

## PROJECT INFORMATION DOCUMENT (PID) CONCEPT STAGE

Report No.: PIDC7955

<b>Project Name</b>	Sahel Women's Empowerment and Demographics Project (P150080)
<b>Region</b>	AFRICA
<b>Country</b>	Africa
<b>Sector(s)</b>	Health (100%)
<b>Theme(s)</b>	Population and reproductive health (70%), Child health (10%), Health system performance (10%), Other communicable diseases (10%)
<b>Lending Instrument</b>	Investment Project Financing
<b>Project ID</b>	P150080
<b>Borrower(s)</b>	Government of Niger
<b>Implementing Agency</b>	MIN. OF POPULATION (H309)
<b>Environmental Category</b>	C-Not Required
<b>Date PID Prepared/ Updated</b>	27-Aug-2014
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<b>Concept Review Decision</b>	

### I. Introduction and 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 also not resulted in greater gender equality especially in terms of female mortality and access to economic opportunity. 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 transition, the pace is too slow and the 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. 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.

### **Sectoral and Institutional Context**

High fertility in the Sahel is accompanied by high maternal mortality, malnutrition and child dependency ratios. High fertility has strong implications for maternal mortality, since 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 (Table 1). Over the last decades, the Sahel region has been plagued by repeated food security crises to the point that this has become a “chronic emergency” in the region. Recurrent droughts, erratic rainfall, land degradation and desertification result in the loss of agricultural production and livestock, leading to 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 capital 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.

A 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 (Table 1), means that there are 105 children under age 15 for every 100 adults of working age – thus, there are fewer working age adults supporting a larger number of children under age 15, 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.

Other health, nutrition and population indicators, including service utilization, are also lagging behind in the Sahel. Table 1 also shows that contraceptive prevalence rates (CPR) in countries in the Sahel region are far below the SSA average of 24 percent. Low contraceptive prevalence rates (CPR) are prevalent across the region ranging from only 5 percent in Mauritania to a high of only

15 percent in Burkina Faso – these are far lower than the SSA and low-income country averages. One of the factors for the low CPRs is the frequency of stock-outs for contraceptives. Skilled birth attendance (a proxy for maternal health) remains lower than what is needed for substantial improvements in maternal mortality. In Niger, for example, only 29 percent of births are attended by skilled personnel, far below the average of 50 percent average of SSA. These low results are – in part – due to the low density of midwives and other personnel skilled in reproductive health (including community-based health workers).

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.

Early marriage and childbearing are common in the region. 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 (out of 1,000 women of age 15-19). 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.

Furthermore, 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 (Table 3). 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 delay marriage and childbearing.

Building women's capacity to effectively achieve their desired fertility is important and 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.

There is a strong rationale for addressing these constraints at the regional level, complementing national level efforts. Countries of the Sahel region share both challenges, constraints and opportunities to harness a demographic dividend that 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, 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), to achieve slower population growth and healthier, better nourished youth that are more educable and empowered with skills that match future jobs. A regional approach would indeed advance and harness regional public goods, efficiencies and economies of scale. It would also 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. The project draws on the potential to galvanize national action, leverage linguistic and cultural similarities across borders, capture cost-savings, and enhance quality through sharing of technical expertise and resources.

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, but given the harnessing of public goods and cross border spill-over, other countries in the region will also benefit. The selection of countries 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 moreover strong commitment and ongoing plans by regional bodies such as WAHO, ECOWAS and AMREF, as well as partners such as France, USAID, Bill and Melinda Gates Foundation (BMGF) and WHO. With UNFPA, all 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 as a joint effort between UNFPA and the Bank.

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.

### **Relationship to CAS**

The proposed project is in line with the World Bank Group (WBG) Sahel Regional Initiative which includes two inter-related pillars: (1) vulnerability and resilience; and (2) economic opportunity and integration. Instability and fragility in the Sahel derive from a complex web of interrelated factors such as land pressures from rapid population growth; desertification and extreme climate conditions (including drought and flash floods); and lack of economic opportunity. These factors have created a regional 'fragility trap'. The proposed project addresses the first pillar by addressing vulnerabilities within sub-populations in the Sahel (women and children) and the second pillar by facilitating the region to reap the economic benefits of a demographic dividend. In addition, the proposed project is in line with the cross-cutting themes of the Regional Initiative: gender and demographics.

