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Report No: PAD1137

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A PROPOSED GRANT

IN THE AMOUNT OF SDR 68.2 MILLION
(US$94 MILLION EQUIVALENT)

AND A PROPOSED CREDIT

IN THE AMOUNT OF SDR 6.6 MILLION
(US$9 MILLION EQUIVALENT)

TO THE

REPUBLIC OF NIGER

FOR A

POPULATION AND HEALTH SUPPORT PROJECT

May 1, 2015

Health, Nutrition and Population Global Practice – GHNDR
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2015)

Currency Unit	=	XOF
XOF 610	=	US$1
US$1.388	=	SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AFD	French Development Agency
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
AWP	Annual Work Plan
AYSRH	Adolescent and Youth Sexual Reproductive Health
BEEEI	*Bureau d'Evaluation Environnementale et des Etudes d'Impact* (Environnemental Evaluation and Impact Studies Office)
CA	Community Agent
CBD	Community Based Distribution
CCT	Conditional Cash Transfer
CER	Contingent Emergency Response
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CPS	Country Partnership Strategy
CSO	Civil Society Organization
DA	Designated Account
DHIS 2	District Health Information Software 2
DHS	Demographic and Health Survey
DLI	Disbursement Linked Indicator
ECHO	European Union Humanitarian Aid and Civil Protection Department
EEP	Eligible Expenditures Program
EFA	Education for All
EU	European Union
FCPDL	Fund for Continuing Professional Development and Learning
FGM	Female Genital Mutilation
FM	Financial Management
GAM	Global Acute Malnutrition
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GDPP	General Declaration of Population Policy
GII	Gender Inequality Index
HDI	Human Development Index
HDP	Health Development Plan
HIV	Human Immunodeficiency Virus

HMIS	Health Management Information System
HRH	Human Resources for Health
IEC/BCC	Information, Education, Communication/Behaviors Communication Change
IHP	International Health Partnership
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
INS	*Institut National de la Statistique* (National Institute of Statistics)
ITN	Insecticide-treated Bed Nets
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MEG	Essential Generics Drugs
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MOH	Ministry of Health
MOP	Ministry of Population, Woman Promotion and Child Protection.
MOSS	Ministry of Secondary School
MPLMCD	Ministry of Planning, Land Management and Community Development
MWMP	Medical Waste Management Plan
3 N	Nigeriens Nourish Nigeriens
NGO	Non-governmental Organization
ONPPC	*Office National des Produits Pharmaceutiques et Chimiques* (National Office of Pharmaceutical & Chemical Products)
ORS	Oral Rehydration Salt
PBF	Performance Based Financing
PDES	Plan for Economic and Social Development
PMCT	Prevention Mother to Child Transmission
PSCPSD	Public Sector Capacity and Performance for Service Delivery Project
RH	Reproductive Health
RHN	Reproductive, Maternal, Newborn and Child, Adolescent Health and Nutrition
RRA	Rapid Results Approach
RBF	Results Based Financing
SBCC	Social and Behaviors Communication Change
SC	Steering Committee
SDGP	Skills Development and Growth project
SDI	Service Delivery Indicators
SDR	Special Drawing Rights
SG	Secretary General
SNIS	*Système National d'Information Sanitaire* (National Information System of Heath Services)
SR	Sexual Rights
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
SSNP	Social Safety Nets Project
SWAp	Sector Wide Approach
SWEDD	Sahel Women Empowerment and Demographic Dividend Project
TFR	Total Fertility Rate

UNDP	United Nations Development Program
UNFPA	United Nations Population Funds
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fun for Women
VCT	Variable Cash Transfer
WHO	World Health Organization
XOF	*Franc Communauté Financière Africaine* (African Financial Community Franc)

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Country Director:	Paul Noumba Um
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Practice Manager/Manager:	Trina S. Haque
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NIGER

Population and Health Support Project (P147638)

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PAD DATA SHEET

Niger

Population and Health Support Project (P147638)

PROJECT APPRAISAL DOCUMENT

AFRICA

Report No.: PAD1137

Basic Information			
Project ID P147638	EA Category B - Partial Assessment		Team Leader(s) Djibrilla Karamoko
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 21-May-2015	Project Implementation End Date 31-Dec-2021		
Expected Effectiveness Date 30-Aug-2015	Expected Closing Date 31-Dec-2021		
Joint IFC No			
Practice Manager/Manager Trina S. Haque	Senior Global Practice Director Timothy Grant Evans	Country Director Paul Noumba Um	Regional Vice President Makhtar Diop

Borrower: REPUBLIC OF NIGER			
Responsible Agency: Ministry of Health			
Contact:	Dr Idrissa Maiga	Title:	Secretary General
Telephone No.:	(227-20) 722-782	Email:	idrissa2005@gmail.com
Responsible Agency: MP/WP/CP (Ministry of Population Woman Promotion and Child Protection)			
Contact:	Dr Aissatou Abdou Laouali	Title:	Secretary General
Telephone No.:	(227-20) 723505	Email:	aissatabdou@yahoo.fr

Project Financing Data (in USD Million)					
[ ] Loan	[X] IDA Grant	[ ] Guarantee			
[X] Credit	[ ] Grant	[ ] Other			
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

Expected Disbursements (in USD Million)

Fiscal Year	2016	2017	2018	2019	2020	2021	2022
Annual	14.00	17.00	18.00	18.00	18.00	12.00	6.00
Cumulative	14.00	31.00	49.00	67.00	85.00	97.00	103.00

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%

Human development	Population and reproductive health	45
Human development	Child health	25
Human development	Nutrition and food security	20
Human development	Health system performance	10
Total		100

Proposed Development Objective(s)

The project development objective is to increase the utilization of reproductive health and nutrition services in Targeted Areas.

The PDO will be achieved by implementing: (i) high impact interventions which increase the supply and quality of Reproductive, Maternal, Newborn and Child, Adolescent Health Nutrition (RHN) services especially in remote and underserved communities; and (ii) Social and Behavior Communication Change (SBCC) and women and girls' empowerment activities to overcome demand-side constraints.

