Public Disclosure Authorized

Public Disclosure Authorized

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

Appraisal Stage | Date Prepared/Updated: 26-Feb-2019 | Report No: PIDISDSA25059

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Burundi	P165253	Investing in Early Years and Fertility in Burundi (NKURIZA)	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	14-Dec-2018	30-Apr-2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Public Health and Fight against AIDS	

Proposed Development Objective(s)

Increase the coverage of community based nutrition interventions among women of reproductive age and children under two and to increase utilization of family planning services in targeted areas

Components

Community interventions to increase coverage of nutrition services and utilization of family planning services
Strengthening institutions, leadership and monitoring
Contingency Emergency Response Component (CERC)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	30.00
Total Financing	30.00
of which IBRD/IDA	30.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	30.00

IDA Grant	30.00

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. **Burundi is a fragile country, affected by recurrent cycles of violence and political instability.** Burundi's decade of civil war and its long period of recurring political insecurity have resulted in stagnant economic development, increased poverty, displacement of the local populations, and destruction of existing infrastructure. Progress in the peace process and the 2000 signing of the Arusha Peace Accords ushered in a period of fragile political stability which was interrupted by the crisis resulting from the 2015 elections. After two years of contraction in 2015 and 2016, Burundi's economy returned to low but positive real growth in 2017, expanding by an estimated 0.5 percent. The suspension of external budget support, precipitated by the 2015 election crisis led to fiscal consolidation and increasing reliance on the Central Bank to finance the Government deficit. Foreign exchange shortages remain acute, leading to Government policies to ration supplies. Growth is projected to recover over the medium term, but the economy will remain at a low-level equilibrium. Real Gross Domestic Product (GDP) growth for 2018-2019 is projected at 1.5 to 2.5 percent[1].

2. **Poverty, food insecurity and land scarcity are major factors of fragility for the population.** Burundi has a total population of 11.4 million, predominantly rural (88 percent). Its GDP of $218 per capita (constant 2010 $) makes it one of the poorest countries in the world: close to 3 out of 4 Burundians are poor[2] and 3.6 million Burundians are in extreme poverty.[3] Burundi ranks 185 out of 189 countries in the 2017 Human Development Index. Burundi has the second highest density in Sub-Saharan Africa (410 inhabitants/ km²) [4] and structural problems of low access to land, loss of soil fertility, low yields, poor quality of production and food consumption, underlie the food stress recorded for almost 45% of the rural population.[5]

[1] World bank (2018) Macroeconomics, Trade and Investment Global Practice
[2] 72.9 percent live with less than US$1.9 per day
[3] World Bank (2016). *Burundi Poverty Assessment.*
[4] https://data.worldbank.org/indicator/EN.POP.DNST?locations=BI
[5] IPC in Burundi; ipcinfo.org

3. **Population growth constitute a major challenge for the country's economic development.** With a population growth rate of 3.1 percent, Burundi's population is expected to double every 21 years. The total fertility rate (TFR) of 5.5 children per women in 2016-17, a slight decrease compared to the 2010 level, is higher than the sub-Saharan Africa average (4.8 in 2016). Burundi's population is very young, with those under the age of 19 making up 55 percent of the population.[6] High fertility limits girls' education, and hence their workforce participation, leaving most women in the informal sector in lower productivity, wage, and low-skilled jobs that do not help realize the demographic dividend.

Sectoral and Institutional Context

4. **Burundi's development prospects are jeopardized by an alarming prevalence of stunting countrywide.**[7] Burundi has the second highest prevalence of stunting in the world (56 percent in 2016/17), which remained virtually unchanged over the last decade. Apart from the urban area of the capital, the prevalence of stunting is above 49 percent in all provinces. Stunting increases susceptibility to diseases and infections and results in cognitive delays in children, compromised learning, and losses in work productivity. Fetal growth restriction and preterm birth are the first cause of stunting in Burundi, followed by limited access to clean water sources, poor sanitation and personal hygiene as well as mother and child feeding and care practices.[8] High fertility rates, inadequate infant and child practices, and increasing strain on natural resources hinder the ability to meet the nutritional needs of children. Childhood stunting rises with birth order: among the poorest households, stunting rates increase from 59 percent for the first birth to 68 percent for the third birth. There is also an inter-generational cycle of malnutrition: stunted mothers are more likely to have stunted babies; young mothers under 20 are also more likely to have low-birth weight babies (14 percent in 2010) compared to mothers aged 20-34 (10 percent).

