



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 08-May-2018 | Report No: PIDISDSA24433



BASIC INFORMATION

A. Basic Project Data

Country Djibouti	Project ID P164164	Project Name Towards Zero Stunting in Djibouti	Parent Project ID (if any)
Region MIDDLE EAST AND NORTH AFRICA	Estimated Appraisal Date 08-May-2018	Estimated Board Date 25-Jun-2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Economy and Finance	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The project development objective is to reduce stunting among children under 5 in Djibouti.

Components

High-impact Health and Nutrition Services to Reduce Stunting
 Strengthening Multi-sectoral Interventions for Stunting Reduction
 Strengthening Coordination, Project Management and Monitoring and Evaluation
 Contingent Emergency Response

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

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

DETAILS

World Bank Group Financing

International Development Association (IDA)	15.00
IDA Credit	15.00



Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

- 1. Djibouti is a small lower-middle income country which occupies a pivotal position for trade and security in the Horn of Africa and the Gulf of Aden.** It overcame violent civil conflict in the early 1990s to reach a political accommodation between the major ethnic groups in the country, and has been able to accelerate economic growth by securing foreign direct investments and rents from foreign countries' military bases and port services. Its annual gross domestic product (GDP) growth rate was estimated at 6.5% in 2016, and the inflation accelerated up to 3.5% in 2016 from 2.6% in 2015, spurred mainly by demand for housing and services.
- 2. Djibouti remains a fragile state and faces serious obstacles to poverty reduction and improved health of its population.** In 2013, an estimated 40.7% of Djiboutians lived in poverty, consuming less than DJF 117,134 per capita per year or US\$2.98 per day (2011 PPP). In the same year, 23% of Djiboutians lived in conditions of extreme poverty spending less than DJF 78,157 per capita per year or US\$1.99 per day (2011 PPP), with rural areas showing higher rates of extreme poverty (44 percent). Unemployment remains widespread with the rate reaching 39% in 2015 according to official estimates; the rate is higher among women (49 percent) and in rural areas (59 percent).
- 3. There are persistent concerns with food insecurity, mainly due to limited arable land, and low rainfall which has adverse effects on livelihoods and agriculture production.** The location of Djibouti also means that it has an arid desert climate, high temperatures year-round, prolonged droughts, limited rainfall, limited arable land, and a scarcity of ground water. As a result, agriculture is almost nonexistent, accounting only for about 3% of GDP and 2% of employment. The country is heavily dependent on food imports, as well as imports of manufactured goods and energy products. Furthermore, the recent prolonged drought in Djibouti exposed at least 20% of the population in Djibouti city and 75% of rural households to food insecurity.
- 4. A key factor behind the limited transmission of growth to prosperity and poverty reduction is the accompanying rise in inequality which increased in Djibouti between 2002 and 2017. Inequality, poverty and food insecurity lead to a multitude of challenges, with childhood malnutrition being particularly damaging.** Despite improvements in the last 20 years in Djibouti's score on the Global Hunger Index (from 46.7 in 2000 to 31.4 in 2017) – a composite indicator of child undernourishment, undernutrition, and



mortality – Djibouti continues to be among the worst performers, ranking 100th out of 119 countries in 2017.¹

