ( $p_{ij}$ ) through sexual intercourses is the conditional probability of transmission depending on condom use ( $c$ ) and STI presence ( $s$ ) given  $j$  is infected multiplied by the probability that  $j$  is infected ,

$$p_{ij}^{c,s} = pr_{ij}^{c,s}(tr | j = infected) \cdot pr(j = infected) .$$

The probability that  $j$  is infected,  $pr(j = infected)$ , is a prevalence rate of HIV/AIDS among the group that  $j$  belongs to. The conditional probability of transmission from  $j$  to  $i$  is specified as

$$pr_{ij}^{c,s}(tr | j = infected) = 1 - [1 - P(i, j, c, s)]^{\# \text{ of sex}}$$

where  $P(i, j, c, s)$  is a transmission probability by one sexual intercourse that depends on gender of  $i$  and  $j$ , whether  $j$  is a sexual worker and STI infection and type, and whether they use condom.

$P(i, j, c, s)$  is assumed as in PAD as follows:

Prevalence STIs (percent population 15-49)	Non-STIs [85%,90%,95%,100%]	STIs –GUD (% among STIs) 50%	STIs non-GUD (% among STIs) 50%
Transmission probabilities without condom			
Male-to-Female	0.2%	4%	2%
Female-to-Male	0.1%	2%	1%
Transmission probabilities with condom are reduced by 98% (effectiveness rate of condom).			

Then the probability that an individual  $i$  gets infected within a specific year,  $P^{c,s}(i = infected)$ , is one less the probability of getting infection from none of his/her partners,

$$P^{c,s}(i = infected) = 1 - \prod_{j=1}^{\# \text{ sex partners}} (1 - p_{ij}^{c,s}).$$

Finally, for a representative agent in an economy, the expected probability of transmission depends on the probability of condom use and STI prevalence. This expected probability should be calculated separately for male and female.

$$EP_g( infected) = \sum_{STI=0}^1 \sum_{condom=0}^1 pr(s = STI) \cdot pr(c = condom) \cdot P^{c,s}(i = infected), \text{ where } g = f, m.$$

For this calculation, the number of sexual intercourse and partners per year is assumed again as in PAD as follows:

Partners	Males	Females	Sex workers
Males	0	2	[8,10]
Females	<i>endogenous</i>	0	0
Sex workers	<i>endogenous</i>	0	0
Contacts	Males	Females	Sex workers
Males	0	30	[2,3]
Females	30	0	0
Sex workers	[2,3]	0	0

Parameters labeled *endogenous* are calculated to ensure internal consistency so that the total number of sexual acts by males is equal to the total number of sexual acts by females.  
Source: Based on Rehle et al. (1998).

#### Annex 4. Bank Lending and Implementation Support/Supervision Processes

##### (a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
<b>Lending</b>			
<b>Supervision/ICR</b>			
Anas Abou El Mikias	Sr Financial Management Specia	MNAFM	
Justine Etiennette Essie Agness Soumahoro	Consultant	MNSHD	
Abduljabbar Hasan Al Qathab	Senior Procurement Specialist	MNAPR	
Sami Ali	Operations Officer	MNSHD	
Karim Kamil Fahim	Auditor	IADDR	
Abdessalem Mohsen Farza	Consultant	AFTH3	
Brigitte S. Franklin	Program Assistant	MNSHD	
Sahar Mohamed Hegazy	Program Assistant	MNC03	
Michele L. Lioy	Consultant	MNSHD	
Mohamed Mehdi	Consultant	MNAFM	
Eileen Murray	Lead Operations Officer	MNSHD	
Wendy Voahangy Ravano	Consultant	MNSHD	

##### (b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
<b>Lending</b>		
FY01	1	11.71
FY02	19	129.92
FY03	42	238.80
FY04	4	3.32
FY05	5	11.03
FY06		-0.27
FY07		0.74
FY08		0.00
<b>Total:</b>	71	395.25
<b>Supervision/ICR</b>		
FY01		0.00
FY02		0.00

FY03		0.00
FY04	30	177.75
FY05	28	161.25
FY06	38	156.92
FY07	30	120.58
FY08	22	98.00
FY09	3	0.00
<b>Total:</b>	151	714.50

**Annex 5. Beneficiary Survey Results**  
(if any)

Not applicable.

