

**PROJECT INFORMATION DOCUMENT (PID)
ADDITIONAL FINANCING**

Report No.: PIDA23448

Project Name	SWEDD AF for Burkina Faso (P154549)
Parent Project Name	Sahel Women's Empowerment and Demographics Project (P150080)
Region	AFRICA
Country	Africa
Sector(s)	Health (100%)
Theme(s)	Gender (40%), Population and reproductive health (40%), Education for all (10%), Health system performance (10%)
Lending Instrument	Investment Project Financing
Project ID	P154549
Parent Project ID	P150080
Borrower(s)	GOVERNMENT OF BURKINA FASO
Implementing Agency	Ministry of Health, Health Development Support Project (PADS)
Environmental Category	C-Not Required
Date PID Prepared/Updated	23-Mar-2015
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Estimated Date of Appraisal Completion	24-Mar-2015
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Appraisal Review Decision (from Decision Note)	

I. Project Context

Country Context

The Sahel sub-region of Africa is marked by high poverty incidence, food insecurity, and multiple stresses that impact on its security and development. The region faces various factors of fragility and instability, ranging from conflicts, repeated droughts, and flooding to vulnerability to global crises (e.g. the financial crisis, food price crisis). Roughly half the population lives on less than US \$1.25 per day with over 11 million at risk of hunger and 5 million children under five facing acute malnutrition. The sub-region is ranked very low on UNDP's Human Development Index.

In recent years economic growth has been high in Sahelian countries, but has not led to higher GDP per capita and better gender equality. Economically, African countries have been growing by 5-8 percent on average in the last few years. Several West African countries are among the fastest growing countries in the world, notably Niger, Côte d'Ivoire, and Burkina Faso. Despite this, GDP per capita is still as low as US\$395 in Niger, US\$652 in Burkina Faso and US\$699 in Mali

compared to the sub-Saharan Africa average of US\$1647. Economic growth has not resulted in greater gender equality especially in terms of female mortality and access to economic opportunity. Chad, for instance, saw impressive economic growth of 9.4 percent annually between 2000 and 2008, but maternal mortality declined by only 8 percent (to 1,200 per 100,000 live births). Many of the Sahel countries score poorly in the UNDP's Gender Inequality Index (GII). In the 2012 GII rankings, Niger was 146th out of 148 countries, with a score of 0.707, Mali 141st (score of 0.649), Mauritania 139th (0.649), Côte d'Ivoire 138th (0.632) and Burkina Faso 131st (0.609). All these countries scored worse than the regional index value of 0.577 for Sub-Saharan Africa (SSA).

A key underlying factor for Sahelian countries not translating high GDP growth into the greater prosperity and wellbeing of its population is the slow demographic transition. A demographic transition—the shift from high to low mortality and fertility levels—has been experienced in all regions of the world. While countries of the Sahel have also started their demographic transition, the pace is too slow and these countries are at high risk of not harvesting the demographic dividend. The demographic dividend is characterized by a period in a country's demographic transition when the proportion of working age population is higher compared to the number of dependents. This period corresponds to an extra economic boost through increased savings and private investments. Triggering such a demographic dividend requires two ingredients: (i) a decreased dependency ratio which is made possible only when fertility is declining more rapidly than mortality, and (ii) adequate policies to foster human capital, employment and investments to ensure that the additional working-age population can get good jobs. In the Sahel while the demographic transition has started with remarkable declines in child mortality in the past decade, the key trigger of rapidly declining fertility has yet to be achieved. Consequently, the age structure of the population has not changed and remains marked by high child dependency ratios. The lagging demographic transition in the Sahel places the region at higher risk of extreme poverty, growing inequities, slower economic growth and increased risk of instability.

As child mortality in the Sahel region has declined at a fast rate, fertility should have declined too. There is strong evidence that improving child survival is a main catalyst for the demographic transition by affecting (reducing) the perceived need of families for additional children (Conley 2007). In the last 10 years, child mortality has been declining fast in the Sahel region, at a rate that is even faster than other regions. Despite these encouraging trends in mortality, fertility remains high in the Sahel. The Total Fertility Rate (TFR) in countries such as Niger (7.6), Mali (6.9) and Burkina Faso (5.8) is far higher than other countries in Sub-Saharan Africa (SSA). As a result the demographic transition is stalled.