Components

Component Name	**Cost (USD Millions)**
Improving the provision of high quality RHN services (DLI-based financing)	66.60
Increasing the demand of RHN services	30.00
Improving capacity to manage, coordinate, monitor and evaluate RHN services and demand-side activities	6.40
Contingent Emergency Response	0.00

Systematic Operations Risk- Rating Tool (SORT)

Risk Category	**Rating**
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	High
9. Other	
OVERALL	Substantial

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [ ]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

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**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Overall Project coordination and Project Steering Committee		30-Nov-2015	

Description of Covenant

SCHEDULE 2.Section I.A.1. (a) The Recipient shall establish not later than 3 months after Effective Date and maintain, throughout the Project implementation, the Steering Committee with composition and terms of reference satisfactory to the Association.

Name	**Recurrent**	**Due Date**	**Frequency**
Grievance mechanism		30-Nov-2015	

Description of Covenant

SCHEDULE 2. Section I.B. The Recipient shall establish not later than three (3) months after the Effective Date and maintain throughout Project implementation, an efficient, cost effective and independent grievance mechanism, based on international experience and best practices adapted to the local context, as further described in the Project Operational Manual acceptable to the Association.

Name	**Recurrent**	**Due Date**	**Frequency**
Recruitment of an External Auditor		29-Jan-2016	

Description of Covenant

SCHEDULE 2. Section II.B.4. The Recipient shall, not later than five (5) months after the Effective Date, recruit an external auditor, with terms of reference satisfactory to the Association, in accordance with the provisions of Section III of the Financing Agreement.

Name	Recurrent	Due Date	Frequency
Independent Verification		30-Dec-2015	

Description of Covenant

SCHEDULE 2. Section II.C.1.(c) The Recipient shall, not later than four (4) months after the Effective Date, appoint external monitoring and evaluation experts ("Independent Verifiers"), to act as third-party verifiers of the proper fulfillment of the DLIs set forth in Schedule 4 to the Financing Agreement.

Name	Recurrent	Due Date	Frequency
Memorandum of Understanding		30-Nov-2015	

Description of Covenant

SCHEDULE 2. Section V. No later than three (3) months after the Effective Date, the MoU has been revised and updated in accordance with the Financing Agreement, in a manner satisfactory to the Association.

Conditions

Source Of Fund	Name	Type
IDA	Adoption of Project Manuals	Effectiveness

Description of Condition

ARTICLE V. 5.01. (a) The Project Manuals have been adopted in form and substance satisfactory to the Association.

Source Of Fund	Name	Type
IDA	Recruitment of Procurement Specialist	Effectiveness

Description of Condition

ARTICLE V. 5.01. (b) The Recipient has recruited a procurement specialist on terms of reference acceptable to the Association.

Source Of Fund	Name	Type
IDA	Assessment Report	Disbursement

Description of Condition

SCHEDULE 2. Section IV.B.1.(i)The relevant EEP Spending and Assessment Report has been submitted to, and found satisfactory by, the Association in accordance with the Independent Verification Reports.

Source Of Fund	Name	Type
IDA	Disbursement Linked Indicators	Disbursement

Description of Condition

SCHEDULE 2.Section IV.B.1.(ii) any applicable Disbursement-Linked Indicators and Disbursement-

Linked Results as set forth in the table in Schedule 4 to the Financing Agreement have been met by the Recipient satisfactory to the Association.

Source Of Fund	Name	Type
IDA	Crisis or Emergency	Disbursement

Description of Condition

SCHEDULE 2.Section IV.B .1. (c)(i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the IRM Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof.

Source Of Fund	Name	Type
IDA	Safeguards Instruments	Disbursement

Description of Condition

SCHEDULE 2.Section IV.B .1. (c)(ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.G.1 of Schedule 2 to the Financing Agreement.

Source Of Fund	Name	Type
IDA	Coordinating Authority	Disbursement

Description of Condition

SCHEDULE 2.Section IV.B .1. (c)(iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.G.1 of this Schedule 2 to the Financing Agreement, for the purposes of said activities.

Source Of Fund	Name	Type
IDA	IRM Operations Manual	Disbursement

Description of Condition

SCHEDULE 2.Section IV.B .1. (c)(iv) The Recipient has adopted an IRM Operations Manual in form, substance and manner acceptable to the Association and the provisions of the IRM Operations Manual remain or have been updated in accordance with the provisions of Section I.G.1 of this Schedule 2 so as to be appropriate for the inclusion and implementation of said activities under the IRM Part.

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Djibrilla Karamoko	Team Leader (ADM Responsible)	Senior Health Specialist	Public Health	GHNDR
Ibrah Rahamane Sanoussi	Procurement Specialist	Senior Procurement Specialist	Procurement	GGODR
Celestin Adjalou Niamien	Financial Management	Sr Financial Management	Financial Management	GGODR

	Specialist	Specialist		
Aissatou Diallo	Team Member	Senior Finance Officer	Financing Tools	WFALA
Alexandra C. Bezeredi	Safeguards Advisor	Regional Environmental and Safeguards Advisor	Environmental Safeguards	OPSOR
Gertrude Mulenga Banda	Team Member	Office Manager	Administration	GHNDR
Amba Denise Sangara	Team Member	Temporary	Administration	GHNDR
Christophe Lemiere	Team Member	Senior Health Specialist	Health Services Delivery	GHNDR
Christophe Rockmore	Team Member	Senior Economist	Monitoring and Evaluation	GHNDR
Claudia Rokx	Team Member	Lead Health Specialist	Nutrition and Public Health	GHNDR
Dominic S. Haazen	Team Member	Lead Health Policy Specialist	Health Management & Administration	GHNDR
Emanuela Di Gropello	Program Manager	Program Leader	Education for All	AFCW3
Gyorgy Bela Fritsche	Team Member	Senior Health Specialist	Health Services Delivery	GHNDR
Hadidia Diallo Djimba	Team Member	Program Assistant	Operations	AFMNE
Helene Barroy	Team Member	Economist	Health Economics	GHNDR
Hocine Chalal	Environmental Specialist	Lead Environmental Specialist	Environment	GENDR
Ibrahim Salaou Barmou	Team Member	E T Temporary	Operations	AFMNE
Jenny R. Gold	Team Member	Senior Health Specialist	Public Health	GHNDR
Medou Lo	Safeguards Specialist	Consultant	Safeguards	GENDR
Meera Shekar	Team Member	Lead Health Specialist	Nutrition	GHNDR
Rifat Hasan	Team Member	Health Specialist	Health Services Delivery	GHNDR
Ruxandra Costache	Counsel	Counsel	Legal	LEGAM
Sybille Crystal	Team Member	Senior Operations Officer	Operations	GHNDR
Aissatou Chipkaou	Team Member	Operations Analyst	Operations	GHNDR
Extended Team				