**Annex 6. Stakeholder Workshop Report and Results**  
(if any)

Not applicable.

## **Annex 7. Summary of the Executive Secretariat's Comments on Draft ICR**

### **Commentaires du Secrétariat Exécutif sur le rapport final de clôture du projet PLSPT de la Banque mondiale (reçus le 3 mars 2009).**

Ce rapport de clôture qui nous a été présenté reflète de façon complète et satisfaisante, les réalités et les données de la mise en œuvre pendant cinq années du projet MAP de Djibouti financé par l'IDA sur la période 2003-2008. Au terme de cet exercice, un certain nombre de remarques peuvent être dégagées de notre part à la lecture et reflète le point de vue de notre institution en tant que Agence d'exécution du projet. En premier lieu, nous saluons l'ensemble des remarques et conclusions de l'équipe de la banque et des consultants et nous sommes conscients que le Secrétariat Exécutif et l'ensemble des ses partenaires aussi bien publics que communautaires en tant qu'entités de mise en œuvre ont été félicité et noté à leur juste valeur. Nous témoignons que la Banque mondiale nous a beaucoup soutenue et faisait partie de cette équipe commune face aux trois maladies que sont le VIH/SIDA, le Paludisme et la Tuberculose du point de vue financier et technique, et à cet égard, mérite la même note que celle du Gouvernement, c'est-à-dire « Hautement Satisfaisant ». Par ailleurs, toutes les pièces justificatifs et rapports liés à la clôture ont d'or et déjà été transmis en bonne et due forme par le Secrétariat.

Le Secrétariat Exécutif est une institution jeune. Malgré sa jeunesse, elle a su faire face jusqu'ici à au moins deux défis majeurs de manière concomitante : se structurer et renforcer ses capacités organisationnelles et en même temps "booster" les différentes facettes de la réponse nationale. Après cinq années de fonctionnement, des progrès notables ont été enregistrés : la professionnalisation de la réponse communautaire est visible et progresse. De nombreuses associations communautaires s'approprient les différentes modalités de la réponse, même si le terrain de la prévention reste celui qui est souvent le plus investi. D'autres associations se structurent, ce qui permet de porter à l'échelle, les interventions à l'ensemble du territoire national, en témoigne la mise en place réussi du DASAP.

De nombreuses organisations aussi bien du secteur public que de la société civile ont pris conscience de la menace que représente l'épidémie de VIH/SIDA pour la santé publique, et pour l'avenir de la nation Djiboutienne. En 2008, Le VIH/SIDA n'est plus cet inconnu pour la majorité des Djiboutiens et des Djiboutiennes; il s'agit d'une réalité familière, dont ils entendent parler à travers les médias (TV, Radio) ; et les interventions de proximité. Les jeunes sont de plus en plus sensibilisés, via des structures scolaires principalement, mais aussi via des structures communautaires comme les CDC (centres de développement communautaire) et les Point Info Jeunesse (PIJ) ainsi que les mosquées. Un combat louable a également été mené contre la tuberculose et le paludisme, ses deus corollaires ce sur quoi revient également le rapport de clôture.

Ces résultats fort encourageants ne sauraient être obtenus sans le leadership politique, notamment l'engagement des plus hautes instances politiques du pays, à commencer par l'implication personnelle du Président de la République de Djibouti, son Excellence Monsieur ISMAIL OMAR GUELLEH, le Premier Ministre et l'ensemble du Gouvernement.

Sur le terrain, il faut saluer le dynamisme, l'engagement et la détermination de l'ensemble des Equipes des programmes de lutte contre le sida des ministères sectoriels, pour leur remarquable travail de coordination mené jusqu'à présent, en des terrains comme dit dans le rapport « nouveaux » et « complexes » à plus d'un titre . Ce travail tel que mentionné dans le rapport de clôture a permis une

implication de plus en plus grande des partenaires au niveau ministériel, associatif et des partenaires au développement, dans la promotion et le respect absolu depuis 2003 du principe « Three Ones ».

La pertinence de ce projet par rapport aux impératifs de développement et aux stratégies de réduction de la pauvreté à Djibouti est réelle. Les progrès accomplis en termes de couverture sont visibles et encourageants. Ce projet mérite d'être poursuivi par un financement additionnel de la banque mondiale pour la mise en œuvre du plan national stratégique 2008-2012, pour consolider les acquis et porter les interventions à l'échelle.