Some common vulnerabilities of the countries of the Sahel region may be further exacerbated if the population dynamics continue as is. A recent study (Green 2013) has found that, in the region, when a legacy of communal land rights is combined with high population growth, low levels of urbanization and internal rural-rural migration, conflicts over land have ramped up (such as in Darfur). And Sahel countries are experiencing these factors more often than other African countries. Furthermore, three of the countries (Chad, Cote d'Ivoire and Mali) targeted by the proposed operation are considered as fragile states. With shared cultural and social patterns, common traditional practices, family norms, and women's status, most countries of the Sahel face common social and political challenges in bringing about a change in their population dynamics. Conversely, the shared challenges across the region also constitute an opportunity for concerted dialogue and action to catalyze faster demographic change, as argued by the forthcoming (2014) World Bank report on Population and Development in West Africa: Opportunities and Challenges.

Sectoral and institutional Context

High fertility in the Sahel is accompanied by high maternal mortality and malnutrition. High fertility means that women are more frequently exposed to the risk of maternal death. Countries such as Mali, Mauritania and Niger all have maternal mortality ratios (MMR) above the regional average. Also, as a result of repeated food security crises due to recurrent droughts, erratic rainfall, land degradation, desertification and associated loss of agricultural production and livestock, the region has experienced cyclic upsurges in malnutrition and disease. Child stunting rates are high, from 16 percent child stunting in Senegal to 55 percent in Niger. Stunting rates are also negatively correlated with GNI per capita as malnutrition results in irreparable and irreversible damage to children's cognitive function and future productivity. Indeed, one of the reasons why households' demand for children has not decreased more quickly may be due to high levels of child morbidity.

Another consequence of high fertility and decreasing child mortality is high child dependency ratios in the Sahel. A child dependency ratio of 105 in Niger, for example, means that there are 105 children under age 15 for every 100 adults of working age, which does not bode well for investments in health and human capital or economic productivity. Across SSA, higher child dependency ratios are associated with poorer households.

High fertility is reflected in the low prevalence of modern contraceptive methods. Modern contraceptive prevalence rates (mCPR) in countries in the Sahel region are far below the SSA average of 24 percent. These low CPRs can be explained by supply-side and demand-side factors.

One of the main obstacles for increasing contraception is related to supply-side issues. Especially in rural areas, stock-outs of contraceptives are frequent. Even when contraceptives are available, qualified staff may not be present to provide adequate counseling or to administer some long-term contraceptive methods. These issues are due to the low density of midwives and other personnel skilled in reproductive health (including community-based health workers).

Demand-side issues are also playing a major role in explaining the low modern contraception rates in the Sahel. Indeed, women's desire to space or limit births has been slow to increase in the Sahel region. Women still report having a high wanted fertility rates, ranging from 3.2 in Senegal to 6.8 in Niger. Evidence suggests that this is due to: (i) insufficient knowledge and understanding of contraceptive methods and reproduction; (ii) gender norms and practices that encourage women to maximize fertility and begin childbearing at an early age; and (iii) a narrow set of opportunities—including educational and economic—that are available to women and girls.

Early marriage and childbearing are common in the region, and contribute to overall high fertility rates. Age at first marriage remains very low and is the lowest in Niger (15.7), Mali (16.6) and Mauritania (17.1). Age at first birth follows a similar pattern with the majority of first births occurring during adolescence. Adolescent fertility rate is as high as 205 in Niger and 176 in Mali. The onset of childbearing at early ages contributes to high overall fertility rates in countries such as Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal. Evidence suggests that a decline of 50 births per 1,000 women aged 15-19 would be associated with a decline of 1.2 children per woman.

The Sahel region has low levels of education (especially for girls), a cornerstone of building human capital and a key driver of demand for contraception. Niger and Mali have seen improvements in net enrolment for primary school but are still at low levels: 64 percent and 73 percent, respectively.

Youth literacy rates are low across the region, and average figures mask gender disparities in all of the countries of the Sahel. For example, in Burkina Faso, 47 percent of male youth age 15-24 are literate compared to 33 percent of female youth. In Niger, youth literacy is 52 percent for males but only 23 percent for females. A perceived lack of future labor market opportunities can reduce the incentives for young girls (and their families) to invest in their own human capital (Jensen 2012) and to delay marriage and childbearing.