Name	Title	Office Phone	Location
Creti Pantaleo	Consultant		Roma

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required?	Consultants will be required

I. STRATEGIC CONTEXT

A. Country Context

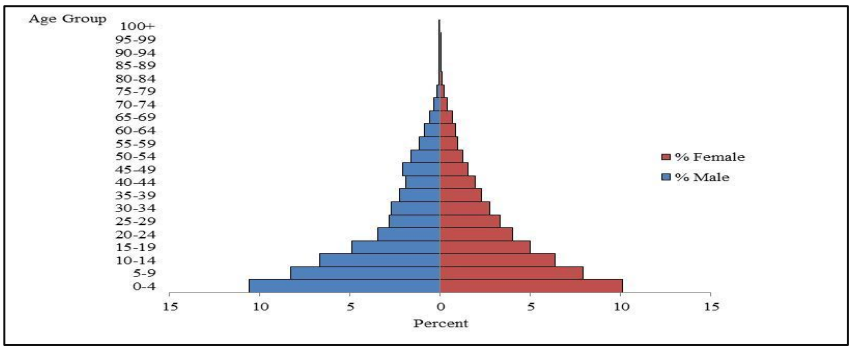
1. **The Republic of Niger is a landlocked country of 19 million people with an area of 1,267,000 square kilometers, surrounded by armed conflict and rebellions.** In Niger, the geographical conditions are aggravated by unfavorable climatic factors (3 percent of the land area can be cultivated given the present level of rainfall). Millet and sorghum are the only cereals that can be extensively cultivated, and only 1 percent of the total land area can be cultivated with maize. The present gap between national production and needs for basic cereals is growing inexorably due to harsh conditions (external shocks, irregular or insufficient rains, poor soils, and diminishing returns) and increasing population pressure. The Libyan conflict, the rebellion in northern Mali and the recent *Boko Haram* attacks in Niger, Cameroon, and Nigeria contribute to regional instability. This insecurity poses huge development challenges to Niger.

2. **Despite these harsh conditions, Niger has made some progress on economic growth and poverty-reduction in recent years, yet these gains are in jeopardy due to the demographic profile and poor human development**. Over the 2008 - 2013 period, annual economic growth was sustained at an average of 5.7 percent. In 2014, the growth rate was estimated at 6.5 percent. On the back of economic growth, poverty declined from 64 percent in 2005 to 60 percent in 2008 and 48 percent in 2011, predominantly affecting rural households and women. Despite this, GDP per capita is still very low at US$360 – this is far below the Sub-Saharan Africa average of US$1647. Furthermore, Niger ranks last among the 187 countries on UNDP's 2013 Human Development Index (HDI).

3. **The economic growth that Niger has experienced is not contributing as much as it could to greater prosperity due to the current and projected demographic profile of the country.** A *demographic transition* – the shift from high to low mortality and fertility levels – has begun through an impressive decline in child mortality. However, fertility remains high and has actually increased in the last five years to 7.6 children per woman. The population is estimated to increase to 35 million by 2030 and 69 million by 2050. Persistently high fertility and declining child mortality have resulted in a very young age structure with 49 percent of the population below age 15 (Figure 1) and a child dependency ratio of 105, meaning that there are 1.05 children for each person of working age. The presence of such a large share of youth has implications at both the household and national levels in terms of health, nutrition, food security, human development, demand for jobs, and economic growth and stability.

4. **However, Niger can still capitalize on its demographics, avert the attendant negative externalities, and reap the benefits of the *demographic dividend*,** which is the accelerated economic growth that can result from a decline in a country's mortality, a rapid decline in its fertility and the subsequent change in the age structure of the population. If fertility declines rapidly, Niger's young dependent population will grow smaller in relation to the working-age population, resulting in lower dependency ratios. With a smaller proportion of people to support and reduced demand for expanding social services, Niger will have a window of opportunity for even more rapid economic growth. Utilizing accompanying policies to foster human capital, employment and investments (e.g., health, nutrition, education, labor, trade, and governance policies), Niger may be able to harness this demographic transition in the form of a *demographic dividend*.

Figure 1: Population Age Structure for Niger[1], 2012



5. **To address Niger's development challenges, the Government of Niger is committed to an ambitious program for accelerated and sustainable economic development and poverty reduction**. Niger's Poverty Reduction Strategy - the Plan for Economic and Social Development (PDES) for 2012-2015[2] – outlines an ambitious investment program in (i) economic growth; (ii) public institution strengthening; (iii) food security and agriculture; and (iv) promotion of social development. The pillar on social development aims to improve the level of social indicators through enhancing access of the population to basic social services and the implementation of a social protection policy for the most vulnerable groups.

B. Sectoral and Institutional Context

6. **Niger has made progress in its health, nutrition and population outcomes, but the country still lags substantially behind other low-income countries and Sub-Saharan African (SSA) counterparts.** Both infant and child mortality have declined remarkably (36 percent or more between 2006 and 2012), placing Niger in a position to achieve Millennium Development Goal (MDG) 4 by 2015. Improved use of bed nets for children under-five and immunization coverage of children under 12 months of age have been key factors in the progress on child health. But chronic malnutrition or stunting, which contributes to over one third of child mortality, remains very high despite its decline from 55 to 44 percent, due to difficult access to health centers, lack of proper sanitation and behavioral factors, all exacerbated by recurrent food shortages.

7. **The implications of poor reproductive, maternal, newborn child, adolescent health and nutrition (RHN) outcomes are substantial and negatively impact the well-being of Nigeriens.** Despite some improvements in maternal health, the maternal mortality ratio (MMR) remains high at 535 per 100,000 live births in 2012, higher than the SSA average of 500. Skilled birth attendance is only 29.3 percent, and the modern contraceptive prevalence rate (CPR) remains low at 12 percent[3]; or about half of the regional average. Niger's fertility rate (7.6 children per woman) is substantially higher than the SSA average of 5.1[4] and highest even in the Sahel sub-region. As a result, Niger[5] is unlikely to achieve MDG 5 on maternal health.