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

Sectoral and Institutional Context

- 6. Maternal and infant malnutrition are the number one cause of death and disability in Djibouti while wasting, diarrheal disease due to poor access to quality water in rural areas, and acute respiratory infections are the most common causes of morbidity and infant mortality.**² Despite recent gains made in maternal and child survival and some improvement in overall nutrition status, Djibouti lags behind countries with similar income level and neighboring countries. While the fertility rate has steadily decreased to 3.1 per 1,000 live births, infant mortality rate (IMR) and maternal mortality ratio (MMR) remain higher than those of economically comparable nations and countries within Djibouti’s geographic region.³ The MMR, although decreasing, is still estimated at 229 per 100,000 live births (2012), markedly higher than the target of 185 that was set for 2015.⁴ This data is indicative of the challenges that remain in improving access to and quality of obstetric and neonatal care. Only 23% of women receive four or more antenatal care visits, and only 54% of women receive any form of postnatal care.⁵ At the same time, although the IMR decreased from 71.7 in 2005 to 54.2 in 2015 the rate remains high.⁶
- 7. Chronic malnutrition (stunting) rates in children remain unacceptably high in Djibouti.** Stunting (height-for-age) is an urgent nutrition and a human development crisis in Djibouti, affecting over 30,000 children in 2013 (30% of children under 5). Between 2002 and 2013 stunting increased by 3 percentage points with an annual average rate of reduction of negative 2.2%, calling for the need to first reverse this trend and then aim for an overall decrease in the stunting rate in Djibouti. The age group most affected by stunting are children 12-23 months of age, with approximately 41.5% of this age group suffering from stunting. Prevalence of underweight (weight-for-age) among children under 5 is 30%. Exclusive breastfeeding protects infants from illness and provides essential nutrition during the first six months of life, but in 2014 only 13.4% of infants less than six months were exclusively breastfed – one of the lowest rates in the world.⁷ In addition, there is a steep and progressive rise in stunting after weaning (i.e. from 19.5% in 6-11-month-olds, to 34.4% in 12-23-month-olds). This is a common pattern in many developing countries, as a child is

¹ IFPRI. 2017. Global Hunger Index.

² Institute of Health Metrics and Evaluation. 2016 Djibouti Country Profile.

³ Ibid.

⁴ Ibid.

⁵ Ministry of Health Djibouti - Statistics and Studies Department, and Pan Arab Project for Family Health. 2012. Djibouti Family Health Survey.

⁶ Ibid.

⁷ Ministry of Health Djibouti, UNICEF and the European Union. 2013. National survey on nutrition using SMART methodology 2013.



introduced to greater disease risks through inadequate complementary feeding and inappropriate water, hygiene and sanitation conditions and practices.

- 8. Stunting and wasting are national challenges, affecting all geographical areas and wealth quintiles, although the poor and rural populations are at a proportionately higher risk.** Despite having one of the highest proportions of urban populations among the lower middle-income countries in Middle East and North Africa (MENA) and Sub-Saharan Africa (with around 80% of the population in urban areas and 60% in Djibouti City), the prevalence of stunting is higher among rural residents, compared to their urban counterparts (42.3% vs. 30.0%). Obock, Dikhil and Tadjourah regions have the highest stunting rates at 45.9%, 44.2% and 40.8%, respectively. Malnutrition is also linked to the socio-economic status of the household, and stunting is higher among the poorest twenty% of the population as compared to the richest (37.2% vs. 18.2%).
- 9. It is estimated that, globally, one-third of perinatal deaths and one-tenth of maternal mortality are attributable to iron deficiency anemia, and anemia increases the risk of premature delivery and low birthweight.** The adequate intake of micronutrients, particularly iron, vitamin A, iodine and zinc, from conception to age 24 months is critical for child growth and mental development. In Djibouti, nearly half (43%) of children under five and one-third (32%) of pregnant women suffer from anemia. This form of malnutrition increases mortality, weakens immunity, hinders cognitive development, and results in birth complications. In addition, vitamin A supplementation rates have dropped from 95% in 2011 to 50% in 2015. Adolescence is a time of rapid physical growth, second only to the first year after birth; and is a period of time in which one can gain up to 50% of their adult weight and skeletal mass, and more than 20% of their adult height. Adolescent girls have an increased risk of being undernourished since their rapid growth during puberty increases their needs for protein, iron and other micronutrients, and undernourished girls are more prone to complications of labor and delivery, and to give birth to low birth weight babies. Therefore, it is important to reach adolescents girls and women early and improve their health and nutrition status prior to entering their reproductive health years, such as through intermittent weekly iron and folic acid supplementation.
- 10. According to a contextual analysis conducted by the Ministry of Health (MoH) in 2014, and presented during the Identification Mission, the underlying determinants of stunting include poor infant and young child feeding (IYCF) practices, environmental health and food insecurity.** In addition, access to and utilization of essential health services are constrained by both supply and demand side barriers. Community-based interventions are essential for promoting appropriate nutrition knowledge and behaviors as well as for increasing demand for essential services. In January 2018, the government has elaborated and validated a new national strategy for the prevention of malnutrition. This strategy is yet to be implemented.
- 11. Beginning in 2012, the community health workers (CHW) program in Djibouti was re-organized to focus on provision of services at the health facility level, thereby diminishing their role in the active identification and referral of children with malnutrition in the community.** Furthermore, the coverage of high impact nutrition interventions at the facility, community, and household levels (e.g., deworming, vitamin A supplementation, growth promotion, etc.) is low in general and varies widely by region depending on the presence and support provided by development partners (DPs). Meanwhile, Djibouti has the capacity to treat malnutrition cases, if they are properly identified and referred. The country has one nutrition referral center in each of the five regions, and one national nutrition referral center in Djiboutiville; these referral



