



Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 24-Mar-2018 | Report No: PIDISDSC22744



BASIC INFORMATION

A. Basic Project Data

Country Djibouti	Project ID P164164	Parent Project ID (if any)	Project Name Towards Zero Stunting in Djibouti (P164164)
Region MIDDLE EAST AND NORTH AFRICA	Estimated Appraisal Date Apr 20, 2018	Estimated Board Date Jun 28, 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 contribute to the reduction in stunting among children under 5 by expanding the coverage of multi-sectoral interventions proven to reduce stunting.

Financing (in USD Million)

Financing Source	Amount
International Development Association (IDA)	15.00
Total Project Cost	15.00

Environmental Assessment Category B-Partial Assessment	Concept Review Decision Track II-The review did authorize the preparation to continue
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Other Decision (as needed)

B. Introduction and Context

Country Context

- 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 percent in 2016, and the inflation accelerated up to 3.5 percent in 2016 from 2.6 percent in 2015, spurred mainly by demand for housing and services.

2. **Djibouti remains a fragile state and faces serious obstacles to poverty reduction and improved health of its population.** In 2013, an estimated 40.7 percent of Djiboutians lived in poverty, consuming less than DJF 117,134 per capita per year or US\$2.98 per day (2011 PPP). In the same year, 23 percent of Djiboutians lived in conditions of extreme poverty spending less than DJF 78,157 per capita per year 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 percent in 2015 according to official estimates; the rate is higher among women (49 percent) and in rural areas (59 percent).
3. **Limited arable land and limited rainfall have had adverse effects on livelihoods including contributing to high levels of food insecurity.** The location of Djibouti means also an arid desert climate, high temperatures all year round, prolonged droughts, and limited rainfall, limited arable land, and a scarcity of ground water. Agriculture is almost nonexistent, accounting only for about 3 percent of GDP and 2 percent of employment. The country relies heavily on food imports, imports of manufactured goods and energy products. The recent prolonged drought in Djibouti exposes at least 20 percent of the population in Djibouti city and 75 percent of rural households to food insecurity.
4. **A key factor behind the limited transmission of growth to prosperity and poverty reduction is the accompanying rise in inequality which increased in Djibouti between 2002 and 2017. Inequality, poverty and food insecurity lead to a multitude of challenges, with childhood malnutrition being particularly damaging.** Despite improvements in the last 20 years in the 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 (2013-2017) set an ambitious agenda for improving the standard of living.** Through Vision 2035, the Government of Djibouti 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 strategy 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. **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 and maternal mortality ratio (MMR) remain higher than those of not only economically comparable nations but also the countries within Djibouti's geographic region.² The MMR, although decreasing, is still estimated at 229 per 100,000 live births (2012), markedly higher

¹ IFPRI. 2017. Global Hunger Index.

² Ibid.



than the target of 185 that was set for 2015.³ The data are indicative of the challenges that remain in improving access to and quality of obstetric and neonatal care. Only 23 percent of women receive four or more antenatal care visits, and only 54 percent of women receive any form of postnatal care.⁴ At the same time, although infant mortality decreased from 71.7 in 2005 to 54.2 in 2015 the rate remains high.⁵ Maternal and infant malnutrition are the number one cause of death and disability in Djibouti⁶. Wasting, diarrheal disease due to poor access to quality water in rural areas, and acute respiratory infections associated with stunting are the most common causes of morbidity and infant mortality.

- 7. Chronic malnutrition (stunting) rates in children remain unacceptably high in Djibouti.** Stunting is an urgent nutrition and human development problem in Djibouti, affecting over 30,000 children (30% of children under 5). Stunting rates have remained relatively unchanged and between 2002 and 2013 increased by 3 percentage points, with an annual average rate of reduction of negative 2.2%. 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 13.2% 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.
- 8. Acute malnutrition (wasting) rates in children are very high and far exceed the World Health Organization's threshold of concern.** Wasting remains high at 22% among children under 5, and 5.7% of children are severely wasted. Djibouti has the second highest wasting prevalence rates globally, after South Sudan (23%)⁸. Given the direct link between wasting and child mortality, the high rates of wasting in children under 5 signal a critical situation requiring an urgent response (wasting prevalence rates above 15% are classified by WHO as being critical levels of public health significance⁹).
- 9. Stunting and wasting are national issues for all areas and wealth quintiles, with higher proportions of poor and rural populations affected.** Despite having one of the highest proportion of urban population among the LMI countries in MENA and SSA (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 percent of the population as compared to the richest (37.2% vs. 18.2%).
- 10. It is estimated that globally one-third of perinatal deaths and one-tenth of maternal mortality are attributable to iron deficiency anaemia and anaemia 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

