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PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC5669

Project Name	Population and Health Support Project (P147638)
Region	AFRICA
Country	Niger
Sector(s)	Health (100%)
Theme(s)	Population and reproductive health (50%), Child health (30%), Health system performance (10%), Nutrition and food security (10%)
Lending Instrument	Investment Project Financing
Project ID	P147638
Borrower(s)	Ministry of Planning, Regional and Community Development
Implementing Agency	Ministry of Health, MP/WP/CP (Ministry of Population Woman Promotion and Child Protection)
Environmental Category	B-Partial Assessment
Date PID Prepared/ Updated	08-Sep-2014
Date PID Approved/ Disclosed	02-Dec-2014
Estimated Date of Appraisal Completion	23-Dec-2014
Estimated Date of Board Approval	05-Mar-2015
Concept Review Decision	Track I - The review did authorize the preparation to continue

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I. Introduction and Context

Country Context

1. The Republic of Niger is a landlocked country with an area of 1,267,000 square km. In Niger, the geographical conditions are aggravated by unfavorable climatic factors. The present gap between national production and needs for basic cereals is growing inexorably due to harsh conditions (external shocks, irregular or insufficient rains, poor soils, and diminishing returns) and increasing population pressure.

2. Despite these harsh conditions, Niger has made some progress on economic growth and poverty-reduction in recent years, yet these gains are in jeopardy due to the demographic profile and poor human development. Over the 2008-2013 period, annual economic growth was sustained at an average 5.7 percent. On the back of economic growth, poverty declined from 64 percent in 2005 to 60 percent in 2008 and 48 percent in 2011. Despite this, GDP per capita is still very low at US$395

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– this is far below the sub-Saharan Africa average of US$1647. Furthermore, Niger ranks last among the 187 countries on UNDP's 2012 Human Development Index (HDI).

3. The economic growth that Niger has experienced is not translating into greater prosperity and is, in fact, at risk due to the current and projected demographic profile of the country. A demographic transition – the shift from high to low mortality and fertility levels – has begun in Niger through an impressive decline in child mortality. However, fertility remains high and has actually increased in the last five years – the fertility rate is currently 7.6 children per woman. As a result of high fertility and declining child mortality, the population has a very young age structure – 49 percent of the population is below age 15 and the child dependency ratio is 105, meaning that there are 1.05 children for each person of working age. The presence of such a large young population, together with such a high dependency ratio, has implications at both the household and national levels in terms of health, human development and economic growth and stability.

4. However, Niger could still capitalize on its demographics, avert its negative externalities, and reap the benefits of the demographic dividend. If fertility declines rapidly, Niger's young dependent population grows smaller in relation to the working-age population, resulting in lower dependency ratios. With fewer people to support and reduced demand for expanding social services, Niger will have a window of opportunity for rapid economic growth. With accompanying policies to foster human capital, employment and investments (e.g. health, education, labor, trade, and governance policies), Niger may be able to harness this demographic transition in the form of a demographic dividend. Furthermore, lower fertility – including higher age at first birth, better birth spacing and fewer children - is not only necessary for reaping the demographic dividend but also associated with better maternal and child health outcomes.

5. Niger's Poverty Reduction Strategy - the Plan for Economic and Social Development (PDES) for 2012-2015 – outlines an ambitious investment programs in (i) economic growth; (ii) public institution strengthening; (iii) food security and agriculture; and, (iv) promotion of social development. The promotion of social development aims to improve the level of development of social indicators through enhancing access of the population to basic social services and the implementation of a social protection policy for the most vulnerable groups.