5. **Burundian women face multiple and mutually reinforcing constraints on women's agency, which directly or indirectly affect their childbearing patterns and ability to ensure survival of their children.** Women have limited economic opportunities and low control over domestic resources within the household. Women who report participating in three or more household decisions in Burundi are more likely to use family planning (FP) than those who do not. Higher level of education of mothers is also associated with greater autonomy, delayed marriage, lower demand for children, and improved child health.[9] The prevalence of girls between 15-19 years of age being mothers or pregnant with their first child remains low relative to regional peers at 8.3 percent. Early birth increases risks of delivery complications and low birth weight (thus increasing the risk of a child being stunted); it also limits prospects for further education or for engaging in high value employment.

6. **High levels of childbearing stem primarily from high rates of marital fertility and low levels of contraceptive use.** Modern contraceptive prevalence increased only from 18 to 23 percent between 2010 and 2016-17. Stated ideal family size declined from 5.3 in 1987 to 4.2 in 2010, with virtually a one child

[6] http://hdr.undp.org/en/countries/profiles/BDI

[7] Stunting is defined as the percentage of children, aged 0 to 59 months, whose height for age is below minus two standard deviations (moderate and severe stunting) and minus three standard deviations (severe stunting) from the median of the WHO Child Growth Standards.

[8] Danaei, G., Andrews, K. G., Sudfeld, C. R., Fink, G., McCoy, D. C., Peet, E., ... & Fawzi, W. W. (2016). Risk factors for childhood stunting in 137 developing countries: a comparative risk assessment analysis at global, regional, and country levels. *PLoS medicine*, *13*(11), e1002164.

[9] World Bank (2018). *Demographic Challenges and Opportunities in Burundi* (Unpublished). Washington, D.C.: World Bank Publications.

difference between ideal size of the poorest in comparison to the best off. As FP services at health facility level are available[10], the large unmet needs suggest the existence of social, cultural and economic barriers. In Gitega, religious factors were found to be the primary cause of under-utilization of FP.[11] Unmet need for FP also varies according to the level of education (32.5 percent for women with no education against 20.2 percent for women with secondary education) and wealth (30.8 percent in the poorest quintile against 25.4 in the richest).

7. **The national introduction of free maternal and child health services and performance-based financing (PBF) resulted in considerable improvements in access to care but in lower than expected gains in mortality reduction.** Institutional deliveries increased drastically from 31.8 percent in 2005 to 85 percent in 2016-17 but mortality remains high, due to high fertility[12]. Under-five mortality was estimated at 78/1000 and the maternal mortality ratio at 392/100,000 in the recent 2016-17 DHS.

8. **Key indicators for early children development, which are related to households' behavior and practices, are lagging behind and are not experiencing progress overtime.** Only 10 percent of children 6-23 months consume a minimum adequate diet in 2016-17 compared to 9 percent in 2010; only 5 percent of households use soap for handwashing and a large majority of households have no access to improved latrines. Early stimulation programs for children under 3 are not supported by the GoB and early learning programs for children aged 3-6 years old are only accessible to 12.6 percent of the target population.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

Increase the coverage of community based nutrition interventions among women of reproductive age and children under two and to increase utilization of family planning services in targeted areas

Key Results

9. **The project aims to address the high stunting prevalence in the country doubled with high fertility.** This dual problem affects children's chances to reach their full potential and to contribute to economic growth and prosperity in Burundi.

10. **The overarching expected impact is to reduce demographic pressure and for children to reach their full potential through optimized healthy growth and improved childhood environment.** The Nkuriza project aims to reduce demographic pressure through increased coverage of FP services at community level, revamped and strengthened behavior change and communication strategy and dialogue with Catholic authorities to address cultural/social barriers to FP. The Nkuriza project also aims to support a shift in approaches by turning the focus of the GoB from managing acute malnutrition to preventing stunting at the community level. The project will optimize child growth through: improved community nutrition service delivery approach; social and behavior change at the community level;

[10] The SARA survey reported that in 2017 FP services were available in 74 percent of facilities and their overall operational score was 86 percent.
[11] In Gitega, under-utilization of contraceptives was found to be due to sanctions inflicted by faith leaders to couples using modern contraceptives methods and to the lack of explanation of possible side effects. In Yadufashije, C., & Ndayizeye, A. (2017). The factors of under-utilization of family planning services by the population of Gitega health District in BURUNDI, in 2015.
[12] FP is the primary prevention of maternal mortality as the fewer women are pregnant, the less risk of dying in pregnancy and childbirth; risks of delivery complications are also greater with short birth spacing and early pregnancy.

improved household feeding practices and child environment, including better access to quality nutritious foods as well as to water, hygiene and sanitation.

