Project Information Document/ Identification/Concept Stage (PID)

Concept Stage | Date Prepared/Updated: 04-Aug-2020 | Report No: PIDC178564

BASIC INFORMATION

A. Basic Project Data

Project ID	Parent Project ID (if any)	Environmental and Social Risk Classification	Project Name
P170014		Moderate	Empowering Communities for Better Nutrition
Region	**Country**	**Date PID Prepared**	**Estimated Date of Approval**
MIDDLE EAST AND NORTH AFRICA	Djibouti	04-Aug-2020	
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Djiboutian Social Development Agency	Djiboutian Social Development Agency	

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	2.73
Total Financing	2.73
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	2.73
Japan Social Development Fund	2.73

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 for military bases and for port services. Real Gross Domestic Product (GDP) increased by 4.6 percent on average per year between 1999 and 2018 (nominal GDP grew from US$536.1 to US$2,959 during the same period). As a result, per capita GDP also increased more than two-fold from US$1,380 in 1999 to exceed US$3,000 in 2018.

Growth has been driven by transportation and logistics, telecommunication and banking services thanks to the boom in Ethiopia, the largest and fastest growing economy in East Africa.

Djibouti remains a fragile state and faces serious obstacles to poverty reduction and to the improved health of its population. Based on the findings of the last Household Survey (2017), the 2019 Poverty Assessment shows that one out of six people (17 percent) were living with less than US$1.90 per day (in 2011 Purchasing Power Party terms) in Djibouti in 2017. At the district level in Djibouti City, while extreme poverty is low at 3 percent in the 1st district and 6 percent in the 2nd and 3rd districts, it is estimated at 13 and 11 percent respectively in the 4th and 5th districts located in Balbala, where new migrants and displaced people have tended to settle. These last two districts have a concentration of nearly 77 percent of the total number of the poor in Djibouti City, or 32 percent of the poor in the country. Despite some progress in job creation, the official unemployment and underemployment rate remain high, with the 2017 Household Survey reporting the unemployment rate at 47 percent in 2017, an increase compared to 39 percent in 2015. Moreover, the labor participation rate remains low at 42 percent of the working age population.

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 (International Food Policy Research Institute, 2017 Global Hunger Index).

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 Social Protection Strategy recognizes the critical role of social safety nets in alleviating the devastating effects of poverty. 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

Maternal and infant malnutrition are the number one cause of death and disability in Djibouti, while 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. Despite recent gains in maternal and child survival and some improvement in overall nutrition status, Djibouti lags behind neighboring countries as well as countries with a similar income level. While the fertility rate has steadily decreased to 2.7 births per woman in 2018, infant mortality rate (IMR) and maternal mortality ratio (MMR) remain higher than those of economically comparable nations and countries within Djibouti's geographic region. The MMR, although decreasing, is still estimated at 248 per 100,000 live births (2017), markedly higher than the target of 185 that was set for 2015. This data is 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. At the same time, although the IMR decreased from 71.7 in 2005 to 49.8 in 2018, the rate remains high.

Chronic malnutrition (stunting) deprives children of their right to grow, thrive and reach their full potential. If not corrected during the critical 1,000-day "window of opportunity", from pregnancy to a child's second birthday, stunting can have devastating life-long physical and cognitive development consequences. The Standardized Monitoring and Assessment for Relief and Transition (SMART) surveys indicate the level of stunting in children under five dropped significantly between 2013 and 2019 from 29.7 percent to 20.9 percent, though with substantial regional disparities – 40 percent in Obock region and 14.5 percent in Djibouti City excluding Balbala. Therefore, stunting remains an urgent nutrition and human development crisis in Djibouti. The age group most affected by stunting are children aged 24-35 months, with approximately 25.2 percent of this group being stunted, and boys are slightly more affected by stunting at 21.7 percent than girls at 20.2 percent. Malnutrition is linked to the socio-economic status of the household, and stunting is higher among the poorest twenty percent of the population compared to the richest (37.2 percent vs. 18.2 percent) (Pan Arab Project for Family Health - PAPFAM, 2012). Stunting is the result of cumulative growth failures beginning in utero and continuing after birth. Exclusive breastfeeding protects infants from illness and provides essential nutrition during the first six months of life, but in 2014 only 13.4 percent of infants less than six months were exclusively breastfed – one of the lowest rates in the world (PAPFAM, 2012). The complementary feeding period (6-23 months) is also a critical time for growth and development, and a child is introduced to greater disease risks through inadequate complementary feeding and inappropriate water, hygiene and sanitation conditions and practices.