[1] Niger: Population was estimated at 17.2 million in 2012, with a very high growth rate of 3.9 percent.
[2] New PDES 2016-2020 is under preparation.
[3] Unmet need for family planning is 16% in 2012.
[4] High fertility is explained by early marriage and childbearing (partly due to cultural attitudes, religious beliefs, and gender inequity as evidenced by low socioeconomic status of women), inadequate availability and quality of reproductive health and family planning information and services, and high illiteracy rate. See: *Population and Development in the Sahel*, World Bank, Washington, DC, November, 2014.
[5] INS, Demographic and Health Survey 2012, Report of September 2013.

8. **Low coverage and utilization of RHN services are attributed to both supply and demand side constraints.** On the supply side, service utilization is low due to inadequate provision of quality health services, including challenges with respect to the geographic distribution, the quality and the skills-mix of human resources, despite the recruitment of 2,410 additional health workers in 2011. Despite the financial incentives provided by the government to encourage staff to work in rural areas, the spatial distribution still shows regional disparities, particularly in favor of Niamey, which has 8 percent of the total population but about 50 percent of health staff (doctors, nurses and midwives), including one-third of the doctors. The doctor density in Niamey is 17 times greater than in Tillaberi and 13 times greater than in Dosso, two of the poorest regions of Niger.

9. **Another supply-side constraint in the provision of health services is the lack of predictability of reimbursements and the unavailability of affordable drugs across health facilities.** Niger has put in place a fee exemption policy in 2006 for specific vulnerable groups and priority services (services for children under 5, prenatal consultations, family planning commodities, cesarean sections, and female cancer). With the financial support from donors, the Government has made an effort to pay on time, in order to help health facilities purchase drugs and others commodities. However, reimbursements for the selective free health care policy are generally late, incomplete and unpredictable, leading to the inability of health facilities to maintain their drug revolving funds and debts with drug suppliers.

10. **Quality of care is poor with untimely and inappropriate care being provided to clients.** According to the 2012 DHS, among children with diarrhea and acute respiratory infection, only 43 percent and 53 percent, respectively, received appropriate care. Only 35 percent of pregnant women received the two recommended doses of drugs for the Intermittent Preventive Treatment of Malaria. Use of health services is limited among adolescents: 16.4 percent of pregnant adolescents aged 15-19 do not receive any antenatal care; two thirds deliver at home with no assistance and only 7 percent use contraception. A quality survey conducted in 2013 by the MOH also reported inadequate providers' practices and behaviors toward women and adolescent health including: lack of privacy, inconsistency of clinical practices, staff absenteeism, and lack of adolescent-friendly approaches.[6]

11. **Niger has successfully scaled up the treatment of severe acute malnutrition among under-five children, covering up to 400,000 children each year, however, chronic malnutrition and underlying determinants have not been similarly addressed.** In response to food security crises, international aid organizations have taken the lead to address both acute and chronic malnutrition, with collaboration from local non-governmental organizations (NGOs). Interventions to prevent chronic malnutrition and promote healthy nutrition behavior such as exclusive breastfeeding and appropriate complementary feeding as part of the Essential Family Practices package are being successfully implemented at the community level, mainly by NGOs. However coverage is low, and a key challenge is to scale up such interventions.

12. **On the demand side, the health services are fraught with inequities of all types – geographic, cultural, structural, and financial.** Only 49 percent of the population has access to

[6] A Service Delivery Indicators survey (SDI) will be conducted with Bank technical assistance in 2012.

a health facility within five kilometers of their home, and the poor availability and high cost of transportation presents additional challenges to accessing care for 41 percent of women. The disparities in health outcomes per wealth quintile are substantial. In the 2012 DHS, 60 percent of women faced financial barriers to using a health service with a higher proportion in rural areas (62 percent rural versus 49 percent urban). In addition, lack of education for women and girls (only 22.4 percent of women between 15-24 years old are literate) and socio-cultural barriers both constrain women's use of reproductive health services (including modern contraceptives) and increase the likelihood of early marriage and early pregnancy. Cultural factors also constrain women's ability to use health services: 21 percent of women stated that the need to get the permission of their husbands created problems in seeking care.

13. **Niger has low levels of education, which is the cornerstone of building human capital.** This is true especially for girls. Primary school enrollment is below the regional average, and girls in particular are lagging behind – only 57 percent of girls aged 7-12 are enrolled in primary school. Secondary school enrollment is substantially lower, at just 10 percent for girls and 14 percent for boys aged 13-19. Youth literacy figures are also alarming, especially for girls. These trends greatly constrain Niger's capacity to progress in human development in all its key dimensions.

14. **Early marriage and early childbearing are common, and despite national support for adolescent reproductive health, young people experience high levels of unplanned pregnancies, unsafe abortions, sexually transmitted infections and maternal mortality and morbidity.** The median age at first marriage is 15.7 years, the lowest in the Sahel, and age at first birth follows a similar pattern with the majority of first births occurring during adolescence: the median age at first birth is 18.6 years and the adolescent fertility rate is high at 206 births per 1,000. 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 with early sexual activity and childbearing. Adolescent childbearing affects not only the health of these young women and their children but also the mothers' long-term education and employment prospects. A decline of 50 births per 1,000 women aged 15-19[7] would be associated with a decline in total fertility of 1.2 children per woman.

15. **The low demand specifically for RHN services results from additional factors, including social barriers to access (religious and male opposition to family planning[8]), high desired fertility[9], low perceived need for RHN services, low levels of women's empowerment, and weak leadership on implementation of relevant policies.**[10] According to the 2012 DHS, women still reported that they wanted to have an average of 7.4 children, higher than in sub-regional neighbors such as Mali, Burkina Faso, Benin and Nigeria. Evidence indicates that some key factors affecting women's desire to limit or space births include: (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 for women and girls including educational and economic resulting in low bargaining power.

[7] From an African average of 115 births per 1,000 adolescents (UN 2011).
[8] *Population and Development in the Sahel*, World Bank, Washington, DC, November, 2014.
[9] According to successive rounds of the DHS the ideal number of children has actually been increasing in Niger since 1992.
[10] *Population and Development in the Sahel*, World Bank, Washington, DC, November, 2014.