centers/hospitals can treat severe acute malnutrition with complications that requires hospitalization of patients. The country has seven nutritionists working in the referral centers.

12. All the regions in Djibouti have both critical levels of stunting (i.e. over 30 percent) and low coverage of key nutrition actions such as counseling on exclusive and complementary feeding, maternal health and nutrition interventions, education on sanitation and hygiene, and cash transfers for the vulnerable.

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

13. Aside from low access to and utilization of basic services, high levels of food insecurity are contributing to high malnutrition rates.

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

14. Infants and children from vulnerable and poor households in rural areas have significant deficits in environmental health, that places them at a greater risk of stunting.

In the last decade, there has been improvement in access to improved water and sanitation. Nevertheless, more than 23% of Djibouti's population practices open defecation, and 78% still lack access to improved toilets. There are also significant disparities between urban and rural areas: 77% of rural inhabitants practice open defecation compared to only 7% of urban inhabitants, and 70.4% of urban inhabitants have access to sanitation facilities while only 16.4% of the rural population has access to latrines.⁸ Not only is water a scarce commodity in Djibouti, but recurrent droughts since 2009 have been negatively affecting the rural and urban vulnerable communities.

15. The presence of refugees and migrants has created additional pressure on infrastructure and further stretched the limited capacity of the health system to provide basic health and nutrition services.

In two out of the three main refugee camps in Djibouti, global acute malnutrition (GAM) rates exceed WHO's serious (10-14%) and/or critical ($\geq 15\%$) severity thresholds. Obock, the region with the highest stunting and wasting rates in the country, is currently hosting the largest refugee population from Yemen. Refugees, asylum seekers and migrants are fleeing from Somalia, Yemen and Ethiopia due to recurring armed conflicts

⁸ WHO/UNICEF. Joint Program for Water Supply (JMP). 2017.



and extreme poverty to seek asylum in Djibouti or to transit through Djibouti to the Gulf countries in search of better living conditions.⁹ According to the United Nations, more than a quarter million people needed humanitarian assistance in Djibouti in 2017, which includes Djiboutians living in extreme poverty, refugees and asylum-seekers as well as migrants.

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

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

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective is to reduce stunting among children under 5 in Djibouti.

Key Results

18. Progress towards stunting reduction will be monitored through appropriate impact indicators and intermediate indicators that focus on practices and behaviors that are known to have an impact on the nutritional status of infants and children and pregnant and lactating women. The main PDO level indicators include: 1) Percentage of infants 0-6 months exclusively breastfed; 2) Percentage of children 6-23 months consuming a minimum acceptable diet/diverse diet; 3) Percentage of women who attended at least four antenatal care visits during their most recent pregnancy; 4) Percentage of children 6-59 months who are stunted; 5) Number of women referred by CHWs and registered at the health facility within 4 months of pregnancy (disbursement-linked indicator - DLI - #1A); 6) Number of women referred by CHWs, who completed at least 4 antenatal care visits at the health facility (DLI #1B); and 7) Number of women referred by CHWs, who completed at least 2 postnatal visits at the health facility (DLI #1C).