³ Ibid.

⁴ Ministry of Health Djibouti - Statistics and Studies Department, and Pan Arab Project for Family Health. 2012. Djibouti Family Health Survey.

⁵ Ibid.

⁶ Institute of Health Metrics and Evaluation. 2016 Djibouti Country Profile.

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

⁸ UNICEF. State of the World's Children. 2016

⁹ WHO. Nutrition Landscape Information System (NLIS) country profile indicators: interpretation guide. 2010



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, while 58% of children under five suffer from Vitamin A deficiency.

- 11. According to a contextual analysis conducted by the Ministry of Health (MoH) in 2014, and presented during the identification mission, the underlying determinants of stunting include poor infant and young child feeding (IYCF) practices, environmental health and food insecurity.** In addition, access to and utilization of essential health services are constrained by both supply and demand side barriers. Community-based interventions are essential for promoting nutrition knowledge and behaviors as well as for increasing demand for essential services, but currently there is no coherent strategy to deliver such interventions nationwide. 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. The nutrition referral centers/hospitals at the national and regional level have the capacity to 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.
- 12. All of 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.** Health care workers (HCW) have limited training in nutrition and therefore are unable to encourage necessary behavior changes essential to improving nutrition outcomes. CHWs are working in the health facilities instead of working in the community, filling the gap due to insufficient number of HCWs in the health facilities. In addition, convergence of multi-sectoral efforts - e.g., health, agriculture, food security, nutrition, WASH, early stimulation, social protection – is suboptimal. 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.
- 13. On the demand side, socio-cultural beliefs and practices, geographic and financial impediments including long distance to facilities, and general high levels of poverty and vulnerability all impede demand for health and nutrition services and behavior change that lead to favorable nutrition outcomes.** For example, while 88% of women aged 15-49 years had at least one visit with a skilled health professional during pregnancy, less than a quarter (23%) complete all four World Health Organization (WHO) recommended antenatal care visits. In rural areas, the distances to health care facilities and the poor condition of roads mean that the time, effort, and cost required to arrive at the point of delivery can be substantial.
- 14. The presence of refugees and migrants has created additional pressure on infrastructure and further stretched the limited capacity 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. The camps and GAM rates are as follows: Ali Adehh (5.6% GAM); Holl Holl (11.9% GAM); and Obock



(17.6% GAM). Obock, the region with the highest malnutrition rates (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 and extreme poverty to seek asylum in Djibouti or to transit through Djibouti to the Gulf countries in search of better living conditions.¹⁰ According to the United Nations, more than a quarter of a million people needed humanitarian assistance in Djibouti in 2017, which includes Djiboutians living in extreme poverty, refugees and asylum-seekers as well as migrants.