Sectoral and Institutional Context

6. Over the past years Niger made progress in its health, nutrition and population outcomes, but the country still lags substantially behind other low-income countries and sub-Saharan African counterparts. Both infant and child mortality have declined remarkably, placing Niger in a position to achieve MDG 4 by 2015. Improvements in the use of bed nets for children under five, immunization coverage of children under 12 months of age, and coverage of measles vaccination have been key factors in the progress on child health. In addition, malnutrition accounts for more than one third of child mortality in the country and remains high due to host of health, sanitation and behavioral factors, exacerbated by recurrent food shortages. Only 23 percent of children under 6 months were exclusively breastfed in 2012. Anemia is prevalent in both children and adults: 73 percent of children 6-59 months, 46 percent of women and 26 percent of men are anemic. Furthermore, 44 percent of children are stunted and 36 percent are underweight. While both stunting and underweight rates have declined, wasting (weight-for-height) has actually increased by 50 percent (from 12 percent to 18 percent) between 2006 and 2012. Finally, there is a growing divergence in poor nutrition: 16 percent of women have a state of chronic energy deficiency while 14 percent of women are overweight. The rate of Global Acute Malnutrition (GAM) among

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children under five has declined from 16.7 percent in 2010 to 13.3 percent in 2013, which is still above the critical threshold of 10 percent after years of being above the emergency threshold of 15 percent (WHO).

7. The implications of poor reproductive, maternal, newborn and child health and nutrition (RMNCHN) are substantial and negatively impact the well-being of Nigeriens. Despite some improvements in maternal health, the maternal mortality ratio (MMR) remains high at 535 per 100,000 live births in 2012, higher than the SSA average of 500. Skilled birth attendance is only 30 percent, and the modern contraceptive prevalence rate (CPR) remains low at 12 percent. The CPR is only 50 percent of the regional average. Niger's fertility rate (7.6 children per woman) is substantially higher than the sub-Saharan Africa average of 5.1 and highest even in the Sahel sub-region. As a result, Niger is unlikely to achieve MDG 5 on maternal health and substantial efforts are required to strengthen the health system to ensure comprehensive access to skilled birth attendance and other important maternal and reproductive health services.

8. Furthermore, Niger has low levels of education (especially for girls), the cornerstone of building human capital. Primary school enrolment is below the regional average, and girls in particular are lagging behind – only 57 percent of girls are enrolled in primary school (Table 2). Secondary school enrolment is substantially lower. Youth literacy figures are also alarming, especially for girls. These trends facing Niger greatly constrain its capacity to progress in human development in all its key dimensions.

9. In addition to low levels of education, empowerment of women is also poor due to early marriage and early childbearing. Age at first marriage in Niger is 15.7 years, the lowest in the Sahel. Age at first birth follows a similar pattern with the majority of first births occurring during adolescence (the adolescent fertility rate is high at 206 births per 1000 and the median age at first birth is 18.6 years in 2012). Early marriage negatively affects a range of health and development outcomes for young women, including poorer schooling outcomes, higher risk of exposure to violence, and greater health risks associated early sexual activity and childbearing.

10. Low coverage and utilization of RMNCH and nutrition services are attributed to both demand and supply side constraints. On the supply side, service utilization is low due to inadequate provision of quality health services, including challenges with respect to the geographic distribution, the quality and the skills-mix of human resources, despite the recruitment of 1,500 additional health workers in 2011. MoH needs to make an effort to promote the strategic management of human resources, including setting up a human resources information management system and ongoing capacity building.

11. Another supply-side constraint in the provision of health services is the unavailability of affordable drugs across health facilities. Niger has put in place a fee exemption policy in 2006 for specific vulnerable groups and priority services. However, reimbursements for the selective free health care policy are in general late, incomplete and unpredictable leading to inability of health facilities to maintain their drug revolving funds, and have led to debts with drug suppliers. The measures taken to restructure the Office National des Produits Pharmaceutiques et Chimiques (ONPPC) are not well implemented. Poor drug legislation and regulation governing the pharmaceutical sector and inadequate implementation guidelines has resulted in limited access to medicines. Poor availability has been exacerbated by poor prescription practices.

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12. Quality of care is poor with untimely and inappropriate care being provided to clients. Among children with diarrhea and acute respiratory infection, only 43 percent and 53 percent, respectively, received appropriate care. Another 15 percent of children received anti-malarial drugs in case of fever, but only 12 percent received them in a timely manner. Although 59 percent of pregnant women received anti-malaria drugs, only 35 percent received the two recommended doses of SP/Fansidar for the Intermittent Preventive Treatment of Malaria (DHS-2012).