⁹ UNOCHA. 2017. UN Humanitarian Response Plan.



D. Project Description

- 19. Component 1: High-impact Health and Nutrition Services to Reduce Stunting.** This component focuses on the delivery of services and interventions that address stunting at both the facility and community levels.
- 20. Subcomponent 1.1: Strengthening of health and nutrition services at the facility level.** To address gaps in service delivery, this subcomponent will improve the provision, quality and utilization of an enhanced package of high-impact nutrition and health interventions at the facility level. These interventions include those identified in the government's National Nutrition Program which are in line with the 2008/2013 Lancet recommendations of the most effective interventions in reducing stunting, including: (i) growth monitoring and promotion and effective tracking of faltering children, exclusive breastfeeding from birth to six months and appropriate complementary feeding thereafter, deworming, and micronutrient supplementation (i.e. Vitamin A supplementation, therapeutic zinc supplementation with Oral Rehydration Salts, multiple micronutrient supplement powders); (ii) critical nutrition and health interventions for women (i.e. four antenatal care visits, four postnatal care visits, iron/folic acid supplementation, post-partum family planning, counseling on child care, complementary feeding and hygiene); (iii) improving water, sanitation and hygiene in health care facilities including through water treatment, safe water storage, and promotion of hygienic practices in health facilities; and (iv) improving linkages, referrals and counter-referrals between health facilities and the community. Health facilities will be held accountable to provide these interventions, as well as benefit from training, and commodities and logistical support from the national level. For nutrition referral centers, the project will aim to improve the quality of treatment for services provided at the regional and national levels. Through the ongoing PAPSS, incentives are provided to health workers/health facilities for nutrition service delivery at the facility level utilizing results based financing. The project will also support the training of Central Medical Stores (Centrale d'Achat des Medicaments et Matériels Essentiels) staff on nutrition supply management and improving the management of nutrition supply system.
- 21. Subcomponent 1.2: Prevention and management of stunting and wasting at the community level.** This subcomponent will support the delivery of health and nutrition services at the community level, as well as the critical element of community sensitization and promotion. This sub-component will be financed through an investment project financing (IPF) portion for Sub-component 1.2a and a results-based funding (RBF) portion using DLIs for sub-component 1.2b.
- 22. Subcomponent 1.2a Supporting behavior change and outreach at community level.** Through this portion of the subcomponent, financed through IPF, the project will: (i) Support behavior change, health promotion, and community mobilization and sensitization by utilizing a Behavioral Change Communication (BCC) strategy, that incorporates locally appropriate messaging on maternal nutrition, IYCF and WASH; (ii) Define a common community participation strategy between the different sectors and facilitate convergence of a multi-sectoral minimum package of services at community level; (iii) Utilize the positive deviance approach by identifying good practices from mothers in the community who have well-nourished children; (iv) Address the essential WASH elements by providing targeted support to vulnerable households to improve access to WASH interventions (i.e. water treatment, handwashing stations with soap and safe water storage); (v) provide adolescent girls with iron and folic acid supplementation; and (vi) increase the number of mobile clinics/teams and the number of visits they conduct to ensure rural and nomadic populations have access to health and nutrition services. The nutrition services offered by both the mobile clinics and the bi-annual medical caravans will be strengthened with support from the project.



