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Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 18-May-2020 | Report No: PIDC28009

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Niger	P171767		Project to Support Human Capital in Niger (P171767)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA WEST	Sep 15, 2020	Nov 18, 2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministère du Plan	Ministère de la Santé Publique du Niger	

Proposed Development Objective(s)

Increase the utilization of a quality RMNCAH-N package of services and address key behaviors known to improve health and nutrition outcomes as well as girls and women´s empowerment.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	120.00
Total Financing	120.00
of which IBRD/IDA	100.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	100.00
IDA Credit	100.00

Non-World Bank Group Financing

Trust Funds	20.00

Global Financing Facility	20.00

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Niger is one of the poorest and youngest countries in the world with one of the most daunting social contexts.** Niger is a landlocked country of 1.27 million square kilometers in the heartland of the Sahel region. Despite its vast territory and underexploited natural resources, Niger remains among the poorest countries in the world with a GDP per capita of US$907 PPP. Climatic conditions hinder agriculture and food security and increasing conflict and social unrest create an additional challenge for the country. Niger has an estimated population of 21.5 million people, of which 50 percent are female and 80 percent live in rural settings. More than half of its population, around 58.2 percent, is children below 18 years, half of them (48 percent) live under the monetary poverty line, and 75 percent of children under-five are deprived from three or more essential social services.

2. **Niger's Human Capital Index (HCI) score compares poorly at a global scale, lagging behind the sub-Saharan Africa (SSA) average of 0.4.** The HCI for Niger is 0.32, ranking 155 out of 157 countries. This means that if key health and education outcomes and trends remain constant, the cohort of children born today in Niger will achieve only 32 percent of their potential productivity when they reach adulthood. Out of the five indicators that compose the HCI, Niger fares particularly low on those related to health and education: i) the rate of children not stunted is 58 out of 100 children, meaning that 42 out of 100 children are stunted and at risk of cognitive and physical limitations that can last a lifetime; ii) in Niger the expected years of schooling of a child are 5.3 by their 18th birthday; and iii) when factoring in what children actually learn, the learning-adjusted school years decreases to 2.6 years.

3. **Women and girls do not fare well in Niger, and their challenging conditions are inextricably linked to the development of theirs and the country's, human capital.** Niger has the highest total fertility rate (TFR) and adolescent fertility rates in the world with 7.6 children per woman and approximately 206 births per 1,000 women, respectively. Furthermore, the high prevalence of children married before the age of 18 (76.9 percent) and its link to the high rates of drop-outs in lower secondary education (52 percent) are part of these determinants that hinder the achievement of better human capital outcomes for women and girls in the country[1]. In addition, to the low access to family planning and sexual and reproductive health services, there are deeply engrained societal and religious norms that drive beliefs, behaviors,

[1] Niger - Enquête Démographique et de Santé et à Indicateurs Multiples, 2012.

and practices around women's and girl's health, nutrition, education, and opportunities.

4. **Niger´s population suffers from poor nutritional status and health, and stunting, in particular, presents a significant challenge to the country´s long-term development of human capital.** In Niger, stunting affects 45.7 percent of children under-five and is one of the highest in the world[2], predisposing these children to higher mortality rates, cognitive delays, and low educational attainment; thus, decreasing lifelong income-earning potential and labor force productivity. The underlying determinants of stunting in Niger are multidimensional, and these affect the different stages of the *first 1,000 days* of the life course. Approximately, half of women in reproductive age (48 percent) are undernourished, only one in five children under 6 months of age is exclusively breastfed, and only half of the country's under-five children benefit from diversified and high nutritional meals. Moreover, the lack of improved water and sanitation sources, especially in rural areas in the country, as well as, food insecurity, the low purchasing power of the population, and the lack of social safety nets, contribute to the poor health and nutrition outcomes of the most underserved populations.

Sectoral and Institutional Context

5. There are four main dimensions that hinder the improvement of the health, nutrition, and education outcomes of the population in Niger.

6. **There is a need to strengthen the service delivery effectiveness both at the primary health care (PHC) and community levels in Niger.** The country presents one of the lowest financial allocations to health (USD 30 per capita), a significantly high out-of-pocket expenditure proportion (almost 50 percent of the total health expenditure), and its already constrained envelope does not reach the PHC system and the front lines of care. This lack of financial resources weakens the rest of the health system, resulting in a low service coverage and a low availability and quality of frontline health workers, especially in rural and remote areas, creating significant disparities among the regions in the distribution of human resources, health supplies, and technology. Furthermore, these challenges are heightened by the shortcomings in the coordination and integration of PHC, community health workers (CWH), and community-based delivery platforms.