Djibouti also suffers from the double burden of malnutrition – with high rates of undernutrition, and overweight and obesity simultaneously, leading to catastrophic costs to individuals, communities and the national healthcare system. As of 2012, the national prevalence of overweight in children under five was 8.1 percent, and 17.1 percent in adolescents. Overweight and obesity in Djibouti are largely the result of urbanization and rapid changes in the food system leading to the availability of cheap ultra-processed food and beverages, as well as reductions in physical activity.

Micronutrient deficiencies, or the inadequate intake of micronutrients such as iron, vitamin A, iodine and zinc, are also common in Djibouti. 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 percent) of children under the age of five and one-third (32 percent) 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 percent in 2011 to 50 percent in 2015 and 53.3 percent in 2019 due to logistical bottlenecks.

Adolescent girls are particularly vulnerable to nutritional deficiencies, that not only impact their own health but also that of their future children. Adolescence is a time of rapid physical growth, second only to

the first year after birth, and is a period in which one can gain up to 50 percent of their adult weight and skeletal mass, and more than 20 percent 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. Undernourished girls are more prone to complications of labor and delivery and to giving birth to low birth weight babies; and adolescent fertility is associated with an increased risk of stillbirths and neonatal deaths, and greater risk of preterm birth, low birthweight and small for gestational age compared to older mothers.[i] Evidence from low- and middle-income countries also indicates that adolescents are substantially (33 percent) less likely to breastfeed.[ii] Djibouti ratified the Convention on the Rights of the Child in 1990, which sets a minimum age of marriage of 18; and in 2018, the estimated adolescent birth rate in Djibouti was 21 births per 1,000 adolescent girls aged 15-19. It is therefore crucial to not only support programs to improve pre-pregnancy and adolescent nutrition, and tackle anemia in adolescent girls, but also provide sexual and reproductive education that reduces and delays early marriage and pregnancy.

According to a contextual analysis conducted by the Ministry of Health (MoH) in 2014, the causes of stunting in Djibouti are multifactorial and include a combination of immediate, underlying and basic causes such as 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.

There are several supply side challenges that currently impede the delivery and access to health and nutrition services in Djibouti. Health care workers (HCWs) have limited training in nutrition and therefore are unable to encourage necessary behavior changes essential to improving nutrition outcomes. Beginning in 2012, the community health worker (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 Djibouti City; 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 Djibouti City, and one in each of the five regions).

On the demand side, socio-cultural beliefs and practices, geographic and financial impediments including long distances 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 percent of women aged 15-49 years had at least one visit with a skilled health professional during pregnancy, less than a quarter (23 percent) complete four antenatal care visits as recommended by the World Health Organization (WHO). In rural areas, the distances to health care facilities, lack of awareness

regarding the need for regular health check-ups, financial barriers and the poor condition of roads mean that the time, effort, and cost required to arrive at the point of delivery can be substantial.

Based on the above constraints, the proposed project seeks to pilot a set of innovative approaches to positively influence nutrition outcomes. Based on an analysis of the gaps, and the selection of geographic areas and activities, the majority of beneficiaries will be children under five years of age and adolescent girls and women. The proposed project would build on and complement the existing health, nutrition and social protection projects in that it will reach and support groups that have traditionally been left out or unable to access critical health and nutrition services through the implementation of new and innovative approaches to raise awareness of and increase access to nutrition services. The project is aligned with the World Bank's "Towards Zero Stunting" aimed at reducing stunting among children under five in Djibouti; and has also been designed in consultation with the Social Protection team which has a safety net program in Djibouti. To avoid duplication of efforts, this JSDF grant has been designed to act as "a bridge" between the health sector and the social protection response to malnutrition in Djibouti. The proposed project aims at piloting a set of community-based approaches to change behavior and improve nutrition outcomes among children under five and adolescent girls and women in two targeted communities of Djibouti City. The proposed project also relies on the capacity built at the implementing agency, Djiboutian Social Development Agency (ADDS), to implement and monitor such a project.

Relationship to CPF

The Country Partnership Framework (CPF) for FY20-25 (expected to be approved by the Bank's Board in September 2020) specifically highlights stunting as an impediment to further develop Djibouti's human capital and reduce poverty. As a consequence, the CPF has explicitly include stunting reduction as one of its objectives: Objective 5 - Increase access to quality health services and reduce stunting among young children. The CPF therefore supports the Government in tackling stunting among girls and boys aged 0-5 years.