- 23. In addition, this subcomponent 1.2a will support increased country-level awareness and action in nutrition through the formation of “nutrition committees” that will be provided with training and communications materials.** These committees are not only key in making the invisible problem of stunting visible at the community level but also for the integration of nutrition in health and WASH activities and policies, and for collecting data on nutrition issues. A mechanism for citizen engagement will also be developed to facilitate the feedback of the beneficiaries on the quality and appropriateness of nutrition services delivered at the community level.
- 24. Subcomponent 1.2b Strengthening the role of community health workers.** Through this portion of the subcomponent, financed through results based financing (DLIs), the project will train, mentor, equip and incentivize CHWs and community volunteers to identify, refer and follow-up on children at-risk of stunting. MOH has an existing cadre of CHWs that will be supported through the project to play an enhanced role in community outreach that is critical for the behavior change needed to prevent and reduce stunting.
- 25. CHWs and other community health actors, including *mères conseillères* and community health volunteers, are a critical link in improving access to health and nutrition services in Djibouti.** This subcomponent will support increased productivity and performance of CHWs through enhanced training, improved supervision and mentorship, new and innovative technologies to enhance their effectiveness and strengthen links between the community and health facilities, and strengthening of the commodity supply chain. The DLI (#1) - “1A-Number of women referred by community health workers and **registered** at the health facility within the first 4 months of pregnancy; 1B-Number of women referred by community health workers who **completed at least 3 antenatal visits** at the health facility; and 1C-Number of women referred by community health workers who **completed at least 2 postnatal visits** at the health facility” (total DLI value = \$1.45 million) are proposed to revitalize the CHW program and promote expedited progress in the implementation of community-based interventions by CHWs that are important for stunting reduction in the first 1000 days. CHWs will provide supportive supervision and ensure technical quality of community based nutrition interventions including the work of *mères conseillères* and being the linkage between the community and the health facilities. CHWs are salaried MoH staff who work in a catchment area of a health facility, while *mères conseillères* are volunteers and they interface directly with households at the community level and the ones supported by the Bank’s Social Safety Net project receive food rations. One CHW will have several *mères conseillères* working in their intervention area that they would provide support to.
- 26. Component 2: Strengthening Multi-sectoral Interventions for Stunting Reduction.** This component will focus on creating an enabling environment for strengthening multi-sectoral interventions that are critical for reduction on stunting.
- 27. Subcomponent 2.1: Using multi-sectoral platforms for the prevention and management of stunting.** Under this subcomponent a mass media and Behavioral Change Communication (BCC) strategy will be developed (informed by KAP surveys and stakeholder consultations) to facilitate the development of locally appropriate stunting prevention messaging, including the consumption of fish which is a good source of protein but is not widely consumed in Djibouti. Additionally, this component seeks to ensure linkages with the WB Djibouti Crisis Response Social Safety Net Project and PRODERMO when conducting follow-up of stunting cases, case management, and prevention.



- 28. Subcomponent 2.2: Addressing stunting in relevant policies and strategies.** This subcomponent will support and engage the line ministries involved in the multi-sectoral response to create an enabling environment for stunting prevention. The line ministries will be supported to formulate or update their policies, strategies, norms, guidelines and protocols to facilitate an enabling environment for the implementation of multi-sectoral nutrition interventions.
- 29. Subcomponent 2.3: Multi-sectoral capacity building.** To strengthen the capacity of sectoral institutions to deliver nutrition interventions, this subcomponent will complement and scale-up ongoing initiatives under the National Nutrition Program, including technical assistance, training, coordination, supportive supervision, and associated materials to build the capacity to deliver multi-sectoral nutrition services to communities; as well as focus on improving the capacity at all levels (national, regional, health facilities, etc.) to address the multi-sectoral nature of stunting. As a first step, a gap analysis will be undertaken to identify capacity needs at a national, regional and facility level to ensure effective targeting of the support provided through the project. Specifically, the subcomponent will: (i) Support multi-sectoral coordination at political and technical levels; (ii) Strengthen the leadership and capacity of the MoH national and regional nutrition programs so as to more effectively play a coordination and facilitation function; and (iii) Support the development of a National Nutrition and Food Authority (NNFA) that will aim to strengthen the capacity of key stakeholders involved in the delivery of nutrition services including health professionals and organizations/associations working at the community level.
- 30. Component 3: Strengthening Coordination, Project Management and Monitoring and Evaluation (M&E).** The activities under this component support and complement the interventions under Components 1 and 2, aiming to improve the capacity of national implementing entities to effectively manage the project implementation, coordinate various entities, and monitor the implementation progress and evaluate effects of the project. This component will be financed through an investment project financing (IPF) portion for Sub-component 3.1 and an RBF portion using DLIs for sub-component 3.2.
- 31. Sub-component 3.1: Institutional strengthening for coordination, project management and M&E.** This IPF-financed sub-component will support: (i) the day-to-day management of project activities including fiduciary activities; (ii) technical assistance and capacity building activities to support the implementing entities; (iii) building capacity for programmatic mapping including geospatial mapping for strategic planning and to identify gaps in service provision (see Box 1 below); and (iv) M&E activities such as periodic surveys, nutrition surveys and assessments, and impact evaluations to draw timely lessons on what works, how much it costs, and how it can be scaled up, and monitor implementation progress and address any implementation challenges.
- 32. Sub-component 3.2: Strengthening the use of information systems for enhanced M&E capacity.** This DLI-financed sub-component will support the development, promotion and use of information systems to identify, refer and track children and women, early malnutrition detection, as well as ensure the correct structures and systems are in place to implement and monitor nutrition interventions. The DLI #2 - "Percentage of health facilities that have annual disaggregated data using the District Health Information System (DHIS2)" (total DLI value = \$0.5 million) is proposed to accelerate progress in this area, the achievement of which will lead to transformational change for Djibouti. This will be important for (i) the project both in terms of the application of technological solutions for beneficiary tracking and monitoring as well as timely availability of data from both health facility and community levels; and (ii) strengthening the