D. Project Description

Component 1: Community interventions to increase coverage of nutrition and family planning services

Sub-Component 1.1: Nutrition specific and nutrition sensitive interventions

11. **The objective is to improve demand for and utilization of essential services known to improve nutritional status of children under-two by integrating community-based interventions related to maternal health, nutrition (specific and sensitive) and early stimulation.** This component will build on existing and adapted community-led approaches to develop the demand-side. Engaging and empowering communities will be key to promote utilization of services and adoption of adequate behaviors for child development. The children under two related services will be on child growth promotion and cognitive development, infant and young child feeding practices, management of childhood illness and acute malnutrition at community level, while the pregnant and lactating women will be sensitized to use antenatal and post-natal services and will benefit from counseling and nutrition education. The existing CHW will be the entry point allowing the expansion of the community-based service delivery platform with high impact interventions on pregnant and lactating women as well as children under-two. The health system (health center level) will support community-level service delivery by providing training and supervision to community actors. This sub-component will also build on the community-based approach to implement nutrition sensitive interventions targeting the most vulnerable. The nutrition sensitive interventions will focus on household food security and access to safe water and sanitation.

Sub-Component 1.2: Family planning and reproductive health services

12. **The objective is to address the demand side barriers of FP to reduce fertility rates in Burundi**. Persistent high levels of fertility imply a high rate of population growth and therefore a higher number of stunted children. In turn, high levels of childbearing impede on women's ability to ensure good nutritional status of their children. Burundi benefits from a rather satisfactory supply of contraceptives as illustrated by the 2017 SARA survey which reported that FP services are available in 74 percent of facilities; their overall operational score is 86 percent. The large unmet need for FP and still low contraceptive prevalence thus suggest persistence of demand side barriers, including cultural and social norms, that this sub-component aims to tackle. The Project will support a health facility active approach and Community Based Family Planning delivery; quality improvement of FP services; development of culturally appropriate, sensitive approaches; and support to governance and leadership.

Sub-Component 1.3: Social and behavior change communication activities

13. **Social and behavior change (SBC) communication is central to the success of community level interventions supported by the Project.** The objective of this sub-component is to change people's behaviors through educating the community on benefits of birth spacing, as well as on good nutrition practices for mothers and children to prevent stunting and ensure health growth of children. Community members will be mobilized around community-level delivery platform. All community initiatives supported by the Project will also be accompanied by enhanced SBC communication around nutrition and fertility.

Component 2: Strengthening institutions, leadership and monitoring

Sub-component 2.1: Strengthening institutions and capacities

14. **This component aims to enhance national capacities for stewardship and coordination of strategies, policies, programs and projects related to nutrition and demographic issues**; to support the development and implementation of a strong communication strategy and promote stronger leadership on nutrition and demographic issues; to build and strengthen capacities to implement the project and the Government's strategies related to nutrition and demography; and to ensure adequate resources and means for project management. Four main areas will be supported through this sub-component to strengthen the Government's stewardship, leadership and coordination functions: (i) governance structure and management of nutrition; (ii) capacity building; (iii) communication; and (iv) building evidence.

Sub-component 2.2: Monitoring, evaluation and project management

15. The Project will support supervision, coordination and oversight of project's activities. It will support day-to-day management of project activities by the Project Technical unit and Provincial Project Coordinators including fiduciary aspects.

E. Implementation

Institutional and Implementation Arrangements

16. **The institutional, implementation and coordination arrangements for the project will be anchored on existing platforms adapted to reflect the need for a multisectoral approach:**

(a) General *Directorate of Health Services and HIV/AIDS of the Ministry of Health:* As for KIRA, the MoH will ensure oversight and coordination of the project.

