PROJECT INFORMATION DOCUMENT (PID)
IDENTIFICATION/CONCEPT STAGE

Report No.: PIDC36806

Project Name	BURUNDI MATERNAL CHILD NUTRITION ENHANCEMENT PROJECT
Region	AFRICA
Country	Burundi
Sector(s)	Crops (35%), Health (65%)
Theme(s)	Other social protection and risk management (10%), Health system performance (15%), Nutrition and food security (75%)
Lending Instrument	IPF
Project ID	P157993
Borrower Name	WORLD VISION BURUNDI
Implementing Agency	WORLD VISION BURUNDI
Environment Category	C - Not Required
Date PID Prepared	17-Nov-2015
Estimated Date of Approval	31-Oct-2016
Initiation Note Review Decision	The review did authorize the preparation to continue

I. Introduction and Context

Country Context

Poverty in Burundi remains stubbornly high, despite the annual Gross Domestic Product (GDP) growth of 4.5 percent (2013). The poverty headcount ratio has decreased from 86.4% (1998) to 81.3% (2006), but the absolute number of people living on less than $1.25/day has increased dramatically from 5.6 million (1998) to 6.5 million people (2006). After 10 years of open conflict, almost three years of economic embargo, and a four-year post-emergency period, Burundi has one of the lowest per capita Gross National Income (GNIs) in the world (US$280 in 2013). Although its Human Development Index (HDI) ranking has improved recently, it remains in the 178th position of 186 countries on the 2013 HDI, and is ranked last on the 2014 Global Hunger Index. Undernutrition undermines economic growth and poverty and is a critical element in this ranking because of its contributions to productivity losses from poor physical status, increased healthcare costs, and reduced cognitive functions and learning performance. Conversely, a population with adequate nutritional status, reflecting investments in social and human capital, contributes to sustained and equitable economic growth. The Copenhagen Consensus concluded that nutrition interventions generate returns among the highest of 17 potential development investments. Children under the age of 2 years and women of reproductive age are particularly vulnerable to poverty and fragile health systems. Other effects of the conflict include weak health institutions and infrastructure and poor coverage of health and social services, particularly in rural areas.

Despite improvements in child and maternal mortality, achieving the health-related MDGs 4 and 5 by 2015 remains a key development challenge. Annual rates of mortality reduction (3.1% for

under-5 mortality (1990-2013)[iv] and 1.5% for maternal mortality (1990-2010)[v] are significantly lower than the annual rates of reduction required to achieve the MDG targets (4.4% for under-5 mortality and 5.5% for maternal mortality). Additionally, Burundi has the highest level of chronic malnutrition in the world with a prevalence of 58% in children under the age of 5 years. Although the prevalence of chronic malnutrition is higher among the poorest quintile of households (70%), even the high-income population suffers from greater than 40% chronic malnutrition, which by international standards is extremely high. This fact suggests that malnutrition is not only a poverty issue, and it underscores the contribution of sub-optimal nutrition behaviours and practices including poor feeding, sanitation, caring, and hygiene practices. Moreover, micronutrient deficiencies (often called “hidden hunger” as they may not be visible to the naked eye) are widespread in Burundi, especially amongst women and children: 28% of under-5 children and 12% of pregnant women are vitamin A deficient, 45% and 61% of children are anemic and iodine deficient, respectively, 26% of pregnant women are anemic, and there is 47% zinc deficiency throughout the population. Undernutrition increases mortality and morbidity and increases expenditure on health overall.

Sectoral and Institutional Context

Burundi has one of the highest rates of stunting in the world and will not attain MDG1c[1] by 2015, resulting in significant threats to human development through lower cognitive development, increased disease burden, compromised learning performance, and reduced economic productivity. Globally, child and maternal malnutrition underlie 45% of all child deaths. Stunting, caused by chronic undernutrition, has remained virtually unchanged over the last two decades and is far removed from the Millennium Development Goal (MDG) target of 29%. Stunting begins at conception and is largely irreversible beyond the first two years of life. Undernutrition has further economic costs through cognitive delays in children and lower economic productivity in adults. Causes of lower economic productivity include lower physical strength, lower wages, and more days away from work due to illness among adults[xvii]. As a result, there is a greater than 10% reduction in lifetime earnings for each malnourished individual and approximately 8% loss in GDP. Chronic malnutrition is costing Burundi an estimated US$102 million per year, which is twice the annual budget of the Burundi Ministry of Health (MoH). Addressing undernutrition is cost effective: costs of core micronutrient interventions are as low as US$0.05-3.60 per person annually. Returns on investments are as high as 8-10 times the costs (For further economic analysis, refer to Annex 4). Burundi ranks the country with the highest prevalence of chronic malnutrition. The levels of chronic malnutrition increased since 1987 (56%) and has shown no change from 2005 to 2010 (58%). Furthermore, as a result of 10 years of open conflict, Burundi as a country has a weak health system structure, poor coverage of health and social services and poor integration between sectors. Thus, Burundi is a country that desperately needs support in the area of nutrition through nutrition-specific and nutrition-sensitive interventions.