C. Project Development Objective(s)

Proposed Development Objective(s)

The Project Development Objective (PDO) is to increase awareness of sound nutrition and child care practices among adolescents and parents of children under 5 in the target areas, i.e. poor communities in Djibouti City, namely in the sub-communities of Arhiba and Bache à Eau (located in the municipality of Balbala).

Key Results

Implementation progress and progress towards achieving the project's development objective will be measured by a set of indicators:

a) Number of direct project beneficiaries: 5000
b) Number of child length mats distributed: 3000
c) Number of parenting sessions conducted with mothers and fathers of children under five: 100
d) Number of adolescents (disaggregated by gender) aged 10-24 participating in club activities: 1000
e) Mass awareness strategy developed: Yes/No

D. Preliminary Description

Activities/Components

To achieve the PDO, the proposed project will pilot a set of complementary community-based approaches to test their potential of improving nutrition outcomes and education among poor and vulnerable groups in Djibouti. Specifically, the proposed project will aim to: (i) address key underlying causes of malnutrition (stunting in particular) through increased knowledge and uptake of preventative nutrition and health services; and (ii) support community mobilization and awareness raising about malnutrition causes and risks by engaging mothers, fathers, adolescents and other community members. The integrated approach incorporates community mobilization and beneficiary-specific nutritional messages that highlight behavior change and linkages to nutrition services.

The project's geographic scope covers two sub-communities of Djibouti City - Arhiba and Bache à Eau (located in the municipality of Balbala). Djibouti's population is 78.1% urban and while stunting rates are generally lower in urban areas than rural areas, the urban population of Djibouti contains pockets with high stunting rates, especially in urban slums. As such, the targeting of these regions is based on the following criteria: (i) most concentrated number of the extremely poor; (ii) limited access to existing health and nutrition services by targeted populations (and absence of other development partners currently engaged in nutrition in these areas); and (iii) physical accessibility and availability of basic infrastructure to facilitate the implementation of the project. The final selection of beneficiaries will be made in consultation with the respective local government according to transparent selection in order to ensure ownership of project activities.

This proposal builds upon a series of in-country consultative workshops (Annex 1) with key stakeholders to explore options to improve nutrition and increase awareness at the community level. The consultations were structured through focus group discussions and in-depth interviews, as articulated in the JSDF Seed Funding Proposal, using consultation guides translated into Afar and Somali for the focus group discussions and the in-depth interviews. The guides were initially pilot tested with a few beneficiaries and subsequently improved based on the results of the pilot testing. The consultations included three groups of key stakeholders and were conducted in Afar and Somali with: (i) pregnant women, breastfeeding mothers and mothers of infants less than 2 years of age; (ii) health facilitators and mères conseillères; and (iii) mothers with children that have had severe acute malnutrition with complications. A total of ten consultations were organized, five in each area (i.e. five in Balbala and five in Arhiba). In total, six focus group discussions were conducted with mothers, mères conseillères, and health facilitators, and four in-depth interviews were conducted with mothers with kids that have severe acute malnutrition with complications. The focus group

discussions and in-depth interviews focused mainly on nutrition practices, water and sanitation and hygiene practices, and prevention, diagnosis and treatment of malnutrition. Based on the findings articulated in the report, the Bank team held the design, M&E and wrap-up workshop with the key stakeholders, to finalize the design of the planned interventions, M&E framework and implementation arrangements of the present JSDF grant.

Component 1: Child Length Mats to Promote Healthy Child Growth and Follow-up

The objective of this component is to increase community's understanding and participation in identifying and addressing malnutrition (stunting) through community mobilization and awareness raising using an innovative tool – the child length mat. Adequate linear growth in the first two years of life is a sign of overall child well-being and development, and low length- or height-for-age, or stunting, indicates a failure to achieve one's own genetic potential for healthy growth. Effective interventions are needed to prevent stunting in the critical 1,000-day window from the start of a woman's pregnancy until the child's second birthday. However, in Djibouti stunting is often invisible because so many children are stunted or it is simply normalized as a genetic issue. Even health workers do not give chronic malnutrition measured by linear growth the same attention as acute malnutrition, and height is not routinely measured, especially in community programs.