health system more broadly. As part of the effort to improve the health information system, the existing disease surveillance mechanism will also be strengthened to capture any early warnings for possible consequences of climate change, such as extreme temperatures and drought which have been identified as having high potential impact on the project implementation.

- 33. Component 4: Contingent Emergency Response Component (CERC).** A CERC will be included under the project as a US\$0 component, in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact with public health consequences.
- 34. An “Emergency Response Operational Manual” (EROM) will be prepared as part of the Project Operational Manual (POM).** Triggers for the CERC will be clearly outlined in the EROM acceptable to the World Bank. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this activity will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made.

E. Implementation

Institutional and Implementation Arrangements

- 35. Institutional arrangements for the National Program on Nutrition.** Given the importance of the nutrition agenda in Djibouti, a National Council on Nutrition (NCN) composed of all the sectors involved in the agenda will be created. The establishment of the NCN was a key recommendation following the elaboration of the 2018 strategy to address prevention of the different forms of malnutrition, and emanated from the need to have a multi-sectoral coordination mechanism at the highest level. The NCN will be composed of several ministries (Ministry of Health, Ministry of Agriculture, Ministry of Education, Ministry of Commerce, Ministry of Women and Family, and State Secretariat for Social Affairs), with representation at the Ministerial level, and they will meet twice a year to review progress and national targets on the nutrition agenda. The focus of the NCN will be to review targets and progress made with respect to the different types of malnutrition.
- 36. Implementation arrangements for the project.** A Project Steering Committee (SC) chaired by the Secretary General of Health and comprising the following Secretary Generals of the following Ministries (Ministry of Agriculture; Ministry of Women and Family, and State Secretariat for Social Affairs) will be established. The SC will meet monthly during the first six months of project implementation, and every 3 months thereafter. The functions of the Steering Committee will be (i) project oversight, including provision of overall project guidance; (ii) approval of annual work plans and budgets; (iii) facilitation of coordination of project activities; and (iv) Preparation for the NCN Meetings that will be held every 6 months.
- 37. The project will be implemented by the National Nutrition and Food Authority in the MOH that will be formed on the basis of the current Nutrition Division** which is under the Department of Maternal and Child Health. The new NNFA will have a direct reporting line to the Minister of Health, and will ensure multi-sectoral coordination and action to address the different forms of malnutrition and in particular to prevent and reduce the high stunting rates in Djibouti. MoH has already appointed key technical staff (Director, and



staff responsible for M&E, social mobilization and communication) for the NNFA and they have been part of the Ministry's project preparation team. Fiduciary staff will be appointed by Negotiations. To achieve the PDO, a multi-sectoral response is required with the MoH leading the nutrition specific interventions and other Ministries (Ministry of Women and Family, Ministry of Agriculture; Ministry of Commerce; and the State Secretariat for Social Affairs) implementing nutrition sensitive interventions. In an effort to simplify implementation arrangements, and in recognition of the Djibouti country context, the MoH will be responsible for implementing activities based on its mandate and will also house the project management functions under the NNFA (playing the coordination role and being responsible for the day to day management of the project).