16. **While child mortality has been declining, the prevalence of child morbidity has remained high, suggesting that the expected tradeoff in terms of lower child mortality and fertility has not been fully realized.**[11] In other words, parents may continue to have more children due to uncertainty either over child survival (from multiple episodes of childhood illness) or whether the surviving children will be healthy and able to support them in their later years.

17. **The government's interventions for adolescents so far have mostly focused on strengthening the supply of healthcare services, while insufficiently addressing the demand-side.** On the demand-side, three main types of interventions have been developed on a small scale: (i) life skills development for women and adolescent girls; (ii) peer education; and (iii) behavior change activities. This multi-pronged approach to stimulating the demand for services can help women and adolescent girls to acquire the tools that help them have more control over their socioeconomic environment and the ability to make choices, and better equip them to be involved in decision making and defend their rights.

18. **Overall financing for the health sector is a major challenge, underlying many of the supply and demand-side barriers.** Niger's health sector suffers from chronic under-funding. Only 2.4 percent of Niger's GDP is allocated to the health sector.[12] Given the reliance on out-of-pocket expenditures as the main source of health financing, the cost and unaffordability of health services remain the leading barriers for poor people who represent 48.2 percent[13] of the population. Annual per capita health spending is US$8, which is far below global health care financing benchmarks. Due to declining donor contributions, government expenditures on health declined significantly between 2008 and 2010, from XOF 55.4 billion to XOF 29.6 billion (US$92.9 million to US$49.6 million), which represents a decline of 47 percent during this period.[14] Between 2010 and 2011, health expenditures increased to XOF 40.5 billion (US$67.9 million), which is a significant improvement but still less than the amount in 2008. As a share of total government expenditure, health expenditures have also fallen, declining from 12.4 percent in 2008 to 7.1 percent in 2011. The total contribution of health expenditures of bilateral and multilateral agencies including NGOs also dropped drastically from 33.5 percent in 2005-2006 to 20 percent in 2009. Spending on goods and services declined by 11 percent, and spending on transfers and subsidies fell by 3.6 percent, while personnel costs increased drastically after 2011. Capital expenditures continued to decline, representing only 8.4 percent of total public expenditure in the sector.

19. **The government has endorsed a national COMPACT[15] with its development partners and committed to concerted efforts to tackle the bottlenecks hampering the delivery and scaling up of RHN services.** The implementation of the Health Development Plan (HDP) is supported by the sector wide approach (SWAp) which helped to harmonize and align donors' funds with national budget contributions for district health plan financing. Donors support the sector through: (i) stand-alone projects implemented by an independent unit; and (ii) a pooled fund (see Annex 6), which has been set up by a number of partners: Spain, France, United

[11] Aksan A-M. 2014. Childhood Mortality and Morbidity in sub-Saharan Africa's Fertility Transition. Presented at Population Association of America Annual Meeting 2014 (Boston).
[12] MOH, National Health Accounts (NHA) 2011, December 2013.
[13] INS, National Survey on Household living conditions and Agriculture - ECVMA – 2011.
[14] World Bank, PER 2012.
[15] COMPACT: Country compact is written commitments made by government and development partners that describe how they will work together to improve health outcomes through the International Health Partnership (ihp+).

Nations Children's Fund (UNICEF), Global Alliance for Vaccines and Immunization (GAVI), United National Population Fund (UNFPA), and the World Bank. Annex 9 shows the current activities of various partners in the health sector, while Annex 11 shows the memorandum of understanding (MoU) signed by the pooled fund donors.

20. **Niger has committed to address the challenges noted above through a number of strategic documents** (see Annex 8 for details):

- the 2011-2015 HDP[16] to improve maternal and child health with a strategic focus on delivering essential health services to children, women and most vulnerable groups of the population;
- the Government Declaration of Population Policy (GDPP)[17], adopted in 2007, to decrease population growth by addressing contraception and early marriage, with the overall objective of contributing to poverty reduction;
- the Government Nutrition policy linked to the 3N ("*les Nigériens Nourrissent les Nigériens*" or Nigeriens Nourish Nigeriens) initiative to address malnutrition comprehensively in a multi-sectoral approach with a focus on food security, malnutrition prevalence, and chronic malnutrition; and
- the adolescent-friendly policies which have been increasingly mainstreamed in national strategies for poverty reduction, health, education, and jobs. The adoption of the Reproductive Health Law in 2006 marked a milestone in acknowledging sexual and reproductive health rights, especially for young women, as a top priority for government action. A specific National Plan for Adolescent Sexual and Reproductive Health was also adopted in 2011 in Niger.

C. Higher Level Objectives to which the Project Contributes

21. **The FY13-16 Country Partnership Strategy (CPS) is aligned with priorities of the government Plan for Economic and Social Development (PDES).**[18] Pillar 2 of the CPS aims to reduce vulnerability through increased access to clean water, sanitation, health and population services for the most vulnerable people. The proposed project is included in Pillar 2 of the CPS and will be a multi-sectoral operation targeting the health and population sectors. The main focus areas of the project will be strengthening of health service delivery, improvement of community-level behaviors, and the empowerment of women. The project will make a contribution to: (i) the improvement of reproductive health, maternal health, and child health including nutrition; and (ii) the social and behavior change to improve outcomes of women and adolescent girls, including the involvement of change agents, such as traditional and religious leaders at the community level.

22. **The World Bank has committed itself to the twin goals of eliminating extreme poverty and boosting shared prosperity**. Women and children are at the core of a country's current and future economic productivity and as such, are at the center of the Bank's twin goals. Improving health and nutrition using all segments of the health system including creating a stronger public private partnership (use of NGOs) will improve cognitive development of

[16] New Health plan for 2016-2020 will be available at the end of 2015.
[17] The revision of the policy planned at the end of 2015 under the support of the SWEDD project.
[18] PDES: Plan de Développement Economique et Social 2012-2015.

children, educational achievement, and economic productivity, contributing to the elimination of extreme poverty. Furthermore, the project will give priority to the worst-off regions in Niger and benefit women, both of which will contribute to reducing geographical, socioeconomic, and gender inequities. Lastly, although the emphasis of the project activities is geared towards preventing chronic malnutrition, this will contribute to reducing the stubbornly high acute malnutrition rates in Niger.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

23. The project development objective is *to increase the utilization of reproductive health and nutrition services in Targeted Areas*.

