INTEGRATED SAFEGUARDS DATA SHEET
CONCEPT STAGE

Report No.: ISDSC8445

Date ISDS Prepared/Updated: 11-Feb-2015

Date ISDS Approved/Disclosed: 12-Feb-2015

I. BASIC INFORMATION

A. Basic Project Data

Country:	Niger	**Project ID:**	P147638
Project Name:	Population and Health Support Project (P147638)		
Task Team Leader(s):	Djibrilla Karamoko		
Estimated Appraisal Date:	25-Feb-2015	**Estimated Board Date:**	23-Apr-2015
Managing Unit:	GHNDR	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (100%)		
Theme(s):	Population and reproductive health (45%), Child health (25%), Nutrition and food security (20%), Health system performance (10%)		

Financing (In USD Million)			
Total Project Cost:	103.00	Total Bank Financing:	103.00
Financing Gap:	0.00		

Financing Source	**Amount**
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	9.00
IDA Grant	94.00
Total	103.00

Environmental Category:	B - Partial Assessment
Is this a Repeater project?	No

B. Project Objectives

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.

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.

C. Project 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. Specifically, it will help strengthen the supply of health services by addressing constraints related to service delivery, commodities and human resources for health. 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. Disbursement-linked indicators (DLIs) will be used to incentivize the development and implementation of improved management structures and processes while performance-based financing (PBF) will be used to contract health facilities to achieve service delivery results. This component will benefit from complementary efforts of the regional Sahel Women's Empowerment and Demographic Dividend (SWEDD) Project. The activities and complementarities are summarized in Table 3 and described in greater detail thereafter.

32. The component will be implemented by the MoH through the existing pooling arrangements (supported by UNICEF, GAVI, UNFPA, Spain, and France) which support the priority needs of the health system. Results-based approaches will be used by the project to determine the contribution to the pooling of funds. Funds will be disbursed to the pool after a performance assessment carried out by a third party, allowing the financing of the eligible expenditures for the activities in the annual sector plan.

33. The PBF mechanism will incentivize providers using a fee-for-service payment scheme based on both the quantity and quality of services provided. Payments will be made once results have been independently verified. The contracts with health facilities may explicitly include the role of community health workers who are associated with each health facility to deliver services at the community level in addition to services delivered in the health facility. Furthermore, an equity bonus may be incorporated to offset the extra costs and hardships faced by facilities in remote or hard-to-reach areas. Upon completion and evaluation of the PBF pilot under the current HIV/AIDS project (P116167), further arrangements will be detailed out for RMNCHN services and scale-up of the PBF to other facilities.

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. This component will support innovative strategies that can help ensure sustainable results which will be achieved through culturally-sensitive, context-appropriate, and gender-aware approaches. Several synergies and complementarities 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. The activities and complementarities are summarized in Table 4 and described in greater detail below.

- Sub-component 2.1. Promote Social and Behavioral Change. The project 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. With technical support from the SWEDD Project, various SBCC approaches will be developed and implemented to discuss with women best practices during and after pregnancy (e.g. ANC visits, assisted deliveries and post-natal care visits), delayed marriage and childbirth, healthy birth intervals (birth spacing), and benefits of investing in children's health and education. Complemented by edutainment (television and/or radio messages) and mass media supported by the SWEDD Project, this component will operate at the community level with interpersonal communication and social marketing. Community-level SBCC strategies also include targeting male partners and other family members. The contracts for SBCC may also be expanded to include community-based distribution (CBD) of commodities (e.g. contraceptives, ORS, mosquito nets, etc.). The role of the Relais communautaires will be complementary to that of the community health worker to strengthen the links between the health facility and the community and better reach beneficiaries. Given the current high variance in performance of NGOs, it will be helpful to use a performance-based approach to ensure quality of activities conducted as well as the CBD protocols developed under the SWEDD Project.

- Sub-component 2.2. Reaching opinion leaders. The sub-component aims to expand peer 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. Men in the community – including religious and community leaders – shape the ideas and social norms of the community and decisions that are made at the household level. These decisions extend to their wives' use of health services, fertility, their daughters going to school, and the use of family planning. As such, it is essential to involve them in the SBCC efforts. This sub-component will engage religious leaders and support implementation of peer-education programs at community-level with SBCC targeted to these specific stakeholders. An initiative that targets men in the community – Ecole des Maris (EdM – Husband Schools) – is already bein g piloted in selected communities in Niger. These are community groups for "discussion, decision-making and action". There is an opportunity to implement and evaluate this approach rigorously before scaling up nationally, especially given costs of implementati on. This sub-component will additionally benefit from the SWEDD Project's establishment of a regional network of religious leaders – the participation in the regional network of peers will strengthen implementation of the sub-component at the community level.