- 38.** The proposed arrangement would ensure that the nutrition program is integrated into the structure of the MOH. The NNFA will be headed by a Director who will also serve as the Project Coordinator who reports directly to the Minister of Health. The NNFA will manage the national multi-sectoral nutrition program and coordinate with relevant ministries and stakeholders, as well as be responsible for the effective implementation of the project. The NNFA will be responsible for carrying out the: (i) the administrative and financial functions, including financial management by a financial officer and project procurement by a procurement specialist; (ii) the technical functions that ensure the quality of the provision of nutrition services, the design of strategies for the promotion of adequate nutrition, the planning and organization of nutrition training, the monitoring and evaluation of all nutritional interventions, and the communication. The NNFA will monitor and evaluate the progress of the Project and prepare Project Progress Reports every semester, starting from effectiveness, and submit to the World Bank no later than one month after the end of the period covered by such report. The Progress Report will provide detailed reporting on project progress by components, procurement, financial management, verification reports received from independent verification and environmental and social issues. In addition, an annual external audit, combining both technical and financial audit components, will be conducted to ensure the appropriate use of funds and to monitor progress in the project activities.
- 39. Institutionalization of the project to ensure sustainability of the project.** During the identification mission, the Ministry of Finance and the MoH expressed a desire to have the project institutionalized within the existing Government structures and not to establish parallel structures, e.g. a Project Management Unit (PMU) staffed with consultants that cannot be sustained beyond the life of the project. Therefore, with the establishment of the NNFA within the MOH, the use of existing staff and the appointment of a few critical positions including both technical and fiduciary capacity will ensure institutionalization and sustainability of the program.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project will cover the whole country as stunting prevalence is high throughout the country. Prioritization and geographic targeting of specific areas within regions will be determined based on the SMART survey results and other surveys that provide disaggregated data on the prevalence of malnutrition including stunting as well as on the immediate, underlying, and basic causes of stunting. The project will be multi-sectoral in nature and will focus on improving the supply and quality of health and nutrition services at both facility and community levels, including increasing access to health interventions for women such as



antenatal and postnatal consultations, immunization, family planning services; combining monitoring of the healthy child and immunization with supplementation of vitamin A, micronutrients and deworming; increasing the number of mobile clinics and teams and the number of visits they conduct to ensure rural and nomadic populations have access to health and nutrition services; training and equipping community health workers (CHWs) to refer and follow-up at-risk or malnourished children and women; providing community-based screening for children and women; facilitating linkages, referral and counter referrals between the facility and the community. The WASH activities will comprise some facility and household level water treatment including the delivery of chlorine tablets; and improving access to soap and handwashing stations in rural areas.

G. Environmental and Social Safeguards Specialists on the Team

Antoine V. Lema, Social Safeguards Specialist

Mohamed Adnene Bezzaouia, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>The project is categorized as a B. Sub-Components 1.1 Strengthening of Health and Nutrition Services and 1.2 Prevention and Management of Stunting at the Community Level have the propensity to generate some Public Environmental, Health and Safety impacts resulting from the misuse of water treatment procedures or due to the medical waste generation from immunization activities.</p> <p>All the other funds will be allocated mostly for supporting the delivery and strengthening of health and nutrition services. Some minor renovation of existing buildings are also expected generating some minor occupational health and safety and environmental impacts essentially related to the management of non hazardous and hazardous solid wastes, generation of noise, fugitive dust and sanitary wastewater discharges. All these impacts are easily remediable and will be easily mitigated. An Environmental and Social Management Framework (ESMF) has been prepared since the</p>



exact localizations to be financed under components 1.1 and 1.2 are not known.

In addition to detailing the process for screening and implementation arrangements, the ESMF has included the following: (i) generic Checklist EMP for minor renovations/civil works; (ii) health care waste management plan; (iii) health and safety plan for water treatment to beneficiary populations; and (iv) equity issues in the social assessment, to address potential issues of social exclusion to the services provided.