- 15. The Government of Djibouti has demonstrated its commitment to improving nutrition by adopting the new strategy for preventing all forms of malnutrition and instituting national policies and initiatives; however, more is needed to translate these into action.** In 2006, a National Nutrition Policy (2008-2012) was developed to guide government actions in nutrition and in 2012, the Social Safety Nets Strategy (2013-2017) was adopted. The latter emphasizes the importance of a long-term, development-oriented approach integrating different forms of social assistance through a national, nutrition-based program. Recently in early 2018, the strategy for preventing all forms of malnutrition was developed with a focus on the first 1,000 days of life from pregnancy through the first 2 years of a child's life. Ongoing challenges include: inadequate numbers and poorly distributed human resources; 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. Specifically, poor managerial capacity for coordination and human resource constraints have limited the Ministry of Health's capacity to deliver nutritional services under the National Nutrition Program and to provide overall coordination for a multi-sectoral national nutrition agenda. The major challenge is therefore to refocus efforts on prevention at the community level, as the cost to prevent malnutrition is half the cost to treat it, and to ensure the involvement of other sectors that are engaged in various aspects of nutrition service delivery by integrating nutrition-sensitive interventions.
- 16. Similar to a number of other countries in the region, Djibouti has taken a look at innovative solutions for addressing issues of food and nutrition insecurity.** Given the fact that the country is heavily reliant on imports for key staples, it has sought solutions to reduce its exposure from global market fluctuations for basic commodities including the establishment of the Djiboutian Food Security Company (Société Djiboutienne de Sécurité Alimentaire, SDSA), charged with keeping food prices manageable. In addition, the country has legislation mandating the fortification of domestic wheat flour with iron, zinc and folic acid – currently 95% of wheat is fortified in Djibouti.

Relationship to CPF

- 17. The proposed project is fully aligned with the Country Partnership Strategy (CPS) for FY14-FY17, which supports Djibouti Vision 2035, the Government's long-term approach to development.** Vision 2035 includes a pillar on consolidation of human capital to ensure the well-being of the population, to which the CPS' pillar of "reducing vulnerability", corresponds. One of the outcomes under this pillar of reducing vulnerability is improved utilization of good quality maternal and child health (MCH) care services and communicable disease control programs. The proposed project contributes to better MCH outcomes by targeting pregnant and lactating women and tackling childhood malnutrition and stunting in particular, a key component and significant challenge for improving MCH outcomes.

¹⁰ UNOCHA. 2017. UN Humanitarian Response Plan.



- 18. The upcoming Systematic Country Diagnostic (SCD)¹¹ identifies health and nutrition issues, with acute and chronic malnutrition being most common causes of morbidity and infant mortality as well as most fundamental challenges for improved human development in Djibouti.** An influx of refugees is also noted as a significant burden on the already stretched health system. One of the priority areas of the SCD is “making institutions accountable and enhancing capacity” through, inter alia, building social sustainability and addressing fragility, where limited access to and low quality of available health services and lack of capacity and strategy to cope with refugee influx are included as areas to be addressed. The proposed project contributes to this priority area as it aims to improve access to quality health and nutrition services, involving different government entities and other stakeholders. There are anticipated synergies between the existing WB nutrition-related portfolio and the proposed stunting project.
- 19.** Through the provision of quality health service delivery and by supporting the health system that is taking the added burden due to an influx of refugees, the proposed project also contributes to two pillars of the MENA Regional Strategy – “renewing the social contract” and “resilience to refugee/IDP shocks”.

C. Proposed Development Objective(s)

- 20.** The project development objective is to expand coverage of multi-sectoral interventions proven to reduce stunting.

Key Results (From PCN)

- 21.** Progress toward the PDO achievement will be measured through the following set of proposed outcome indicators:

Outcome indicators:

- % of infants 0-5 months exclusively breastfed
- % of children 6-23 months consuming a minimum acceptable diet
- % of pregnant women with at least 4 antenatal care visits
- % of pregnant women who received adequate quantity of Iron and Folic Acid (IFA) tablets during their current prenatal care visit (enough supplies to last until their next visit)
- % of health workers and community health volunteers with knowledge of stunting, and proper child feeding, care, and hygiene and sanitation practices
- The presence and functioning of a multi-sectoral nutrition coordinating mechanism that meets at least twice a year

D. Concept Description

- 22. The project will support the Government of Djibouti to combat stunting multi-sectorally through the adoption of a “Zero stunting” strategy that is centered around a community based approach along with scaling up the delivery of high impact nutrition services.** The Government has prioritized a package of essential nutrition-specific and nutrition-sensitive interventions that need to be implemented at scale to achieve the goal of an 8-percentage point reduction in stunting by 2025 (from 32% in 2017 to 24% in 2025). The project will draw on global best practices and focus on a national scale-up of high impact, cost effective interventions. The project will focus on

¹¹ The SCD is scheduled to go to the Board in FY18Q3.



stunting given that the Government, other DPs including UNICEF and WFP, and PAPSS are already focused on treatment of acute malnutrition.