Les défis demeurent cependant énormes et les recommandations de plusieurs ordres afin d'enrichir le contenu du rapport de clôture. En premier lieu l'on devrait mettre un accent particulier au niveau du pays à la poursuite de l'assainissement du dispositif institutionnel, notamment dans la restructuration de l'Unité de Communication au niveau du Secrétariat Exécutif, afin d'améliorer la qualité des outils programmatiques dans le domaine de la communication et intégrer l'approche « Life skill ».

La dimension genre est un aspect de la mise en œuvre que nous avons encouragée et cela n'apparaît pas clairement dans le rapport, ces aspects liés au genre ont été pris en compte dans la programmation et la mise en œuvre des interventions à tous les niveaux. Enfin, nous devrions dans les années à venir recruter à des postes de décisions les personne(s) vivant avec le VIH, notamment au Secrétariat Exécutif et au PLS santé ; pareille démarche doit être encouragée et soutenue au niveau de toutes les instances ministérielles afin d'atténuer la stigmatisation et la marginalisation des PVVS encore très présente dans la population Djiboutienne et de promouvoir leur acceptabilité sociale.

Enfin, nous terminerons cette note de commentaires, en demandant instamment aux décideurs de la Banque mondiale de promouvoir le « best practice » de Djibouti dans le cadre de la lutte contre le VIH/SIDA en permettant aux acteurs nationaux de cette réussite phénoménale de faire partager dans le monde arabo-musulmans leurs méthodes et expériences en matière de prévention, de prise en charge et de réduction d'impact aux travers des colloques, des reportages et d'appui techniques apportés à ces pays amis.

## **Annex 8. Comments received from the Global Fund**

The Global Fund started to fund HIV-AIDS activities in Djibouti in 2004, through the Round 4 grant; which has been followed by the three other grants (HIV, Tuberculosis and Malaria). The total contribution of The Global Fund on the three diseases is USD 30,472,390 since the Round 4 (HIV grant) which started in 2004 and closed in 2008. All the grants are managed by the Executive Secretariat (ES) as Principal recipient.

The overall programmatic performance is satisfactory. After 18 months of implementation, the HIV grant reaches 86% of achievement of its targets for indicators related to Prevention, treatment and care, including those related to co-infection. The indicators related to PMTCT remain low. The TB grant is reaching 90% of the intended results. The good performance includes the treatment, the co-infection and the extension of the services in the country making them available at local level. The Malaria grant registers a satisfactory performance on prevention and control, with 109% of achievement on these related indicators. However, the treatment related indicators remain drastically low with 9% of achievement. The Global fund co-funded with UNICEF and WHO a prevalence survey. This survey confirms the low prevalence of Malaria in Djibouti, with low prevalence (0.6%).

Among the main strengths noticed, The Global Fund notes i) the capacity of the Sub Recipients (National Programs under the Ministry of Health mainly) in implementing the activities on a timely manner, ii) the coordination role of the ES by mobilizing additional resources; iii) the cooperation with the TB grant (Centre Paul Faure which is the National center of reference for TB) and the National TB program for co-infection activities.

On the other hand, when the ES was created in 2003, it was only receiving funds from the World Bank and then from the Round 4 grant. Since then, the ES has seen an increased number of grants to manage, from various donors. As a result, the workload has increased and the systems in place would need to be reviewed to face this organizational development. At last, The Global Fund also shares the rating given in this report regarding “Financial management”, with overspending of human resources and 0.2 million disbursed to sub-recipients remained unjustified at the end of December 2008 as per the latest audit report on the HIV grant.

## Annex 9. Detailed Project Risks, Key Indicators, and Components (as approved)

The risk factors specific to Djibouti included the following:

- (i) Trade: Djibouti is a highly urbanized state with economic activity centered on the port. About 1,000 transport trucks move daily between the port and Ethiopia, where the HIV/AIDS prevalence rate is higher, estimated by UNAIDS at more than 10% in 2002. Djibouti is therefore highly susceptible to the spread of HIV/AIDS through the transport sector.
- (ii) Migration: Djibouti has a large influx of refugees and displaced persons from neighboring Ethiopia, Somalia, and Eritrea.
- (iii) Gender inequality: Women, the most vulnerable segment of Djiboutian society, have low economic participation rates and low levels of education. Maternal mortality was 740 per 100,000 births, which is caused by low rates of delivery by skilled staff, high fertility rates, and anemia from malnutrition. The project approach, which emphasizes gender as a key issue, is consistent with one of the key levers of the regional strategy of the International Development Agency (IDA).
- (iv) Tuberculosis: With 588 cases of TB per 100,000 inhabitants, Djibouti had the second highest rate of TB in the world. However, about 40 percent of cases are among people from neighboring countries, particularly Ethiopia, since they know that they can obtain free and higher quality treatment in Djibouti. Although the seroprevalence rate in the general population was less than 3 percent, it was 23 percent among TB patients.
- (v) Malaria: Since 1988, the spread of malaria has increased steadily, reaching areas such as the northern districts of Tadjourah and Obock where it was previously nonexistent. Uncontrolled urbanization with inappropriate water supply, nonexistent wastewater evacuation systems, settlement of nomad population in rural areas, increased irrigated areas, and frequent floods contributed to the endemic pattern of malaria.

The outcome indicators by the end-of-project were expected to be:

- Fifty percent of persons in high-risk groups will have used a condom during their last non-union sexual encounter;
- Ninety percent of the population of Djibouti aged 15 to 49 will be aware of HIV/AIDS;
- Fifty percent of women attending prenatal consultations in centers offering Voluntary Counseling and Testing (VCT) will accept voluntary testing for HIV;
- HIV prevalence among pregnant women aged 15 to 24 will have decreased from 2.7 percent to 2.0 percent;<sup>3</sup>
- Sexually transmitted infection (STI) prevalence rate among pregnant women will have decreased by 25 percent;
- Rate of dropouts (“lost cases”) of tuberculosis will be reduced from 24 percent to 15 percent nationally;
- Hospital mortality due to malaria will be reduced by 50 percent; and
- At least 15,000 households will be using insecticide-impregnated bednets (IIBNs).

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<sup>3</sup> After the Mid-Term Review, the end-of-project target for HIV prevalence among pregnant women aged 15–24 was revised to 2.2 percent.

The following is a summary of the description of the project components as approved in the PAD.

- Component 1: Capacity Building and Policy Development (US\$ 4.0 million). This included: (1) Strengthening the Government's capacity to cope with the spread of HIV/AIDS, malaria and tuberculosis through the provision of technical advisory services and equipment, and carrying out of civil works. (2) Enhancing counseling, voluntary testing, and care and treatment of seropositive persons, through the rehabilitation and extension of the "Centre Younis Toussaint", and construction of a reference laboratory at the "Hôpital Général Peltier" and of the national headquarters for the three programs.
- Component 2: Health Sector Responses to HIV/AIDS/STI, Malaria and Tuberculosis (US\$ 3.8 million). This component aimed to increase access to preventive measures such as condoms, to treatment of STI, opportunistic diseases and Malaria, and to case management, support and treatment of PLWHA. The component's activities include: (1) provision of technical advisory services, equipment and drugs to build on and complement the work to be carried out by MOH under the Health Sector Development Project. (2) provision of technical advisory services, training, drugs, medical consumables and equipment including: (a) strengthening of the national sentinel epidemiological surveillance system and seroprevalence surveys; (b) development and implementation of Voluntary Counseling and Testing (VCT) protocols; (c) the implementation of syndromic algorithms for diagnosis and case management of Sexually Transmitted Infections (STI); (d) development and adoption of a protocol for Tuberculosis and Malaria; and (e) development and implementation of a Condom Distribution Strategy.
- Component 3: Multisectoral Response (US\$ 3.7 million). The objectives of this component are to: (i) strengthen the management and coordination capacity of the ministries participating in the control of HIV/AIDS; (ii) support these ministries in implementing essential activities aimed at preventing HIV infection and reducing the impact of AIDS on their own personnel and on the vulnerable groups for which they are responsible. As mentioned in the PAD, it was originally planned to roll out the implementation in 5 ministries in 2004, 8 ministries by 2006 and in all 11 ministries by 2008. The project was to provide technical advisory services and equipment to facilitate the implementation of the action plans and derived multisectoral sub-projects for the training of peer educators, promoting the use of condoms and their distribution, and promoting counseling and voluntary testing, and different support mechanisms to encourage change in behavior practices.,
- Component 4: Support to community interventions (US\$ 2.6 million). This component supported the implementation of Community Sub-projects prepared by Community-based Associations (CBAs), including provision of grants for the financing of such Community Sub-projects. The component would provide technical advisory services and equipment for: (a) the promotion and the distribution of condoms; (b) targeted information, education, and communication campaigns aiming at changing behaviors related to HIV transmission; (c) interventions aiming at improving the status and autonomy of women; (d) psycho-medico-social and economic support and care to people infected with and affected by HIV/AIDS; (e) promotion of voluntary counseling and testing (VCT); (f) promotion of prevention of mother-to-child transmission; (g) prevention of malaria; and (h) continued support to tuberculosis patients. The implementation of essential activities will require the development of the institutional capacities of Djiboutian NGOs and associations. A very important step for this component would be to identify 9-10 institutions/NGOs that have the potential to train and supervise local NGOs and associations that will be responsible for carrying out community interventions. The financing of community sub-projects and contracts with supporting organizations will be carried out