(b) *Memorandum of Understanding between MoH and other line ministries:* As the project is multisectoral by nature, the MoH will sign MoUs with other participating line ministries, namely the ministry in charge of agriculture and livestock, the Ministry in charge of local development and home affairs, the Ministry of Education and the Ministry in charge of Gender. Signing participating line ministries will be responsible for planning and budgeting annually project's interventions within their scope of expertise and responsibility.

(c) *Project Technical Unit (PTU)*: The existing PTU within the MoH will be responsible for day to day project management. The team will be strengthened and high-level technical experts in nutrition, FP, agriculture, WASH, SBC, monitoring and evaluation, accounting and financial management will be recruited. In addition to technical oversight, the PTU will handle fiduciary functions: (i) financial management, including flow of funds to different stakeholders; (ii) procurement of goods to ensure economies of scale and efficiencies; (iii) securing consultant services; and (iv) oversight of safeguard provisions. A technical resource person with track

record on nutrition sensitive interventions will be recruited and appointed in the ministry in charge of agriculture and livestock to support the latter in carrying out identified activities in this specific sector and to work directly with the PTU.

(d) *Project Implementation Manual (PIM):* the PTU will elaborate a PIM with guidance from the Multisectoral Steering Committee (see below) and in close collaboration with the Reproductive Health National Program (PNSR), the National Integrated Program on Nutrition and Food (PRONIANUT) and the Directorate in charge of community health and WASH (DPSHA) along with technical resource persons from participating line ministries.

(e) *Multisectoral Steering Committee (SC*): A SC, based on the SUN platform with participation of all relevant stakeholders (line ministries, Civil Society Organizations/CSOs, development partners) will be constituted to provide guidance to the PTU, monitor progress towards project objectives and facilitate dialogue with participating stakeholders at all levels**.** The SUN Focal Point will chair the SC. The SC will validate the project's action plan, the project's key reference documents (PIM, Annual Work Plan and Budget/AWPB, etc.) as well as monitor and supervise project's implementation.

(f) *Multisectoral Technical Committee (TC):* A TC will be created and will meet monthly to discuss progress, identify challenges, and develop mitigation measures. It will constitute an inter-ministerial body comprising representatives with technical profile from participating line ministries and key development partners involved in nutrition and demographic issues. This TC will handle issues related to nutrition and FP for the project as well as other projects supported by other development partners to facilitate coordination, harmonization of approaches and institutionalization of the TC.

17. **Province level implementation:**

(a) *Provincial Project Coordinator (PPC):* The PTU will recruit a PPC in each province. The PPC will compile and coordinate execution of action plans by the IA within the province. The PPC will report to the provincial platform and to the PTU.

(b) *Implementing Agencies (IAs):* IA will be recruited at provincial level to develop and implement interventions at provincial level and below and in close collaboration with provincial entities of participating line ministries to coordinate all project activities, including SBC, at communal and community levels. IAs can be NGOs or Associations with recognized capacities of implementing community-based interventions at a province level. IAs will report to the PPC.

18. **Community level implementation.** The Project will follow the administrative structure from the commune to the communities to facilitate its implementation. Following the commune, the entry points will be the *colline* and the *sous-colline*. Within the six targeted provinces, the project will cover 620 *collines* and 1933 *sous-collines*.

(a) Local Steering Committees (LSC): LSC will be set up on each *colline* (commune subdivision) building on community dynamics with representation of different segments of the community. The LSC will support and oversee service delivery under the project by supporting the planning process for the different activities at the community level; organizing periodic restitutions to the stakeholders to support continuous performance in the service delivery; and ensuring community mobilization and participation in the different activities.

(b) Community actors: Community actors, such as CHW, Mamans Lumiere and agricultural community actors will carry out activities at the community level.

(c) Implementing Agencies: IA will ensure oversight and supervision of community actors. As the

project promotes a participatory approach, IAs will be requested to propose innovative methods to ensure community involvement and ownership, thus ensuring sound strategies for sustainable community engagement.

(d) Communities: The communities at village level will be asked: to identify and enroll the MLs who are key service delivery; facilitate the services delivery (affecting a suitable place for activities); support the delivery system actors to resolve arising issues.

.