13. On the demand side, the health services are fraught with inequities of all types – geographic, cultural, structural, and financial. Only 48 percent of the population has access to health facility within 5 kilometers of their home, and poor availability and high cost of transportation present an additional challenge to accessing care for 41 percent of women. In 2012, 60 percent of women had financial barriers to use health service with a higher proportion in rural areas (DHS-2012). In addition, lack of education for women and girls (only 22.4 percent of women between 15-24 years old are literate) and socio-cultural barriers both constrain women's use of sexual and reproductive health services (including modern contraceptives) and increase the likelihood of early marriage and early pregnancy. Cultural factors also constrain women's ability to use health services: 21 percent of women need the permission of their husbands to seek care (DHS-2012).

14. The low demand specifically for RMNCHN services results from additional factors, including social barriers to access (religious and male opposition to family planning), high desired fertility , low perceived need for RMNCHN services, low levels of women's empowerment, and weak leadership on implementation of relevant policies. Gender disparities are reinforced by the country's low level of development resources which prevent the country from adopting specific measures that target women and girls' access to public services. According to the UNDP's Gender Inequality Index (GII), Niger ranked 146th out of 148 countries, with a score of 0.707 (slightly better than Yemen and Afghanistan, but worse than Saudi Arabia and the Democratic Republic of Congo). This is well below the regional index value of 0.577 for SSA. Low levels of women's empowerment are correlated with high fertility in Niger. Total fertility has actually increased since 2006 from 7.1 to 7.6 children per woman – in rural areas; it is even higher with an increase from 7.4 to 8.1. Women's empowerment is correlated with social and cultural norms – the demand for children remains high in Niger. Women still reported that they wanted to have an average of 6.8 children in the 2012 DHS. These demand-side barriers are substantial in making progress on the demographic transition, health, education and ultimately the potential for a demographic dividend, although there is still considerable unmet need for family planning.

15. While child mortality has been declining, the prevalence of child morbidity has remained high, suggesting that the quantity-quality tradeoff in terms of child mortality and fertility has not been fully realized. In other words, parents may continue to have more children due either to uncertainty over child survival (from multiple episodes of childhood illness) or uncertainly whether the surviving children will be physically able to support them in their later years. Cultural and traditional values also favor early marriage, early childbearing and large families. Because of low school enrollment levels, child marriage (and thus adolescent pregnancies) is frequent in Niger. In Niger, adolescent birth fertility is not only high, but it also contributes significantly to total fertility rates.

16. Finally, overall financing for the health sector is a major challenge, underlying many of the supply and demand-side barriers discussed above. Only 2 percent of Niger's GDP is allocated to

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the health sector (MoH, 2010). The Government contributes about 32 percent of total health spending, while households contribute 47 percent and donors the remaining 21 percent. Given the reliance on out-of-pocket expenditures as the main source of health financing, cost and unaffordability of health services remain the leading barriers for accessing health care in Niger, particularly for poor people who represent 48.2 percent of the population. Households finance an estimated 42 percent of health care expenditures (an amount equal to about US$3.60 per person per year on average). The share of the health budget in the national budget averages 6 percent, equivalent to an annual per capita health expenditure of US$8, which is far below global health care financing benchmarks.

18. Niger is committed to improving maternal and child health as reflected in the 2011-2015 National Health Development Plan (NHDP) with strategic focus on delivering essential health services to children, women and most vulnerable groups of the population through proven cost effective high impact interventions. The Niger Government Population Policy Declaration (DGPP), adopted in 2007, aims to decrease population growth by addressing contraception and early marriage, with the overall objective of contributing to poverty reduction. It aims to increase contraceptive use by at least 1 percentage point per year. To meet this goal, the policy seeks universal access to safe, effective, affordable and acceptable reproductive health services by 2015.