24. The PDO will be achieved by implementing: (i) high impact interventions which increase the supply and quality of RHN services especially in remote and underserved communities; and (ii) social and behavior change communication change (SBCC) and women's and girls' empowerment activities to overcome demand-side constraints. The proposed project will support supply-side interventions such as improving the availability of care for women and children under five. It will be complemented by demand-side approaches to enhance utilization of services.

B. Project Beneficiaries

25. **The project beneficiaries will be women of reproductive age, pregnant and lactating women, adolescent girls and children under-5 in targeted regions**. Change agents will include men, women, health workers, community leaders and local authorities. The project's SBCC activities will be implemented in five regions: Dosso, Maradi, Tahoua, Tillaberi and Zinder. These regions have high fertility levels, high under-five mortality, low coverage of skilled birth attendance, and high prevalence of stunting among children under-five (Table 1). The majority of the population (88 percent) resides in these regions, with an aggregate population of 15 million across the five regions, including 3.1 million women aged 15-49; 1.65 million adolescent girls aged 10-19; and 3.3 million children under age five.

Table 1: Status of the Regions in 2012 (DHS)

Regions	Total Fertility Rate (Children per women)[a]	Under-Five Mortality Rate (deaths per 1000 live births)[a]	Skilled Birth Attendance (%)[a]	Stunting in Children Under 5 (%)[a]	Number of Adolescent Girls (10-19 years)[b]	Median Age of First Marriage (women 25-49 years)[a]	Adolescents 15-19 who have given birth or are pregnant with first child (%)[a]
Agadez	5.7	51	49.9	39.6	54,594	17.1	26
Diffa	6.4	41	31.7	54.1	51,185	16.8	43
Dosso	7.5	190	33.1	37.3	228,192	16.3	33
Maradi	8.4	166	26.6	53.5	381,645	15.3	44
Tahoua	7.3	140	24.5	38.9	330,437	15.7	46
Tillaberi	7.9	168	29.3	38.1	311,462	16.1	38
Zinder	8.5	160	19.6	52	398,574	15.4	52
Niamey	5.3	80	83.8	20.4	114,575	19.5	15
NIGER	**7.6**	**127**	**29.3**	**44**	**1,870,664**	**15.7**	**40**

[a] DHS 2012.
[b] Population Census 2012.

C. PDO Level Results Indicators

26. **The proposed PDO key results indicators are as follows**:

(i) Women 15-49 years old using modern contraceptive methods (percent);
(ii) Skilled birth attendance at delivery for women 15-49 years (percent);
(iii) Exclusive breastfeeding for children under 6 months (percent);
(iv) Women 15-49 and children (<5) using the basic package[19] of reproductive health and nutrition services (number), of which girls 15-19 (percent); and
(v) Direct project beneficiaries (number) of which female (percent).

27. Achieving the PDO will contribute to improved health and nutrition outcomes, including reduced maternal mortality, infant mortality, fertility and malnutrition.

III. PROJECT DESCRIPTION

A. Project Components

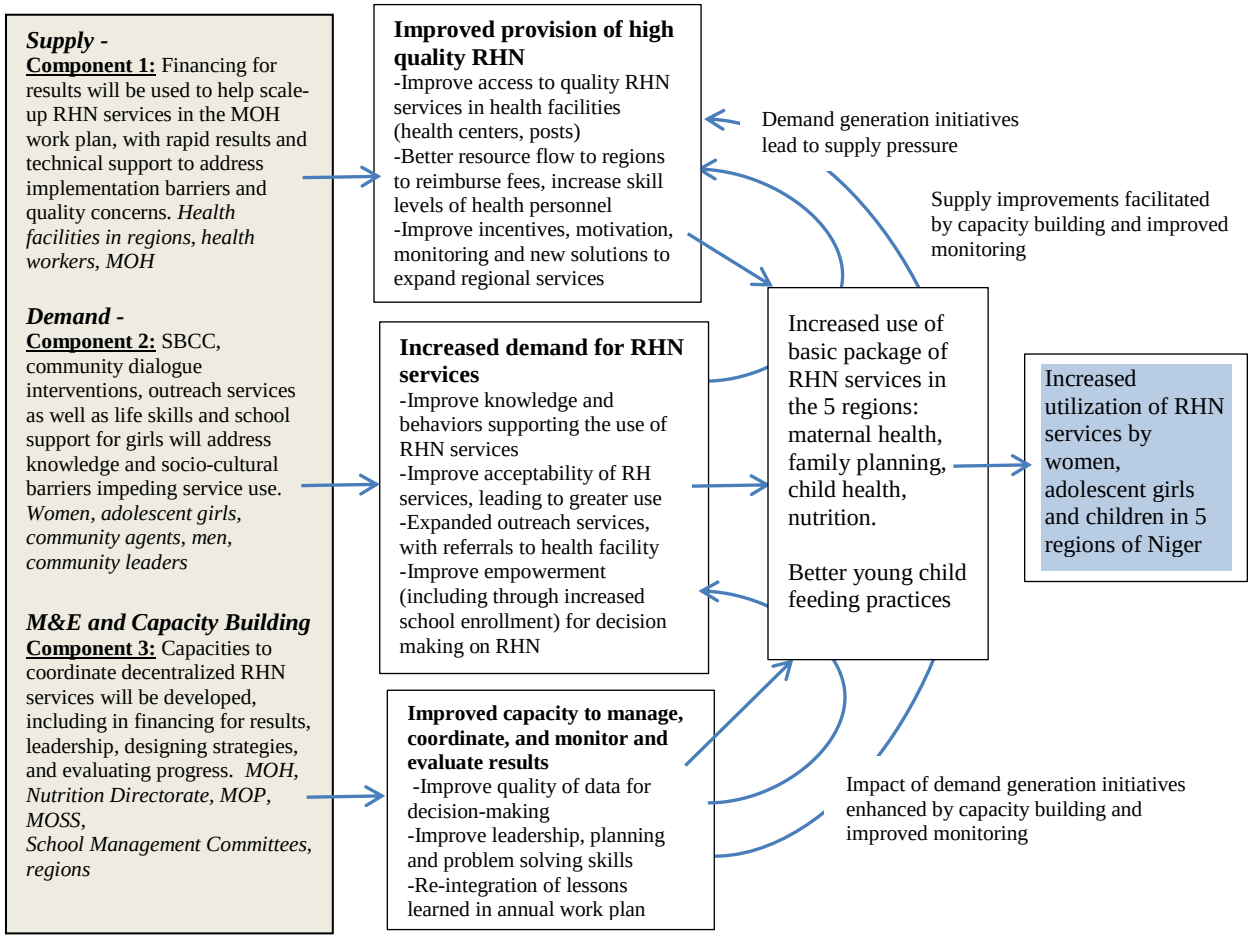
28. The project will be implemented over six years, and it is organized around four components: (i) improving the provision of high quality RHN services (DLI-based financing); (ii) increasing the demand of RHN services; (iii) improving capacity to manage, coordinate, monitor and evaluate RHN services and demand-side activities; and (iv) establishing a contingent emergency response.