by the responsible Community Interventions Support Unit in accordance with the Procedures Manual for Community Interventions developed by the ES.

## **Annex 10. List of Supporting Documents and Project Manuals**

### **World Bank**

- Rapport de l'évaluation à mi-parcours du PLSPT, Conseil Santé SA, Djibouti, mai 2007.
- Rapport sur les enquêtes (séro-surveillance du VIH et surveillance comportementale dans la population générale) d'évaluation à mi-parcours du PLSPT, Conseil Santé SA, Djibouti, mai 2007.
- Aide-mémoire pour le PLCSPT, Mission de revue à mi-parcours du 14 au 22 avril 2007,
- Djibouti – Getting results : an effective, well coordinated response to HIV in Djibouti, Sameh El-Saharty and Omar Ali, WB Global HIV/AIDS Program publication, 2006.
- Aide-mémoire pour le PLCSPT, Mission de supervision du 10 au 17 décembre 2006,
- Aide-mémoire pour le PLCSPT, Mission de supervision du 5 au 15 décembre 2005,
- HIV /AIDS, MALARIA AND TUBERCULOSIS CONTROL PROJECT - Project Appraisal Document (PAD) Report No 25264-DJI, The World Bank April 30, 2003

### **Government and Project**

- Rapport de progrès annuel d'exécution du PLSPT, Unité M&I du Secrétariat Exécutif, Djibouti, 2007
- Evaluation à mi-parcours du Projet de Lutte contre le VIH/SIDA, le Paludisme et la Tuberculose, République de Djibouti, Secrétariat Executif, Comité Inter-Sectoriel de Lutte contre le SIDA Rapport Final par Conseil Santé Paris May 2007
- Le point sur l'Epidémie du SIDA en 2007 UNAIDS WHO Genève Décembre 2007
- Plan Général d'Exécution 2007 – 2008 du PLSPT [under the « three ones » execution framework, consolidated action for World Bank and Global Funds R4 R6 and all other partners] République de Djibouti, Secrétariat Executif, Comité Inter-Sectoriel de Lutte contre le SIDA Djibouti Juin 2007
- Projet « Sœurs-à-Sœurs » pour une meilleure gestion des situations génératrices de risque parmi les femmes en situation de précarité et/ou travailleuses du sexe à Djibouti, République de Djibouti, Secrétariat Executif, Unité d'Appui aux Interventions Communautaires (UAIC) Djibouti 2006 - 2008
- Atelier de Consensus et d'Adoption par les Imams et leaders religieux Djiboutiens des déclarations suivantes (textes originaux en Arabe) : i) Cairo Egypt Declaration for Religious Leaders facing AIDS in Arab lands, ii) Cairo December 11 – 13, 2004, iii) Tarabous Lybia Declaration on Fighting HIV/AIDS with UN Agencies, Tarabous May 28 – 31, 2006 ; République de Djibouti, Ministère Delegué Chargé des Biens WAQFS et des Affaires Musulmanes Haut Conseil Islamique Secrétariat Général - Secrétariat Executif, CTSPT, Unité de Communication (UC), Novembre, 2007
- Atelier multimedia d'élaboration et de production des messages et supports éducatifs sur leVIH/SIDA et IST à Djibouti République de Djibouti, Secrétariat Executif, CTSPT, Unité de Communication (UC), Novembre 2007
- Evaluation de l'impact de l'Agenda Scolaire dans le cadre de la lutte contre le VIH/SIDA en milieu scolaire République de Djibouti, Ministère de l'Education Nationale et de l'Enseignement Supérieur Rapport Final Avril – Juin 2007.
- Marketing Social des Préservatifs à Djibouti – Strategie de Communication 2003 – 2007 République de Djibouti, Secrétariat Executif, Comité Technique de lutte contre le Sida, le Paludisme et la Tuberculose (CTSPT), Unité de Marketing Social, Novembre 2007.
- Plan Stratégique de Communication pour le Programme de Lutte contre le SIDA 2008 – 2012 République de Djibouti, Ministère de la Santé, PLS Santé, Novembre 2007.