Building adolescent girls' and women's capacity to effectively achieve their desired fertility is key for achieving other health and development goals. Women are often disempowered as consumers in the health market and in their interactions with health service providers. Women can also be disempowered within the household, manifesting in constraints to mobility and resources (thus impacting access to health information and services), or low bargaining power to negotiate sex and fertility decisions with their partners. Across 34 countries, about one-third of married or cohabiting women report that they cannot refuse sex, and it exceeds 70 percent in several Sahel countries, including Senegal, Mali, and Niger. On average, across 15 countries for which data are available, 11 percent of women report that their first sex was forced. Furthermore, the share of women (particularly young women) who face opposition from husbands or family members over the use of contraception remains significant in many countries.

Adolescent girls bear extreme and disproportionate health and development consequences of early marriage and childbearing. An adolescent's chances of dying due to pregnancy-related complications are twice as high as that of a woman who waits until her 20s to begin childbearing. Fistula is also more common among younger women with a weak, stunted or underdeveloped pelvis. By one estimate, there are over 30,000 cases of obstetric fistula every year in the Sahel. Early marriage and childbearing can also limit young women's education and economic opportunities. Across Sub-Saharan Africa, 25 percent of 15-19 year olds are mothers or are currently pregnant (DHS). By the time they reach age 20 – the average age at first job – they are already caring for young children, and are constrained in their labor market choices.

There is a strong rationale for addressing these constraints at the regional level, complementing national level efforts. Countries of the Sahel region share similar challenges to harnessing a demographic dividend, but these challenges can be addressed or seized upon effectively and efficiently at the regional level through collective action and cooperation. Given the free flow and movement of goods and human resources (including health workers), and similarities in social and cultural norms, across the Sahel countries, several of the above-mentioned demand and supply side constraints are more effectively addressed at the regional level, through interventions that reinforce and complement national level efforts (which usually focus on strengthening service delivery). For instance, the evidence gap on the best interventions for empowering women and girls can be best filled through a regional evaluation and knowledge sharing effort. Also, the huge transactions costs associated with purchasing commodities could be significantly reduced through pooled procurement. Similarly, the frequent migration of people and health workers in the sub-region requires the regional implementation of a harmonized curriculum for midwifery skills. A regional approach would more effectively address political sensitivities, particularly related to midwifery education and reproductive health issues, acting as a positive catalyst for change and reform in each country. All in all, the project meets the four regional criteria for utilizing the regional IDA funds: (i) involves three or more countries: the project involves six countries: Burkina Faso, Chad, Côte d'Ivoire, Niger, Mali and Mauritania; (ii) has benefits, either economic or social, that spill over country boundaries: the project will support the creation or strengthening of three different types of

regional goods(see annex 2); (iii) reflects strong interest from regional bodies and the region's countries in the project; (iv) provides a platform for a high level of policy harmonization between countries.

Building on ongoing plans and initiatives in the region, the proposed regional project would initially focus on six countries in the Sahel Region, but aims to generate economic benefits that extend beyond the borders of the target countries. The target countries are Chad, Côte d'Ivoire, Niger, Mali, Burkina Faso, and Mauritania. These countries are the ones with the highest fertility rate in the sub-region. The selection of countries also takes into account the governments' political commitment to address demographic issues and their readiness for scaling up of interventions. The proposed countries are committed to further addressing maternal and child mortality rates, as well as very high fertility rates simultaneous with low and stagnating contraceptive prevalence rates. On these issues, there is strong commitment and ongoing plans by regional bodies such as ECOWAS, WAHO, UNFPA's Regional Office for West and Central Africa, Regional offices of the WHO, the Reproductive Health Supplies Coalition (RHCS) and AMREF, as well as partners such as the government of France, USAID, Bill and Melinda Gates Foundation (BMGF). With UNFPA, all of these partners have formed recently the Ouagadougou Partnership, which has been instrumental in raising the profile of Sahel countries' problems to achieve a demographic dividend. Furthermore, the proposed regional project is being prepared by countries with joint support from UNFPA and the Bank. BMGF is also financially supporting the preparation of the project.