29. The first three components will work together in a mutually supportive way to address the key issues highlighted above: (a) inadequate funds and incentives to provide services; (b) insufficient demand for services; and (c) inadequate capacity for high quality service delivery. The first of these issues will be addressed by Component 1, the second by Component 2 and the third by Component 3. Component 4 is designed to allow the project to quickly address emergency situations if they arise. There are also strong links between the activities under this project and those of ongoing projects within and outside of the health sector, in terms of both complementary efforts and implementation synergies. The Sahel Women's Empowerment and Demographic Dividend Project (SWEDD - P150080), the Social Safety Nets Project (SSNP – P123399), the Skills Development and Growth Project (SDGP – P126049) and the Public Sector Capacity and Performance for Service Delivery Project (PSCPSD – P145261) are of particular relevance. The specific areas of complementarity are included in Annex 3.

30. The theory of change describing how the interventions in each component are expected to advance results to achieve the development objective, emphasizing the results linkages between the supply- and demand- side components of the project, is shown in Figure 2 below. Annex 5 further elaborates on the theory of change including describing the particular institutional capacity constraints on the supply - and demand-sides addressed by each component of the project to support the intended results.

[19] Basic package include prenatal consultations, infant consultations and Vitamin A.

Figure 2: Summary of theory of change between interventions and project development objective, and links between component results (refer to annex 5 for Theory of Change Table)



31. **Component 1: Improving the provision of high quality RHN services (DLI-based financing) (US$66.6 million equivalent).** This component aims to strengthen the supply of health and nutrition services for women of reproductive age (including young women, pregnant and lactating women) and children under age five. For direct nutrition interventions, children under two years of age are the main target population. Component 1 will be implemented using a disbursement linked indicators (DLI) approach, which pays for achievement of results defined by key performance indicators and triggered by independent verification. DLIs are a series of outcomes, outputs and process indicators against which funds will be disbursed to MOH on an annual basis upon the achievement of the indicators and targets listed in the DLI matrix (Annex 2). The process indicators are designed to focus attention on key bottlenecks in the effective achievement of the outcome and output indicators, specifically: (i) the timely release of funds to health facilities so that they can procure required medications; (ii) the training of staff to provide higher quality care; and (iii) the effective monitoring and supervision of staff to ensure that these new and improved skills are being applied. The use of the DLI approach recognizes that the existing network of health facilities is generally capable of providing quality services but requires

additional and timely funding to the front lines, as well as the further training and supervision which the MOH will be able to provide from the DLI funds. Additional capacity building will be provided through Component 3.

32. The component will support the SWAp by utilizing the existing pooled fund arrangements, and the Eligible Expenditure Program (EEP) will include government spending in the following areas: health facilities' operating expenses; maintenance of equipment and facilities; community-based interventions to promote reproductive health and nutrition; training of health workers to improve their clinical skills and undertake supportive, effective and regular supervision; and monitoring and evaluation at the community level. Government expenditures in these areas are expected to range between US$16 million and US$23 million per year over the next five years in the target regions. Furthermore, Rapid Results Approaches (RRA) financed through Component 3 would be used to support the MOH to collaborate with health facilities to define and strengthen the implementation of the Annual Work Plan (AWP) activities by advancing context specific learning on how to achieve the DLIs. The use of DLIs and the payment for results should facilitate the improvement of high impact RHN services by providing funding linked to the achievement of specific performance targets in the five regions.

33. As shown in Table 2 below, the expected amount to be contributed to the DLIs (about US$16.7 million annually) is expected to be less than the amount expected to be spent within the target regions for the relevant eligible expenses (shaded area). This will be monitored on an annual basis.

Table 2: Expenditure Framework based on 2015 AWP (millions of US$)

Type of Expenditure	Central	Target Regions	Other Regions	Total
Salaries (from National Budget)				49,425,147
Operating costs (including training and supervision)	299,241,244	52,435,545	10,868,025	357,733,615
Goods & Capital Expenditures and Equipment	94,148,436	6,225,209	27,774,174	105,594,814
Total	**393,389,680**	**58,660,754**	**38,642,199**	**512,753,576**

34. The following DLIs (Table 3), have been defined based on key elements: (i) success measures, means for verification and targets; (ii) the price of each indicator and payment modalities; and (iii) the eligible expenditures that will be verified for payment. An initial advance payment will allow the MOH to mobilize the necessary resources to achieve the expected Disbursement Linked Results (DLRs) in the first year. Given the nature of the services involved, a higher advance is provided for the first 2 DLIs, as well as for the last 3 process related DLIs.

Table 3: Disbursement Linked Indicators

	Disbursement linked indicators	% of Total DLI amount	Value (millions of US$)
1	Increase in women utilizing modern contraception (Percent and number)	20%	13
2	Increase in women delivered by a trained health professional (Percent and number)	20%	13
3	Increase in new accepters (girls <20yrs) using modern contraceptives (Percent)	6%	4
4	Increase in children <1 year of age having received nutritional counseling and an updated growth chart (Percent)	15%	10
5	Increase in children 0-11months immunized with measles (Percent and number)	15%	10
6	Health facilities receiving payments from the central government for their	9%	6

	revolving fund on time (Percent)		
7	Training of health workers to deliver RH and nutrition services (Number)	8%	5.5
8	Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)	8%	5.1
	Total	**100%**	**66.6**

35. The verification of progress towards achievement of the project's objectives will be based on an annual technical audit that will be carried out by an external monitoring and evaluation experts ("Independent Verifiers") procured according to World Bank procedures, within four months of project effectiveness. The technical audit will be based on a comparison between the documentation provided centrally by the MOH, including the HMIS data, and on-site verification in a representative sample of areas targeted by this component where health facilities will be randomly selected.