The ESMF has developed a screening mechanism for activities resulting in Category A-type risks and impacts to be screened out, likewise to avoid project activities that may trigger OP 4.12.

The preliminary version of ESMF has been consulted with all stakeholders on April 18th and April 26th. Physical copies of the final version of ESMF will be made available in a location easily accessible to PAPs in addition to online disclosure.

The project includes activities that engage citizens through consultations to inform the design of the project, and community-level satisfaction surveys are planned during the life of the project as well as an impact evaluation.

The ESMF has been reviewed, approved, and disclosed in-country and on the external World Bank website on May 7, 2018.

Performance Standards for Private Sector Activities OP/BP 4.03	No	This policy is not triggered as the project will not involve work in the private sector.
Natural Habitats OP/BP 4.04	No	This policy is not triggered as the project will not involve work in natural habitats or protected areas.
Forests OP/BP 4.36	No	This policy is not triggered as the project will not involve work in forests or their rehabilitation nor will support other investments which rely on services of forests.
Pest Management OP 4.09	No	The project will not imply the use of pesticides or other related products.
Physical Cultural Resources OP/BP 4.11	No	The proposed operation will not involve works posing risks of damaging the existing community cultural property.
Indigenous Peoples OP/BP 4.10	No	Djibouti has no population that would qualify as indigenous people, as defined by OP 4.10. Project activities will therefore not affect areas inhabited by indigenous people.



Involuntary Resettlement OP/BP 4.12	No	The project is not expected to induce land acquisition. However, some minor renovation works of some existing facilities may be done.
Safety of Dams OP/BP 4.37	No	The project will not construct or rely on dams.
Projects on International Waterways OP/BP 7.50	No	The project will not affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project is not located in a disputed area.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

Sub-Components 1.1 Strengthening of Health and Nutrition Services and 1.2 Prevention and Management of Stunting at the Community Level have the propensity to generate some Public Environmental, Health and Safety impacts resulting from the misuse of water treatment procedures or due to the medical waste generation from immunization activities. Some minor renovation of existing buildings are also expected generating some minor occupational health and safety and environmental impacts essentially related to the management of nonhazardous and hazardous solid wastes, generation of noise, fugitive dust and sanitary wastewater discharges. All these impacts are easily remediable and will be easily mitigated.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
N/A

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
N/A

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

As the capacity of MoH is weak for E&S management aspects, a focal point to manage all E & S aspects will be appointed. This focal point will be in charge of the monitoring and the reporting related to the implementation of all mitigation measures linked to generic EMP checklist for minor renovations/civil works, to health care waste management plan and to health and safety plan for water treatment for beneficiary populations. The ESMF also provides a capacity building program for all stakeholders.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The key stakeholders are MoH staff and the population who will benefit from health and water treatment services in various localities targeted by this program. The generic EMP check list for rehabilitation works, Medical waste management plan and Health and Safety plan of water treatment for beneficiary populations will be consulted with direct beneficiaries before any project commencement. An understandable summary presenting the main risks



identified as well as the proposed mitigation measures will be made available to public by local display. The ESMF has been published on the MoH website, and other related documents will be as well.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 30-Apr-2018	Date of submission for disclosure 07-May-2018	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
--	--	--

"In country" Disclosure

Djibouti

07-May-2018

Comments

The final version of ESMF was disclosed on the MoH website.

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Yes

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes



All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

CONTACT POINT

World Bank

Elizabeth Mziray
Senior Operations Officer

Borrower/Client/Recipient

Ministry of Economy and Finance
Ilyas Moussa Dawaleh
H. E. Mr.
smibrathu@mefip.gov.dj

Implementing Agencies

Ministry of Health
Djama Elmi Okieh
H. E. Dr.
chehem@msn.com



FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Elizabeth Mziray
----------------------	------------------

Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Ernest E. Massiah	08-May-2018
Country Director:	Asad Alam	08-May-2018