The project would act on the UN-WB commitment and partnership to address the Demographic Dividend in the Sahel. During a high-level visit to the Sahel region in November 2013, President Issoufou of Niger put a spotlight on the link between drivers of fragility in the Sahel, population dynamics, and gender inequality. The World Bank (President Jim Yong Kim) and the UN (Secretary-General Ban Ki Moon) responded with a pledge to actively support Sahelian countries to accelerate the demographic dividend by addressing health, nutrition, and human capital concerns.

Burkina-Faso was part of the preparation of the parent Regional Project with the other five Sahelian countries (Chad, Cote d'Ivoire, Mali, Niger, and Mauritania). However, due to political events in Burkina-Faso late October 2014, it was not possible to proceed to the negotiations with the country and its inclusion into the SWEDD Project had to be delayed. Adding Burkina-Faso to the Regional Project, as it was initially planned, would allow scaling-up the interventions supported by the Project in a sixth Sahelian country and thus enhance the impact of the Regional Project.

II. Proposed Development Objectives

A. Current Project Development Objectives – Parent

The development objective is to increase women and adolescent girls' empowerment and their access to quality reproductive, child and maternal health services in selected areas of the participating countries, including the Recipients' territory, and to improve regional knowledge generation and sharing as well as regional capacity and coordination.

III. Project Description

Component Name

Component 1: Generate demand for RMNCHN services by promoting social and behavioral

Comments (optional) Empowering women and girls

The objective of this component is to increase demand for RMCHN services through (i) better awareness of population on these services as well as (ii) stronger girls and women status .

Component Name

Component 2: Strengthen regional capacity for availability of RMNCHN commodities and qualified health workers

Comments (optional)

This component will build the regional capacity to provide the critical inputs (commodities and qualified staff) required to provide RMNCHN services.

Component Name

Component 3: Foster political commitment and capacity for policy making

Comments (optional)

The component will strengthen advocacy and political commitment on RMNCHN at regional and national levels

IV. Financing (in USD Million)

Total Project Cost:	34.80	Total Bank Financing:	34.80
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			34.80
Total			34.80

V. Implementation

Project implementation will be coordinated by the UNFPA regional office, which will host the regional secretariat of the project. Under this regional coordination, Governments of the 6 participating countries will implement country-level tasks. WAHO will also provide support to countries. This proposed arrangement is fully in line with IEG’s recommendations on regional projects.

Regional coordination will be done through a Regional Steering Committee, whose secretariat will be run by UNFPA (i.e. regional office in Dakar). More generally, UNFPA will be responsible for the technical coordination at regional level. It will also be responsible for the transfer of know-how to regional and national entities participating in the project. WAHO will be in charge of supporting countries regarding specific issues (regional harmonization and quality control of medicines regulation and health workers curricula).

As for financial flows, IDA funds will flow to (i) WAHO (through a direct regional IDA grant) and to (ii) each of the 6 countries. These countries will have to transfer a percentage (13%) of their IDA funding to UNFPA, which will act as technical assistance contractor. A TA contract will be signed between each of the 6 countries and UNFPA.

At country level, a national steering committee and a project implementation unit will be set up for managing project activities to be implemented at country level.

In Burkina Faso, strategic oversight will be provided by the Ministry of Economics and Finance. On a daily basis, the project will be implemented by the support program for health development (PADS) of the Ministry of Health.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
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

Comments (optional)

VII. Contact point

World Bank

Contact: Christophe Lemiere
 Title: Senior Health Specialist
 Tel: 5786+665
 Email: clemiere@worldbank.org

Borrower/Client/Recipient

Name: GOVERNMENT OF BURKINA FASO
 Contact: Ministry of Economie and Finances
 Title: Minister of Economie and Finances
 Tel: 0022650312550
 Email: Dg.coop@finances.gov.bf

Implementing Agencies

Name: Ministry of Health, Health Development Support Project (PADS)
 Contact: Jean Charlemagne YODA
 Title: Coordinateur
 Tel: (226-50) 308-846
 Email: pads@fasonet.bf

VIII. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: <http://www.worldbank.org/infoshop>