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

The main project beneficiaries will consist of children under-two and women of reproductive age in 6 provinces (Bubanza, Cankuzo, Cibitoke, Kirundo, Makamba and Muyinga) to reach them in the critical 1,000-day window of opportunity, as most cognitive and physical development occur between conception and two years of age. Interventions related to FP will focus on both women of reproductive age and men. Other beneficiaries will include adolescent girls to reach women early and to improve their health and nutrition status prior to entering their reproductive health years. The poorest households will benefit from improvements in access to water, hygiene, sanitation and small-scale agriculture interventions.

G. Environmental and Social Safeguards Specialists on the Team

Tracy Hart, Environmental Specialist
Felipe Jacome, Social Specialist
Peter F. B. A. Lafere, Social Specialist
Alexis Manirambona, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	OP 4.01 Environmental Assessment is applicable to this project, which is assessed as an environmental category "B", with limited, temporal, and reversible impacts. Interventions will include backyard/community gardens, small livestock husbandry, use of improved seed varieties and animal stocks, food conservation and transformation technologies, accompanied by enhanced social and behavior change communication. This sub-component will also promote access to safe water

		and sanitation, as well as good hygiene practices. Technical support will be provided to the service delivery providers at central and local level to plan for and implement pro-nutrition activities and enhance their role in promoting healthy growth and good nutrition in women and children. Typical expenditures in this sub component refer to community grants. The limited negative environmental impacts to be generated by these interventions include the generation of wastewater and medical wastes, worker health and safety, and community health and safety. These impacts will be identified, managed, and mitigated through an Environmental and Social Management Framework (ESMF), which includes a Medical Waste Management Plan (MWMP). The project-specific MWMP draws from Burundi's national MWM guidelines.
Performance Standards for Private Sector Activities OP/BP 4.03	No	This project is not working with private sector entities.
Natural Habitats OP/BP 4.04	No	This policy is not applicable. Land use for small livestock husbandry and vegetable gardening will be allocated within existing household and village boundaries.
Forests OP/BP 4.36	No	This policy is not applicable. Land use for small livestock husbandry and vegetable gardening will be allocated within existing household and village boundaries.
Pest Management OP 4.09	No	Although improved seed varieties will be introduced, there will be no purchase or use of chemical pesticides.
Physical Cultural Resources OP/BP 4.11	No	This policy is not applicable. Land use for small livestock husbandry and vegetable gardening will be allocated within existing household and village boundaries.
Indigenous Peoples OP/BP 4.10	Yes	OP 4.10 is triggered given that the Project will include the indigenous Batwa community of Burundi. Through a Social Assessment, it was estimated that there are approximately 30,833 Batwa families present in the project area in the provinces de Bubanza, Cibitoke, Makamba, Muyinga, Kirundo et Cankuzo. On the base of free, prior, and informed consultations with authorities and civil society at the national and provincial level, an Indigenous Peoples Plan was developed to assess

		the impact of the Project on the Batwa population, set out measures to avoid any negative impacts, and establish a specific strategy to deliver project benefits to the Batwa population. The plan has been disclosed on the Bank website and on the site of the MoH.
Involuntary Resettlement OP/BP 4.12	No	This policy is not triggered as the Project does not include any works that could cause affectations to beneficiaries' land, structures, or economic livelihoods.
Safety of Dams OP/BP 4.37	No	This policy is not applicable to this project.
Projects on International Waterways OP/BP 7.50	No	This policy is not applicable to this project.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not applicable to this project.

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:
This overall project is classified as a category "B" given that activities are not expected to produce any large-scale, significant, and/or irreversible impacts.

The proposed activities will include community gardens, small livestock husbandry, use of improved seed varieties and animal stocks, food conservation and transformation technologies, accompanied by enhanced social and behavior change communication. The project will also promote access to safe water and sanitation as well as good practices. Technical support will be provided to service delivery providers at central and local level to plan for and implement pro-nutrition activities and enhance their role in promoting healthy growth and good nutrition in women and children. The limited negative environmental impacts to be generated by these all interventions include the generation of wastewater and medical wastes, worker health and safety, and community health and safety.