20. The government by endorsing the national COMPACT with its development partners was concerted efforts to tackle the bottlenecks hampering the delivery and scaling up of RMNCHN services. The implementation of the NHDP is supported by the sector wide approach (SWAp) which helped to harmonize, and align donor’s funds with national budget contribution on the district health plan financing. The pooled of funds set up by keys donors including the World Bank, responded to the needs with financial, technical and material resources. In order to respond on the urgent needs to enhanced results-oriented service delivery, the refocus on policy dialogue on results is imperative in the country by contributing to build the Results Based Financing (RBF) strategy and the use of Disbursement linked indicators (DLI) financing to accelerate services delivery and utilization by targeted vulnerable groups

Relationship to CAS

21. The FY13-16 Country Partnership Strategy (CPS) is aligned with priorities of the Government PDES. Pillar 2 of the CPS aims to reduce vulnerability through increased access to clean water, sanitation, health and population services for the most vulnerable people. The proposed project is included in Pillar 2 of the CPS and will be a multi-sectoral operation targeting the health and population sectors. The main focus areas of the project will be strengthening of health service delivery, improvement of community-level behaviors, and the empowerment of women. The project will make contribution to: (i) the improvement of the reproductive health, maternal health, and child health including nutrition; and (ii) the social behavior change for woman, and adolescent girls at the community level.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

22. The project development objective is to increase the utilization of reproductive, maternal, newborn, child health and nutrition (RMNCHN) services, including by adolescent girls, in targeted areas.

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23. The PDO will be achieved by implementing:

- high impact interventions which increase the supply of RMNCHN services especially in remote and underserved communities;
- social and behavior change communication (SBCC) and women's and girls' empowerment activities to overcome demand-side constraints

24. In doing so, the project will contribute to: (i) strengthening the health system in areas of access, financing, human resources, and drug supply chain management, which will be critical to maintaining the project's benefits after its closing date; and (ii) strengthening demand for RMNCHN services through improved knowledge, life skills, livelihood training, and schooling.

25. The project will support the introduction or scaling-up of global innovations adapted to the Nigerien context that the global experience has shown to be effective to promote gender equality, better reproductive health and slow down the growth of the population. The design will also include multi-sectoral approach on project preparation, implementation and to carry out joint annual reviews of work plans and sector performance (including expenditures and budget) which will be monitored based on jointly derived performance indicators.

26. The proposed project takes into account the lessons learned from the implementation of the previous projects including: (i) addressing the population agenda needs to be anchored in the highest level of government; (ii) ownership of the project design and implementation by the government is key for successful implementation; (iii) IEC/BCC campaigns should be linked to the support for women empowerment in order to impact on women's economic conditions which then can reinforce the awareness messages and activities in the general population; (iv) interventions should be designed and implemented through a bottom-up approach, using decentralized and community-based approaches; and, (v) there is a need for specialized SBCC expertise and for the design and implementation of interventions to be cognizant of local culture, needs, and issues. The project will aim to help the Government of Niger to be more strategic and selective, prioritize, and use the existing capacity for implementing programs that will have the greatest impact on the behavior change and the use of the reproductive health program. Based on the demographic trend, the project will be implemented through a phased approach, focusing initially on four regions – Zinder, Maradi, Tahoua, and Tillabery – which not only have the largest populations but also the poorest performance on health, nutrition and population indicators.

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Key Results (From PCN)

27. The proposed PDO key results indicators are as follows:

1 Women 15-49 using modern contraceptive methods (percent)
2 Skilled attendance at delivery (percent)
3 Antenatal care coverage (CPN – Consultation Pré-natale) – 4 visits (percent)
4 Exclusive breastfeeding (percent)
5 Direct Project beneficiaries (of which female) (number)

28. Intermediate indicators will be developed during project preparation, and will include relevant IDA Core indicators.

III. Preliminary Description

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Concept Description

29. The experience gained in the implementation of a sector-wide approach as well as the use of pooled funding made the health sector the key entity for the multi-sectoral project management. Tackling health, nutrition and population dynamics will require, among other factors: (i) improved provision of quality RMNCHN services; (ii) expanded community-level interventions to overcome demand-side barriers; and (iii) improvements in educational outcomes for boys and girls while addressing gender gaps. Women's education is negatively associated with infant mortality and fertility and positively associated with female labor force participation, which in turn results in increased opportunity costs of women's time and thus contributes to reducing family size. It is the combination between improved empowerment of women and better access to RMNCHN services which will eventually improve health, nutrition and population outcomes.