The child length mat is designed to raise community awareness of stunting and to facilitate easy stunting detection at the community level by providing a visual cue to determine if a child meets normal height-for-age measurements (based on current WHO growth standards). The purpose is to provide families and communities a simple, objective measure of their children's growth to motivate them and make them feel accountable to improve behaviors towards a healthy child growth. Not only does it enable community health workers and parents to address health and nutrition practices that promote child growth, but also helps identify children needing referrals for additional services and counseling. As child length mats are a new concept in Djibouti, an evaluation of their use and acceptability will be conducted, including lessons learned from early implementation.

A child length mat is a simple, easy-to-use community tool, that can be used to visualize stunting. It is made of inexpensive, lightweight, waterproof materials such as polyvinyl chloride or tightly woven rice sack materials. There are multiple phases/steps envisioned in rolling-out the child length mat. First, the child length mat will be designed in consultation with the Government of Djibouti, as well as community groups and households, and will include tailoring to the age groups and graphics to reflect the national stunting profile and local aesthetic preferences. During the consultations, families' and communities' perceptions around childcare and growth will be documented/considered, in addition to their preference regarding "look and feel" of the mat, and associated nutrition messages to ensure that they are relevant to the context.

Second, community health and nutrition agents (mères-conseillères, CHWs, and community members/volunteers) will be trained on the use and messaging of the child length mat, in addition to general nutrition training to counsel mothers on nutrition and how to prevent stunting. At present, community healthcare workers (CHW) have limited training in nutrition and therefore are unable to encourage necessary

behavior changes essential to improving nutrition outcomes. The aim is to ensure that all children identified as faltering in growth are referred to health posts/centers where there is monthly growth monitoring and promotion sessions.

Third, to distribute the length mat, government counterparts at the central and local level will be engaged in the introduction of the growth visualization tools and efforts to foster accountability. Women (and other caregivers) and children will be familiarized with the mat through small- and large-group activities, including one-on-one counseling in homes and at local health facilities, nutrition education sessions, and community mobilization efforts. Quarterly growth monitoring and promotion and nutrition education sessions targeting female caregivers, husbands, and elders will be used to introduce and follow-up on the child length mat.

Finally, to support continuous learning and awareness raising, community leaders and CHWs will be provided with training and materials to monitor the performance and results of the use of the child length mat. Community mobilization and participatory monitoring strategies will be developed to engage beneficiaries in objective setting, continuous monitoring, and learning; the results of which will be reviews by local community leaders and shared during regular review meetings to monitor progress towards desired outcomes. Meetings should be held every three to six months to discuss results and plan any follow-up accordingly; as well as feed data to the central level to inform any changes to the project. Through the use of the child length mat, it is expected that the utilization of preventative nutrition services by poor/vulnerable households will increase.

Component 2: Gender Mainstreaming for Improved Nutrition

The Government of Djibouti has expressed commitment to support and promote gender equality and improving maternal and child nutrition is critical to achieving this. The project will support women to take better decisions around feeding practices and nutritious foods for their children through the promotion of appropriate health and nutrition services, in combination with new knowledge and skills on maternal, child and adolescent nutrition, at specific periods of the life cycle. In addition, it will engage adolescents (girls and boys) and male partners/caregivers. This component consists of two main activities:

1. **Parental education:** Trainings will be conducted with community volunteers/facilitators to conduct focus group discussions with women and men (separately). A group of mothers will develop task lists to clarify what childcare men and women are currently providing. Then women will be asked to identify which of their current tasks their husbands could do to help them better care for their children. Next, separate facilitated discussions with men will prioritize tasks from the task list created by the women, to identify those behaviors which men in the community were most willing and able to do. The results will be used to develop a parental education strategy which will include community and household discussions on gender roles and social and behavior change activities; the purpose being to enhance nurturing care for children during the vulnerable first years of life and encourage male involvement in the health and nutrition of their families. Building on existing qualitative work financed by the seed fund, which had identified this as a significant issue, and provided this need is confirmed by the focus group discussion, this parental education strategy will also likely include

sessions on household budgeting and expenditures, engaging both the wives and their husbands. Local Community Based Associations (CBAs) will be in charge of recruiting community facilitators, promoting mass awareness (media, radio, door-to-door promotion), and inviting the participants to different sessions. This component will also cover capacity building and implementation support for the CBAs.