Batwa population is present in the project intervention area. Based on their extreme levels of poverty and lack of assets, it is possible to infer that they generally suffer from particularly high levels of malnutrition, stunting, infant and maternal mortality, as well as fertility. The project is designed to ensure the social inclusion of vulnerable groups, and has consulted with national Batwa organizations to ensure that Batwa can participate in and benefit from the project.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Project activities tackling high fertility, stunting, and malnutrition have overwhelmingly positive impacts. Interventions including backyard/community gardens, small livestock husbandry, use of improved seed varieties and animal stocks, food conservation and transformation technologies, and promotion of access to safe water, sanitation, as well as good hygiene practices are not expected to have indirect or long-term impacts.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
No specific project alternatives were considered during preparation of the project. However the project is based on previous interventions in country, and is designed to ensure lessons are learnt and considered prior to committing to further investments in a possible subsequent phase of the project. This also applies for the Project´s activities with the Batwa, in which regular consultations will ensure the delivery of project benefits to this population.

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.
An ESMF/ FMWMP and IPF have been prepared by the Client and remain to be disclosed before the Project Appraisal The project has already developed safeguards instruments such as an Environmental and Social Management Framework as well as a Medical and Fecal Waste Management Plan (ESMF / MFWMP) to guide the elaboration of mitigation measures. The MoH has an environmental health and safety unit that can follow and manage environmental impacts and risks during the project implementation. This unit has previously prepared similar documents on environmental safeguards that include environmental impact assessment and mitigation practices as well as international standards through Kira Project. The impacts have been identified through an Environmental and Social Management Framework (ESMF), which include a Fecal Medical Waste Management Plan (FMWMP). The project-specific FMWMP was drawn according Burundi's national MWM guidance.

An Indigenous Peoples Plan was developed to assess the impact of the Project on the Batwa population, set out measures to avoid any negative impacts, and establish a specific strategy to deliver project benefits to the Batwa population. The Project will also develop a functional Grievance Redress Mechanism (GRM) to collect citizens' feedback and address grievances. This will be carried out through regular forums/consultations at the colline level. Project field offices will also receive and record grievances and inquiries received. Those grievances that cannot be resolved at the local level will be channel to the PIU for follow up. Grievances received will be analyzed and reported regularly in order to improve the services delivered by the project. The GRM mechanism will be extended to the Batwa population through a process of regular consultations set out by the IPP.

The Ministry of Health has demonstrated ability to comply with Burundi national laws and World Bank and safeguards policies in previous health interventions. The Project team counts with 2 dedicated safeguards experts to address project environmental and social impacts, respectively. The Project will hire an NGO/Implementing Agency (IA) for the implementation of Project activities on the ground. The NGO will implement the recommendations formulated in the IPP to deliver Project benefits to the Batwa population.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The national level key stakeholders include the PTU within the MOH and a Multisectoral Steering Committee and Technical Committee (comprised of line ministries, Civil Society Organizations/CSOs, provincial authorities, and development partners). At a subnational level the stakeholders include Multisectoral Provincial Plaforms, the IA, local authorities at the province/commune, and hill level, and health workers, and the general population of the provinces targeted by the Project.

Project activities and safeguards instruments were consulted at the national and provincial levels and will be disclosed after finalization. Specifically, the Indigenous People Planning Framework was consulted at the national level with line ministries and civil society including UNIPROBA (Unissons-nous pour la Promotion des Batwa) and at the province level with administrative and health representatives (COSA et ASC, conseiller communaux et collinaires, etc). Following the

IPP, the IA will maintain a constant consultation process with the Batwa population to ensure that they benefit from Project activities.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors

"In country" Disclosure

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure

"In country" Disclosure

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?

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

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

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?

If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?

If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?

The World Bank Policy on Disclosure of Information

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

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?

All Safeguard Policies

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

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

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

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

CONTACT POINT

World Bank

Laurence Elisabeth Marie-Paule Lannes
Sr Economist (Health)

Alain-Desire Karibwami
Senior Health Specialist

Borrower/Client/Recipient

Ministry of Finance
Desire Musharitse
Responsible for planning and ME
mushdes@yahoo.fr

Implementing Agencies

Ministry of Public Health and Fight against AIDS
Thadée Ndikumana
Minister of Health
ndikumanathaddee@ymail.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):	Laurence Elisabeth Marie-Paule Lannes Alain-Desire Karibwami

Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Evelyn Anna Kennedy	27-Feb-2019
Country Director:	Nestor Coffi	28-Feb-2019

Note to Task Teams: End of system generated content, document is editable from here. ***Please delete this note when finalizing the document.***