30. The project is organized around: (i) improving the supply of high quality RMNCHN services; and (ii) improving the demand for RMNCHN services through SBCC and women's and girls' empowerment.

31. Component 1: Improving the provision of high quality RMNCHN services. This component aims to strengthen the delivery of health services for women of reproductive age (including young women, pregnant women) and children under age five through improvements in the quantity and quality of services. A gradual shift from financing inputs to paying for results, making M&E a core function, and improving transparency and accountability in the sector will be envisaged during the project life through a combination of results-based financing (RBF) approaches. This component will benefit from complementary efforts of the regional Sahel Women's Empowerment and Demographic Dividend (SWEDD) Project.

34. The component will also support the establishment of a PBF Technical Unit as well as the preparation activities identified for the PBF strategy implementation in the sector. This PBF Technical Unit will be strengthened with procurement, logistical and technical capacity to ensure fluid implementation of PBF. The component will also support strengthening of the health information system to improve M&E within the health sector and some initial start-up costs (in the form of investment units) for material and equipment during the start-up phase to strengthen the capacity of health facilities to deliver quality services.

35. Component 2: Increasing the demand for and utilization of RMNCHN services. This component aims to increase demand for and utilization of RMNCHN services by promoting social and behavior change among the main stakeholders and decision makers and empowering women. Several synergies and complementaries have been identified between the proposed activities in this component, the SWEDD Project, and the ongoing Social Safety Nets (SSN) Project and Education and Skills projects in Niger.

- Sub-component 2.1. Promote Social and Behavioral Change. The sub-component will support community-level SBCC activities on RMNCHN, population, and development issues using performance contracts with NGOs and supported by community agents (relais communautaires). SBCC will be used to increase the demand for RMNCHN services by addressing knowledge, social, cultural and gender barriers.

- Sub-component 2.2. Reaching opinion leaders. The sub-component aims to expand peer

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education for behavior change among decision makers at the community level. The sub-component will support the implementation of initiatives to reach opinion leaders, especially men in the community and religious and traditional leaders.

• Sub-component 2.3. Women's and Adolescent Girls' Empowerment. This sub-component will improve community-level demand for RMNCHN services by empowering women and adolescent girls with the knowledge and skills needed to make informed use of RMNCHN services coupled with economic incentives for participation in key initiatives.

36. Component 3: Management, Monitoring and evaluation of the project. The component aims to support project implementation by strengthening management and supervision. It will strengthen MoH and MoP capacities in management and coordination through the provision of (i) administrative, management and fiduciary support, (ii) capacity building at the central, regional and local levels; (iii) technical support to enhance the design of policies and strategies and (iv) implement monitoring and evaluation. The component will finance goods, consultants, training, and operating costs.

IV. Safeguard Policies that might apply

Safeguard Policies Triggered by the Project	Yes	No	TBD
Environmental Assessment OP/BP 4.01	x		
Natural Habitats OP/BP 4.04		x	
Forests OP/BP 4.36		x	
Pest Management OP 4.09		x	
Physical Cultural Resources OP/BP 4.11		x	
Indigenous Peoples OP/BP 4.10		x	
Involuntary Resettlement OP/BP 4.12		x	
Safety of Dams OP/BP 4.37		x	
Projects on International Waterways OP/BP 7.50		x	
Projects in Disputed Areas OP/BP 7.60		x	

V. Financing (in USD Million)

Total Project Cost:	96.00	Total Bank Financing:	96.00
Financing Gap:	0.00		

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	96.00
Total	96.00

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