2. **Adolescent empowerment through the creation of "**Adolescent Clubs": Adolescence is a time of rapid growth and development, and for girls is a particularly vulnerable time with the onset of menstruation and even marriage. While there have been some improvements in the availability of "youth friendly" health and nutrition services in Djibouti, they are still not widely available and accessible. This is particularly true in the case of nutrition for adolescent girls, as there are still no programs in place to reach them with key nutrition services. This activity will target adolescent girls and boys ages 10 to 24 to enhance awareness of nutrition and hygiene issues and context-appropriate life skills (livelihoods and job training) through formation of girls only and boys only "clubs" that will serve as a platform for discussing key life issues. Specifically, girls and boys will be placed in "clubs" according to ages: 10-14, 15-19, and 19-24 years old to ensure that needs are addressed according to their ages. The girls clubs will raise awareness about health, hygiene, nutrition and feeding practices before pregnancy, provide information and support around sexual and reproductive health topics, and provide context-appropriate life skills (livelihoods and job training). Given the importance of the adolescent years to develop responsible parenthood, the boys clubs will focus on engaging boys to make them healthier and better educated fathers. The boys clubs will also build on the discussions held with fathers during the parenting sessions to ensure that information is targeted and relevant. CHWs will identify, mobilize and supervise the clubs; as well as provide them with relevant information and small incentives (such as some foods and materials) to ensure participation, for example through cooking sessions. In addition, to overcome barriers to participation, such as parental and spousal authorization, community sensitization will be carried out, so the objectives and activities of the clubs are well understood and accepted. Finally, in order to reduce discrimination between in school and out of school girls and boys, meetings will be organized in the afternoon.

Component 3: Project Management, Monitoring and Evaluation, and Knowledge Dissemination

This component will support the management, monitoring and evaluation of the implementation of the above two components. It will finance technical advisory services (including consultants, training, workshops and audits), goods including printed materials, trainings and incremental operating costs.

The proposed project will be monitored and evaluated to facilitate continuous learning and improvement. Performance indicators will be selected to capture the overall objectives of the project. Annual reporting is expected, and district health authorities will consolidate technical and financial reports from target districts, health centers, and other stakeholders on a quarterly basis. Progress reports will include information on project activities, key indicators, and beneficiaries.

The impact of the project will also be rigorously evaluated, the results of which will be shared with stakeholders as part of planned workshops to share lessons learned on community-level nutrition activities to improve nutrition among children, adolescent girls, and women. Analyses that will be conducted during project preparation and implementation include: 1) evaluating the implementation of the child length mat using qualitative assessments and focus group discussions to determine the acceptability, replicability and sustainability of the tool; 2) evaluating the impact of different behavior change communication interventions (counseling during home visits on infant and young child care and feeding practices, the use of health care services, growth monitoring and promotion sessions, etc.), such as on the awareness of key messages in relation to nutrition and stunting and male participation in childcare/nutrition; 3) assessing capacity, skills, and competencies of community-level health and nutrition workers; and 4) tracking longitudinally a sample of project beneficiaries over the project period to assess progress. The project will also provide the necessary analytic and technical assistance support to the Government of Djibouti to build a knowledge base and make future decisions on longer term institutional, financing, and policy reforms required to achieve and sustain results over time.

The project is aligned with the World Bank Gender Strategy and contributes to the first pillar - “improving gaps in human endowments” - through the promotion of behavior seeking appropriate health and nutrition services, in combination with new knowledge and skills on maternal, child and adolescent nutrition, at specific periods of the life cycle.

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Environmental and Social Standards Relevance

E. Relevant Standards

ESS Standards		Relevance
ESS 1	Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10	Stakeholder Engagement and Information Disclosure	Relevant
ESS 2	Labor and Working Conditions	Relevant
ESS 3	Resource Efficiency and Pollution Prevention and Management	Not Currently Relevant
ESS 4	Community Health and Safety	Relevant
ESS 5	Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6	Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7	Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
ESS 8	Cultural Heritage	Not Currently Relevant
ESS 9	Financial Intermediaries	Not Currently Relevant

Legal Operational Policies

Safeguard Policies	Triggered	Explanation (Optional)
Projects on International Waterways OP 7.50	No	Project activities are not going to interfere with international waterways.
Projects in Disputed Areas OP 7.60	No	Project activities will not be conducted in disputed areas.

Summary of Screening of Environmental and Social Risks and Impacts

The project activities per se do not entail environmental and social risks. However, the management of the project, in particular its process to select beneficiaries and inform the broader community do entail moderate social risks. These risks may arise should selection criteria be poorly defined and not adequately disseminated. They can be mitigated by putting in place clear and transparent selection criteria that are adequately communicated to the households living in the targeted neighborhoods as well as by putting in place a grievance system.

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