In response to these challenges, the Government of Burundi (GoB) has demonstrated strong political commitment to tackle malnutrition. A multisectoral roadmap for scaling up nutrition actions was finalized in January 2012 and a national strategic plan for nutrition was developed with nine strategic axes, including: reinforcement of political commitment; infant and young child feeding (IYCF) promotion, micronutrient supplementation and food fortification, particularly salt iodization; and increased integration of nutrition interventions in primary health care community levels. The GoB formally launched the Scaling Up Nutrition (SUN) movement in Burundi in 2013 and in 2014 issued a Decree for the formation of the National Burundi Multisectoral Platform of

Food Security and Nutrition or Plan Strategique Multisectorielle de Sécurité Alimentaire et de Nutritionnelle (PSMSAN) to be located at the Second Vice Presidency level with appointment of the Deputy Chief of Staff as the National SUN Focal Point. The GoB established a food security and nutrition budget line (1 billion Burundian Francs, equivalent to approximately US$641,000) for the agriculture sector. These actions are in line with the recent Lancet Series on Maternal and Child Nutrition (www.thelancet.com) that recommended scaling up selected high-impact nutrition-specific[3] and -sensitive[4] interventions to address both the immediate and the underlying determinants of undernutrition.

Relationship to CAS/CPS/CPF

The Country Assistance Strategy (CAS) identifies malnutrition and anemia as key development challenges due to their negative inter-generational impacts on human development. Limited access to basic social services; high rates of returning refugees; and high dependency on agriculture in a context vulnerable to climactic and external shocks are also identified as some of the key development challenges. Under this overarching context, the proposed project will support WB's twin goals of shared prosperity and poverty reduction through a community-based approach to improve access to and quality of nutrition services for vulnerable and underserved groups that are not covered by other projects, especially areas with high rates of returning refugees, and vulnerable populations in the HHs, U2 children and pregnant and lactating women (PLW). Furthermore, the focus on improving nutrition in women and young children addresses one of the key barriers to poverty alleviation identified in the CAS.

II. Project Development Objective(s)

Proposed Development Objective(s)

The Project Development Objective (PDO) is to increase access to nutrition services among selected persons in Gihofi and Makamba, in the southern region of Burundi.

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Key Results

a. Net change in proportion of children aged 0-23 months of age participating in community-based nutrition activities
Baseline: 0
End target: 14,870 (40% of beneficiaries)
b. Net change in proportion of participating households with children 0-23 months of age reporting production of at least three micronutrient-rich crops
Baseline: 0
End target: 18,890 (50% of beneficiaries)

c. Net change in proportion of children aged 6-23 months of age reporting consumption of four or more micronutrient-rich foods in previous 24 hours
Baseline: 6,876 (25% of the estimated beneficiaries)
End target: 16,500 (60% of beneficiaries)

III. Preliminary Description

Concept Description

The project will promote improved nutrition through increased year-round production and consumption of micronutrient-rich foods among smallholder households and increased utilization of community-based nutrition services in project areas targeted to children 0-23 months of age and

their mothers or caregivers. Two Lead Mothers (LMs) will be selected from each village and trained with Agriculture Extentionistas for each hill within the selected health districts. The LMs will lead Mother Support Groups (MSGs), which will act as centers for LM-managed kitchen garden demonstration sites and high iron bean multiplication sites to promote improved practices in production, harvest and post-harvest management, and marketing. MSGs will also act as distribution points for packages of agriculture inputs to mothers with children 0-23 months of age. To build community demand for micronutrient-rich foods, strengthened community health workers will deliver community-based nutrition promotion activities, including growth monitoring and promotion for 0-23 month old children and malnourished children will be referred to Positive Deviance/Hearth (PDH) to be rehabilitated. In the targeted districts, the project will strengthen the technical skills of the relevant line ministry extension and outreach services, including the Ministere de l'agriculture et de l'elevage (MINAGRIE) and Ministere de la Sante Publique et de la Lutte contre le SIDA (MSPLS), to support the community-based agriculture, health and nutrition activities. The project will also support an impact evaluation and knowledge translation, and will enhance capacity for advocacy to scale up effective interventions to reach vulnerable children under-two and caregivers of children 0-23 months of age.

IV. Safeguard Policies that Might Apply

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

V. Financing *(in USD Million)*

Total Project Cost:	2.73	Total Bank Financing:	0.00
Financing Gap:	0.00		

Financing Source	Amount
Borrower	0.00
Japan Social Development Fund	2.73
Total	2.73

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