Furthermore, Country Partnership Strategies (CPSs) for the Sahel countries highlight the importance of population, reproductive, maternal and child health and nutrition for development. In Niger for example, demographics were treated in the new CPS as a cross cutting issue with an expected outcome of increased awareness of and access to family planning. Objectives of the Mali CPS include addressing population issues and reinforcing public service performance. The CPS

(2014-2016) for Mauritania and the CPS (2013-2016) for Burkina Faso are making gender a cross-cutting priority for all Bank operations.

The regional project will be prepared in close coordination with country-level projects and national policies. In particular, HNP projects in Niger and in Côte d'Ivoire are being prepared in FY15 and will inform the preparation of the regional project (and vice-versa). The preparation of the regional project will also ensure high synergies with education and social protection projects.

## **II. Proposed Development Objective(s)**

### **Proposed Development Objective(s) (From PCN)**

The development objective of the project is to increase regional capacity and catalyze national responses to improve women and adolescent girls' empowerment and their access to quality reproductive and maternal health products and trained health personnel in the participating countries.

### **Key Results (From PCN)**

Women and girls empowerment:

- Number of girls (10-19) and women who are schooled, have increased their literacy skills or are not yet married thanks to the project (to be measure through the regional impact evaluations)
- Number of adolescent (girls and boys) that have been reached by regional communication campaigns

Access to quality reproductive and maternal:

- Number of couple year protection (CYP) provided through purchasing and distribution of key reproductive commodities

Access to quality reproductive and maternal personnel:

- Number of midwifery faculty members that have been trained or retrained by the regional training institutions
- Number of students in rural midwifery institutions who come from rural areas

Political commitment and capacity for policy analysis

- National budget amounts allocated/spent for addressing demographic dividend issues
- Number of persons trained on demographic analysis
- Number of completed impact evaluations (related to girls' empowerment and demographic impact)

## **III. Preliminary Description**

### **Concept Description**

Component 1: Improve regional demand for RMNCHN services and increase empowerment for women and adolescents (US\$90 million)

The component will support countries in their Social and Behavioral Change Communication programs (US\$5 million): Strong social and behavior change communication (SBCC) is a critical part of community mobilization which is necessary to address social norms, attitudes and practices, especially for sustainability of results. Social change focuses on the community while behavioral change focuses on the individual, making them complementary approaches that not only change

behaviors but also help the development of positive behaviors. To improve the impact of national SBCC programs, the project will fund two activities:

- Support a regional pool of experts on social mobilization, marketing, mass communications, and knowledge management on the related topics. This pool of experts will offer its services to all the selected countries engaged in large scale SBCC activities.
- Launch a regional media campaign and/or incorporate gender informed messages into existing campaigns, including through social media, radio, newspapers, and other relevant outlets. Such a campaign would also include messages from high-level champions, which would raise awareness among policymakers of issues surrounding access to RMNCHN services. The content would ideally be locally generated so as to be most relevant and culturally appropriate.

The component will also set up a regional fund for designing, financing and evaluating country programs in women and girls empowerment (US\$85 million). A regional fund will be established to finance and foster innovation for adolescent girls' programming. Through a regional call to proposals, the proposed regional mechanism would provide funding, technical assistance and M&E for countries wishing to scale-up already successful experiences or to implement large pilots. Proposals will be submitted by countries for activities that empower girls and women, including (i) support for keeping girls at secondary school (including conditional cash transfers to girls, monetary and non-monetary support to their families, support for accommodation and food for schooled girls), (ii) girls clubs (As in Ethiopia) for providing SBCC on health, nutrition, and population; life skills training; vocational skills training; (iii) income generation activities; and (iv) education curricula improvements to address RMNCHN skills. Such a mechanism would allow reaching both girls who are in school and those who never entered or have fallen out of the school system, or even girls in school whose needs the education sector alone cannot meet (for example, married girls).

#### Component 2: Strengthen Regional Capacity for Availability of RMNCHN Commodities and midwives (US\$90 million)

This component will contribute towards an increase in the critical inputs required to provide RMNCHN commodities and qualified staff.

The component will foster regional harmonization of registration and quality control of Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCHN) Commodities (US \$10 million).