- 23. To achieve the PDO, the proposed project will expand the scope, scale, coverage of ongoing nutrition interventions nationwide.** Several approaches will be implemented to improve the quality, coverage and uptake of nutrition services in Djibouti, including: (i) delivery of high quality essential health and nutrition services at health facilities and in the communities that respond effectively to women and children's needs in health, nutrition, and early stimulation; (ii) strengthening the capacity of health providers, community health workers and community volunteers to deliver high quality nutrition services; (iii) behavior change communication to reach parents, caregivers and children in the communities to enhance their knowledge and create an environment conducive to care seeking behavior; and (iii) policy, coordination and monitoring and evaluation support at the national level in order to ensure that all relevant sectors are involved.
- 24. The proposed project will include three main components emphasizing the scale-up and quality of both supply and demand side interventions.** Given the multi-sectoral nature of the project and the different stakeholders currently engaged in the delivery of nutrition services at the community level, proposed implementing agencies are indicated for each component. These arrangements will be finalized during preparation.
- 25. Component 1: High-impact Health and Nutrition Services.** This component focuses on the delivery of services and interventions that address stunting at both the facility and community level.
- 26. Subcomponent 1.1 Strengthening of health and nutrition services (facility level).** This subcomponent will improve the provision, quality and utilization of an enhanced packaged of high-impact nutrition and health interventions at facility level. These interventions will include those identified in the government's National Nutrition Program and based on international recommendations of the most effective interventions in reducing stunting: (i) growth monitoring and promotion and effective tracking of faltering children, exclusive breast feeding from birth to six months, deworming, and micronutrient supplementation (i.e. Vitamin A supplementation, therapeutic zinc supplementation with Oral Rehydration Salts, multiple micronutrient supplement powders); and (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 quality of care through water, sanitation and hygiene in health care facilities including through water treatment, safe water storage, and promotion of hygienic practices in health facilities including the nutrition referral centers; (iv) improving linkages, referrals and counter-referrals between facilities and the community. Health facilities will be held accountable and incentivized 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 services provided at the regional and national levels. Through the ongoing World Bank Project in the health sector 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 CAMME staff on nutrition supply management and set up a software for management of nutrition supply.
- 27. The MoH will be the implementing agency** for this sub-component utilizing both health care workers at the facility level, and the CHWs that work in the community. To ensure an effective referral and counter-referral system, strong coordination and a clear division of labor will be needed between MoH and other stakeholders that provide services at the community level such as the State Secretariat for Social Affairs, the Djibouti Social Development



Agency (ADDS), Ministry of Women and Family, and NGOs. The MoH will need to play an enhanced role in supportive supervision for nutrition interventions implemented at the community level.

28. Sub-component 1.2: Prevention and Management of Stunting and Wasting at the Community Level: This sub-component will support the delivery of health and nutrition services at the community level, as well as the critical element of community sensitization and promotion. More specifically, the project will: (i) Support behavior change, health promotion, and community mobilization and sensitization utilizing a BCC strategy, that incorporates locally appropriate messaging on 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) Train, mentor, equip and incentivize CHWs and community volunteers to identify, refer and follow-up on children at-risk of stunting; (iv) Use the positive deviance strategy giving incentives to poor mothers with well-nourished children; (v) 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); (vi) target adolescent girls with iron and folic acid supplementation; and (vii) 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.

In addition, this sub-component will include a mechanism for citizen engagement to facilitate the feedback of the beneficiaries on the quality and appropriateness of nutrition services delivered at the community level.

29. 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.

30. 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. It will also aim to provide incentives for mothers who participate in stunting prevention interventions and mothers with healthy children. 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.

31. Subcomponent 2.2 Addressing stunting in relevant policies and strategies. This sub-component will support and engage the line ministries involved in the multi-sectoral response to create an enabling environment for stunting prevention. The line ministries will be supported to formulate or update their policies, strategies, norms, guidelines and protocols to facilitate an enabling environment for the implementation of multi-sectoral nutrition interventions.