- Plan Stratégique pour la Lutte contre le Paludisme 2006 – 2010, République de Djibouti, Ministère de la Santé, Direction du Programme de Lutte contre le Paludisme.
- Questionnaire individuel – Enquête de Surveillance Comportementale du VIH, Population Générale, République de Djibouti, Direction des Informations Statistiques et Etudes Démographiques (DISED), Djibouti 2006
- Report of the UNAIDS Technical Consultation on Social Change Communication applied to the drivers of HIV/AIDS Epidemic (gender inequality, violation of human rights and HIV-related stigma) UNAIDS Geneva 2-3 August 2007 Draft, September 2007.
- Annuaire Statistiques 2006, République de Djibouti, Ministère de la Santé, Direction de l'Hygiène et de l'Epidémiologie, Service National d'Information Sanitaire (SNIS) Mars 2007
- Appui au programme d'extension et de renforcement de la lutte contre le Sida, le paludisme et la Tuberculose Application to Round 6 of the Global Fund, République de Djibouti, Secrétariat Exécutif, 2006
- Etude sur les Connaissances, Attitudes et Pratiques des Jeunes Djiboutiens (Enquête CAP menée en Décembre 2005 et en Janvier 2006 République de Djibouti, Ministère de la Jeunesse, du Sport, des Loisirs et du Tourisme, Rapport Provisoire Mars 2006
- Etude qualitative sur la vulnérabilité au VIH/SIDA des femmes en situation de précarité République de Djibouti, Secrétariat Exécutif, Unité d'Appui aux Interventions Communautaires (UAIC) Djibouti 2006
- Rapport de progrès annuel d'exécution du PLSPT, Unité M&I du Secrétariat Exécutif, Djibouti, 2006
- Résultats partiels de l'enquête de sero prevalence par Immunocomb et Determine chez les forces armées de Djibouti République de Djibouti, Ministère de la Défense, Service Médical des Forces Armées, 2006.
- Stratégie du Dispositif d'Appui Social Accéléré aux Personnes vivant avec le VIH SIDA (DASAP) République de Djibouti, Secrétariat Exécutif, CTLSPT, Unité d'Appui aux Interventions Communautaires (UAIC), Novembre 2005.
- Indicateurs harmonisés du PLSPT, République de Djibouti, Secrétariat Exécutif, Comité Inter-Sectoriel de Lutte contre le SIDA, 2005
- Rapport de l'enquête CAP chez les jeunes, DISED et UNICEF Djibouti, Djibouti, 2005.
- Rapport de progrès annuel d'exécution du PLSPT, Unité M&I du Secrétariat Exécutif, Djibouti, 2005
- Rapport de progrès annuel d'exécution du PLSPT, Unité M&I du Secrétariat Exécutif, Djibouti, 2004
- Epidémie à VIH/SIDA/IST en République de Djibouti – Tome 1 CREDES Paris Janvier 2003

**Project Manuals and Guidelines that guided project preparation and implementation (complementing section 2)**

- Procurement Manual
- Administrative Manual
- Peer education guides for priority vulnerable groups (in French and two local languages)
- A social communication guide
- A manual for the management and quality control of community based projects
- M&E manual
- Flipcharts for priority vulnerable groups
- A social marketing manual
- Original and revised guides to the syndromic approach of STI
- A protocol for voluntary counseling and testing

- PROTOCOLS for antiretroviral treatment and follow-up
- Procedures Manual for community interventions
- A manual for psychosocial support (DASAP)
- A guide for impregnation of bed nets and social mobilization to fight malaria
- A national program guide for directly observed treatment, short course (DOTS)
- A manual for management of accidental exposure to blood in clinical settings