The component will also support a Regional Pooled Procurement Process for purchasing RMNCHN commodities (US\$30 million). The project will support a regional procurement and financing mechanism for certain maternal health commodities such as misoprostol, oxytocin and Mg sulfate and potentially contraceptive pills and that can, through contracts with national distributors, quickly respond to supply shortages at public or NGO facilities. This component will work through an existing regional mechanism: the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) currently operated by UNFPA. Countries will use this mechanism for buying their RMNCHN commodities.

Through a regional fund, the component will support country efforts for enhancing the performance of their RMNCHN supply chain (US\$20 million). The project will support technically and financially requests from countries to improve the distribution part of their supply chain. Country proposals will have to be innovative, that is including use of IT or involvement of the private sector.

One example is the Informed Push Model (currently tested in Senegal). Another example is to include private providers of RMNCHN through a “buyer payment” system, where private providers of RMNCHN will receive a subsidy. Also, the country requests may include support to private franchising networks, so as to expand access to RM commodities. The regional fund will be managed along the lines of the regional fund mentioned in component 1.

The component will also support rural midwifery training institutions in target countries to increase the quantity and quality of midwives and other personnel involved in RMNCHN health (US\$30 million). This component will contribute towards an increase in adequately trained health workers that deliver RMNCHN services, particularly in rural and more remote parts of the Sahel. This will be done by setting up and developing a regional “hub-and-spoke” model for rural midwifery training that rural training institutions can draw on by:

- Strengthening quality assurance and regulation of midwifery education at regional level by supporting WAHO develop its accreditation department (with links to national departments) for accreditation of rural midwifery training institutions, midwifery faculty, and internship sites.
- Building capacity of one large mid-level training institution (i.e. the regional hub) to deliver a new (WAHO-accredited) midwifery faculty training program for the region, and emerge more generally as a regional center of excellence on midwifery education. In addition to capacity strengthening for this regional center, scholarships will also be provided so that midwifery faculty (with priority for those from rural areas) from the country can access this regional training. The regional center of excellence will also have to provide support to countries for their request to (i) revise curricula and teaching strategies including ensuring greater collaboration and division of labor with community health workers and community agents, and (ii) develop and implement “rural pipeline” strategies. The regional center will have to provide in-country training services from the hub, in particular with regards to training clinical instructors.
- Strengthening capacity of rural midwifery training institutions by a) providing financing for rural midwifery training institutions in countries to tap into regional e-learning efforts to deliver theoretical modules of midwifery curricula (freeing up time for clinical teaching), b) funding equipment and supplies for existing rural schools and internship sites, c) funding incentives for individuals/faculty to take serious their clinical supervision functions, and d) supporting these institutions for providing rural training to midwives to be posted in rural areas.

Component 3: Foster Political Commitment, and capacity for policy making and project Implementation (US\$20 million)

The component will strengthen Advocacy and Political Commitment on RMNCHN at regional and national levels (US\$5 million). This would be achieved through:

- Supporting the creation of a club of heads of states or the use of an existing one to discuss and advocate for issues around the demographic dividend at the highest level. This club would also include a peer control mechanism, along the lines of the African Peer Review Mechanism. Country data on policies, budget allocation, and results for addressing the demographic dividend will be collected at least annually and will be presented for discussion to this high-level club.
- Supporting the establishment of regional networks with parliamentarians, religious leaders, and civil society organizations. Data on budget allocations and results related to demographic dividend issues will be collected regionally and will be discussed within these regional networks. The component will support the collection of data and the operating costs of these networks.

The component will also strengthen Capacity for policy making, monitoring and evaluation related to demographic dividend issues (US\$10 million).

The component will strengthen project implementation capacity (US\$5 million). The component will strengthen project management capacities for the implementing agencies. The component will also include support to beneficiary institutions regarding sound management of medical waste and obsolete drugs.

#### IV. Safeguard Policies that might apply

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

#### V. Financing (in USD Million)

Total Project Cost:	200.00	Total Bank Financing:	200.00
Financing Gap:	0.00		
<b>Financing Source</b>	<b>Amount</b>		
BORROWER/RECIPIENT	0.00		
International Development Association (IDA)	200.00		
Total	200.00		

#### VI. Contact point

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