32. Subcomponent 2.3 Multi-sectoral capacity building. This subcomponent will perform a gap analysis to identify the needs and improve capacity at a national, regional and facility level. It will also scale-up the current programs under the National Nutrition Program as well as develop a National Nutrition Institute. Furthermore, a multi-sectoral coordination will occur at both the political and technical levels. To strengthen capacity of sectoral institutions to deliver nutrition interventions, this component will complement and scale-up ongoing initiatives under the National Nutrition Program, including technical assistance, training, coordination, supportive supervision, and associated materials to build capacity to deliver multi-sectoral nutrition services to communities. This sub-



component will focus on improving the capacity at all levels (national, regional, health facilities, etc.) to address the multi-sectoral nature of stunting. A gap analysis will be undertaken to identify capacity needs to ensure effective targeting of the support provided through the project. Specifically, the sub-component will: (i) Support multi-sectorial coordination at political and technical levels; ; (ii) Strengthen the leadership and capacity needed at the MoH national and regional nutrition programs so as to more effectively play a coordination and facilitation function; (iii) Support the development of a national nutrition institute 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. The institute will be a repository of nutrition information (evidence-informed resources in nutrition promotion, national guidelines and standards). It will also provide professional development opportunities such as training in collaboration with recognized training institutes, workshops and forums; and (v) Improve regulations and enforcement of regulations related to food fortification.

33. Component 3: Strengthen Coordination, Project Management and Monitoring and Evaluation (M&E)

34. To complement the interventions described above, this component will support coordination, project management and monitoring and evaluation (M&E). It aims 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 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; and (iii) 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. It will also develop and promote the 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. As part of the effort to improve the health information system, the existing disease surveillance mechanism will be strengthened to capture any early warnings for possible consequences of climate change, as extreme temperature and drought have been identified as having high potential impact on the project implementation.

SAFEGUARDS

A. 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; integrating hygienic practices in the school curriculum; improving access to soap and handwashing stations in rural areas; and utilizing school aged children as an entry point for promotion of optimal health and nutrition practices.

B. Borrower’s Institutional Capacity for Safeguard Policies

The MoH will be the implementing agency. Strong coordination will be needed between MoH and other stakeholders that provide services at the community level such as the State Secretariat for Social Affairs, Ministry of Women and Family, and NGOs. Both MoH and the State Secretariat for Social Affairs have experience in World Bank-financed projects and the implementation of World Bank safeguard policies.

C. Environmental and Social Safeguards Specialists on the Team

Antoine V. Lema, Social Safeguards Specialist
Mohamed Adnene Bezzaouia, Environmental Safeguards Specialist

D. 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.</p> <p>An Environmental and Social Management Framework (ESMF) will be prepared since the exact localizations to be financed under components 1.1 and 1.2 are not known.</p> <p>In addition to detailing the process for screening and implementation arrangements, the ESMF will include the following: (i) generic Checklist EMP for minor renovations/civil works; (ii) hazardous materials</p>



management plan; (iii) health care waste management plan; (iv) health and safety plan for health care beneficiary populations and workers; and (v) equity issues in the social assessment, to address potential issues of social exclusion to the services provided. The ESMF will develop a screening mechanism, activities resulting in Category A-type risks and impacts will be screened out, likewise to avoid project activities that may trigger OP 4.12. The preliminary version of ESMF will be consulted with all stakeholders. Physical copies of the final version of ESMF will be made available in a location easily accessible to PAPs in addition to any 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 will be reviewed, approved, and disclosed in-country and at the external World Bank website prior to appraisal.

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 will not involve any land acquisition. However, some minor renovation works of some existing facilities may be done. Works that require land acquisition (including any economic or physical displacement of squatters) is ineligible for financing under the project. The ESMF will include a screening tool to screen out any activities that might trigger OP 4.12.
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.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Apr 05, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The ESMF will be completed by mid-April.

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APPROVAL

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