7. **In addition to the gaps in the provision of health services, deeply engrained societal norms drive beliefs and cultural practices, particularly around girls and women, that curtail the utilization of the health and nutrition services that are available.** Therefore, improving health and nutrition conditions requires changes in behavior and practices from individuals in the household, who often do not have the agency, knowledge, or resources to make meaningful changes. This requires a coordinated approach, that targets every individual in the community, including leaders and traditional chiefs, by optimizing integration, citizen engagement, and communications. Currently, there are opportunities to scale-up community platforms, interventions, and resources to comprehensively address the multisectoral drivers of these underlying societal and religious norms. Nonetheless, further efforts are needed to address the macro and micro-level convergence obstacles that prevent the effective scaling-up of these platforms and resources.

8. **Micro-convergence at the community level is a challenge the country faces when addressing the service delivery effectiveness gaps and the societal norms that shape the poor human capital outcomes in the country.** Communities lack the ability to implement holistic changes in their communities as services and resources are not sufficiently and expeditiously available. In addition, community platforms grounded beyond the health sector, such as schools, community groups, and CWH are weak, non-existent, are not fully utilized, and lack the coordination to improve the well-being of the

[2] Niger - Enquete Nationale de Nutrition par la Methodologie SMART, 2019.

most underserved populations.

9. **Government policies and strategies in the health sector are geared toward universal health coverage and the improvement of human capital.** However, institutional capacities to operationalize these policies require further reinforcement and coordination with partners, donors, and other government sectors. Currently, the Government of Niger is committed to improving the well-being and prosperity of their population though the 2035 Plan for Accelerating Human Capital in Niger and the 2017-2021 National Health Development Plan. There are several entry points that already have a high level of buy-in at country level to strengthen coordination and management of both the government's and partners' resources, interventions, and efforts. However, these opportunities are not fully capitalized on and the government needs to approach them with innovative, integrated, result-based strategies to fully project the potential these resources have in improving the well-being of Nigeriens.

Long-term vision of the project

10. **Improving human capital in Niger requires a transformational, long-term effort.** Niger presents one of the most challenging country contexts in the world to make progress on human capital outcomes. Therefore, complex issues like reducing stunting, child mortality, maternal mortality, and shifting deep-seated societal norms that drive behaviors and practices require a commitment to a long-term vision to drive transformational change. This perspective goes beyond the beginning and end of a single 5-year operation that may fix only part of the problem and risk a disconnect in what is hoped to be achieved and what can be delivered in terms of an impact. As a first step to catalyze a transformational shift, the WBG, the Government of Niger, and key stakeholders in the country co-created a longer-term vision and are currently defining what will take to achieve this longer-term vision.

11. **The proposed operation is the "first phase" of achieving this longer-term vision of dramatically improving health and nutritional outcomes and the conditions of girls and women in Niger as a contribution to improving human capital outcomes**. The operation will focus on addressing the identified priority bottlenecks. To do this, the project will i) increase access to an integrated package of quality health and nutrition interventions focused on fertility, survival and stunting; ii) focus on behavior change, shifting societal norms, citizen engagement and multisectoral efforts at community level; and iii) strengthen institutional capacity through a focus on operationalizing results-based management of programs addressing relevant governance and PFM issues, expanding the rapid results initiative, and strengthening the capacity for Government to drive multisectoral action. Across the proposed operation, there will be an effort to integrate and rapidly scale innovations where relevant to accelerate impact. Financing under the operation will allow for testing new interventions and implementation modalities with other sectors such as WASH and social protection.

Relationship to CPF

12. **The proposed operation will support the implementation of the 2035 Plan for Accelerating Human Capital in Niger and the 2017-2021 National Health Development Plan.** The proposed operation is in line with the World Bank Group's (WBG) Country Partnership Framework (CPF) for the period FY18-22, specifically, the CPF Focus Area 2: Improved Human Capital and Social Protection. The proposed components and activities within this operation will support the achievement of the CPF Objective 3: Increased access to quality health services; Objective 4: Increased access to quality education and training services, particularly for women; and Objective 5: Improved social protection system and ability to manage forced displacement.