- Sub-component 2.3. Women's and Adolescent Girls' Empowerment. This sub-component would 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. Initiatives aimed at empowering adolescent girls (age 10-19) can be focused on (i) life skills (SBCC on RMNCHN, self-esteem, leadership, peer pressure, etc.); (ii) economic and livelihood training (e.g. literacy, job skills, business or livelihood, and financial assets); or (iii) schooling (e.g. unconditional or conditional cash transfers). These interventions can be implemented separately or in combination and are designed to promote healthy behaviors, change behaviors and create a lasting effect as these adolescent girls become older and assume leadership roles within their communities. This sub-component will support a packaged approach that includes all three categories of interventions to reinforce efforts to improve female school enrollment, life and vocational skills and strengthen women's economic

opportunities. It will build synergies with the Niger Skills Development for Growth project by providing access to 14-19 years old girls to the dual apprenticeships cum entrepreneurship programs put in place under that project. Thus, the project will reach both in-school and out-of-school adolescent girls, a critical combination for maximum impact.

Furthermore, mechanisms are being explored to further leverage and build on ongoing IDA operations in education and social protection to support economic incentives. This could include the use of "girls' stipends" to encourage attendance and use of services building on the already tested safety net program put in place by the Niger SSN Project. The geographical areas where the SSN Project is being implemented overlap with the proposed areas for this project as they are the most disadvantaged, so poor families targeted by the SSN project with daughters of adolescent ages could receive a small parallel cash amount conditional upon girls staying in school, attending skills development initiatives, and/or staying unmarried until finishing school. Those families would also get exposed to SBCC activities building on the behavioral package put in place by the SSN Project. Alternative approaches to providing financial support to girl's education could include scaling-up the scholarship pilot that will be implemented by the Global Partnership for Education Basic Education Project after it has been evaluated, or scaling-up the girl's scholarship pilot put in place by UNICEF which provides financial support to both girls and their host families through selected sc hools. The sub-component will be carried out by NGOs or existing structures (including building on the institutional arrangements supported by other projects). Interventions will be rigorously evaluated to build upon the growing evidence base on girls' and women's empowerment – while implementation of these interventions will be supported by this project, the evaluation will be support ed by the SWEDD Project.

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 coordinatio n 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.

D. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

Project activities will take place at health facilities (hospital, clinics, centers) throughout the country, and at community level through the implement of BCC/IEC activities on population issues. All region will be targeted and both urban and rural zones.

E. Borrowers Institutional Capacity for Safeguard Policies

In 2003, MOH developed a National Plan for Medical Waste Management which, when submitted in the context of the MAP project, was found satisfactory to the IDA ISG group. This plan has been updated and implemented through the sector wide approach closed in June 2011. The same plan has also been updated for the ongoing HIV/AIDS support project (P116167). Despite the MOH's capacity, the plan will be assess and updated consequently in order to contribute to the financing of its parts during the project implementation. It is expected that no special safeguard-related studies will be needed.

F. Environmental and Social Safeguards Specialists on the Team

II. SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project's environmental impacts are related to medical waste resulting from the expanded use of clinical facilities. The current health waste care waste management plan will be assessed, updated and disclosed before appraisal.
Natural Habitats OP/BP 4.04	No	The project does not affect or involve natural habitats.
Forests OP/BP 4.36	No	The project does not involve forests.
Pest Management OP 4.09	No	The project does not involve pest management.
Physical Cultural Resources OP/BP 4.11	No	The project does not affect or involve physical natural resources.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project area.
Involuntary Resettlement OP/ BP 4.12	No	The project does not involve land acquisition leading to involuntary resettlement or restrictions of access to resources.
Safety of Dams OP/BP 4.37	No	N/A
Projects on International Waterways OP/BP 7.50	No	N/A
Projects in Disputed Areas OP/ BP 7.60	No	N/A

III. SAFEGUARD PREPARATION PLAN

A. Tentative target date for preparing the PAD Stage ISDS: 05-Feb-2015

B. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing[1] should be specified in the PAD-stage ISDS:

The assessment of the Waste Management Plan will be conduct after the identification mission which will be held in May 2014. The new plan will be approved and disseminate before the appraisal mission in September 2014.

IV. APPROVALS

Task Team Leader(s):	Name: Djibrilla Karamoko	
Approved By:		
Regional Safeguards Coordinator:	Name: Alexandra C. Bezeredi (RSA)	Date: 11-Feb-2015
Practice Manager/ Manager:	Name: Sybille Crystal (PMGR)	Date: 12-Feb-2015

[1] Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.