C. Proposed Development Objective(s)

Increase the use of a quality package of RMNCAH-N services and address key behaviors known to improve health and nutrition outcomes, as well as girls and women´s empowerment.

Key Results (From PCN)

13. The PDO-level results indicators are:

a. People who have received essential health, nutrition and population services
b. Rate of assisted births by a skilled professional
c. Percentage of children (0-6 months) receiving exclusive breastfeeding
d. Number of pregnant women who have received iron and folic acid supplementation
e. Modern contraceptive prevalence rate (women ages 15-49).
f. Number of children who have received curative services by CHW (for diarrhea and fever)
g. Percentage of children under two receiving essential community-based nutrition and early stimulation services

D. Concept Description

14. The proposed project has four components:

15. **Component 1. Increase access to an integrated package of quality health and nutrition interventions, focused on fertility, survival, and stunting.** This component has two subcomponents: Subcomponent 1.1 Increase access to an integrated package of quality health and nutrition interventions at the health facility level, by improving quality and removing financial barriers; and Subcomponent 1.2: Increase access to an integrated package of quality health and nutrition interventions at the community level, by improving quality and removing financial and geographic barriers.

16. ***Subcomponent 1.1: Increase access to an integrated package of quality health and nutrition interventions at the health facility level, by improving quality and removing financial barriers.*** The proposed activities under this subcomponent include a) financing an integrated package of RMNCAH-N services free to the population, through a performance-based finance (PBF) scheme; b) supporting capacity building of frontline health workers (including strategic scaling of capacity building innovations) to improve quality of service delivery; c) improving the quality of interventions at the primary health care (PHC) level (including strategic scaling of innovations); and d) financing limited health facility operation through procurement of needed equipment.

17. ***Subcomponent 1.2: Strengthening the national RBF program for PHC service deliver Increase access to an integrated package of quality health and nutrition interventions at the community level, by improving quality and removing financial and geographic barriers.*** The proposed activities under this subcomponent include a) supporting the operationalization and capacity building of integrated community health workers (CHWs) (including strategic scaling of capacity building innovations) to expand, and improve quality of community—based services delivery; and b) establishing and reinforcing referrals between community and health centers by strengthening the supervision of CHWs by local NGOs

to ensure delivery of the integrated package

18. **Component 2. Improve health and nutrition outcomes through behavior change, shifting societal norms, citizen engagement and multisectoral efforts at community level.** This component has two subcomponents: Subcomponent 2.1: Comprehensive behavior change (BCC), shifting societal norms, and community engagement to increase demand for and utilization of services and improve key behaviors for stunting reduction and better health outcomes; and Subcomponent 2.2 Support multisectoral delivery structures, modalities and pilot/scale innovations to accelerate improvement in human capital outcomes at community level.

19. ***Subcomponent 2.1: Comprehensive behavior change (BCC), shifting societal norms, and community engagement to increase demand for and utilization of services and improve key behaviors for stunting reduction and better health outcomes.*** The propose activities under this subcomponent include a) supporting with technical assistance for designing cutting-edge, tailored, user-centric behavior-change interventions at household, community, and ecosystem levels with a focus on demographic dividend and child development; b) establishing effective mechanisms for mutual accountability between the health facilities and the community; c) implementing an accountability chain at all levels to engage local communities in various programmatic functions; and d) establishing a robust, gender-sensitive Grievance Redress Mechanism (GRM).

20. ***Subcomponent 2.2: Support multisectoral delivery structures, modalities and pilot/scale innovations to accelerate improvement in human capital outcomes at community level.*** The proposed activities under this subcomponent include a) rolling-out a comprehensive primary and secondary school package that includes sexual and reproductive health, life skills, hygiene, health and nutrition; and b) scale-up existing interventions through multisectoral (i.e. agriculture, social protection, water, governance, etc.) platforms to accelerate improvement in human capital.

21. **Component 3. Strengthen project management and institutional capacity.** The proposed activities under this component include: a) improving management of public funds, information system and use of data, and resource management at central, regional and district level, and support evidence and knowledge production and management; b) improving coordination between different ministries and management at local level; and c) supporting operational costs and capacity building to ensure effective management and implementation of the project.

22. **Component 4. Contingent Emergency Response Component (CERC).**

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Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

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Note: To view the Environmental and Social Risks and Impacts, please refer to the Concept Stage ESRS Document**.**
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APPROVAL

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