36. **Component 2: Increasing the demand of RHN services (US$30 million equivalent).** This component aims to increase demand for RHN services by promoting social and behavior change among the main stakeholders, empowering women and improving availability and accessibility of key RHN commodities in communities. This component will operate at the community level with interpersonal communication, social marketing, social dialogue and community mobilization. It is strongly linked with the health sector through Component 1. While Component 1 strengthens provision of services, Component 2 increases demand for these services. Components 1 and 2 will reinforce one another to increase utilization of services. The activities in this component will be implemented by NGOs, build on the activities implemented by the ongoing SSNP, and complement activities in the SWEDD Project (specific complementarities highlighted in Table 12 in Annex 3).

37. **Sub-component 2.1: Promote Social and Behavioral Change (US$9.5 million).** The sub-component will support community-level SBCC activities on RHN, population, and development issues. SBCC will be used to increase the demand for RHN services by addressing knowledge, social, cultural and gender barriers. With technical support from the SWEDD Project, implementation support from the ongoing Social Safety Nets (SSN) Project, and contracting of NGOs, various SBCC approaches will be further developed and implemented. The SWEDD Project will contribute to a regional pool of experts who will provide technical assistance to develop a national SBCC strategy. In the same targeted regions as the Population and Health Support Project (PHSP), the SSNP is currently implementing SBCC activities[20] focused on early childhood development. The PHSP will develop an SBCC strategy that is comprehensive, complementary and integrated with the SBCC activities currently implemented by the SSNP, and will aim to: (a) expand the scope to include reproductive, maternal and adolescent health themes; (b) intensify delivery modes and possibly the number of community workers and scale up within the household to include all women (all wives) and children; and (c) improve availability and accessibility of key RHN commodities.

38. *Relais communautaires* (Community Agents) are currently mobilized by NGOs and play a complementary role to that of the community health worker, thereby strengthening the links

[20] SBCC at the community level is being particularly targeted toward the most disadvantaged households. The SSNP project's beneficiary targeting system will be used for identification of households (poorest 30%) and implementation of intensive SBCC activities thereby contributing to equity.

between the health facility and the community.[21] Under the project, the *Relais* will receive additional training to strengthen her/his counseling skills and nutrition knowledge as he/she is responsible for one on one counseling and home visits to encourage caretakers to monitor their child's growth at regular intervals.

39. **Sub-component 2.2: Women's and Adolescent Girls' Empowerment (US$17.2 million equivalent).** The sub-component will improve community-level demand for RHN services by empowering women and adolescent girls with the knowledge and skills needed to make informed use of RHN services coupled with economic incentives for participation in key initiatives. Initiatives aimed at empowering adolescent girls (age 10-24) will be focused on: (i) life skills; (ii) schooling; and (iii) skills development. Life skills training will include modules on reproductive health (especially family planning), health and nutrition, hygiene, self-esteem, and financial literacy. Financial support to poor households to maintain their adolescent girls at school is expected to contribute to the reduction in the drop in enrollment between primary and secondary school.[22] The schooling intervention will be implemented in the same geographical areas as the SSNP and will utilize the already established beneficiary targeting[23]and payment systems. Skills development activities for out-of-school adolescent girls will be developed in collaboration with UNFPA, and implemented through local NGOs. Training modules will be tailored to livelihood opportunities specific to each region and may include sessions on: agriculture, cooking, agro-business, handicraft, sewing, etc.

40. **Sub-component 2.3: Mobilize opinion leaders (US$3.3 million equivalent).** The sub-component aims to expand the SBCC strategy to 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.

41. **Component 3: Improving capacity to manage, coordinate, monitor and evaluate RHN services and demand-side activities (US$6.4 million equivalent)**. The component will support project management, implementation, monitoring and evaluation. It will strengthen the capacity of MOH, MOP, MOSS and MPLMCD capacities in management, monitoring and coordination by providing: (i) administrative, management and fiduciary support; (ii) leadership and skill building at the central, regional and local levels to support implementation, particularly through the use of Rapid Results Approach (RRA); (iii) technical support to enhance the design of policies and strategies and the revision of training programs to improve the quality of care (for reproductive health and nutrition); and (iv) implementation monitoring and evaluation. It will also support technical assistance (TA) for capacity building of MOH and MOP in nutrition, SBCC and demography.

[21] In the scope of the SSNP, NGOs make operators available for the project and select 1 community educator for each 25 beneficiaries. Both NGO operators and *relais communautaires* receive a two-week training at the beginning of the activity, as well as another two-week refresher training after 6 and 12 months of implementation. NGO operators provide coaching to *relais communautaires* during their monthly visit to each community. Thorough quality control procedures are put in place, with quality controllers hired by the implementing NGOs, as well as quality controllers hired directly by the project. Each NGO operator covers 10-15 villages, and there is one quality controller for every five NGO operators. In addition to quality control, beneficiary participation in program activities is registered in the project Management and Information System (MIS).

[22] In Niger there are two main points of school drop-out for girls: after primary school and after the first year of secondary school. After these points, attendance is relatively stable.

[23] The selection of eligible households for the schooling intervention will be made based on the SSNP register.

42. **Component 4**: **Contingent Emergency Response (US$0).** The objective of this component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by OP/BP 8.00 (Rapid Response to Crisis and Emergencies). Niger is experiencing serious environmental problems including land degradation, desertification, soil erosion, water pollution, floods and droughts, leading to epidemics of communicable diseases such as meningitis and cholera, as well as other health problems such as malnutrition which are related to these environmental issues. There is a moderate to high probability that during the life of the project, environmental or other factors could lead to a major epidemic or other disaster which causes a major adverse economic and/or social impact (e.g., Ebola), which would result in a request from the country to the Bank to support mitigation, response, and recovery in the region(s) affected by such an epidemic. In anticipation of this, an emergency component is proposed.

43. The request would be appraised and reviewed, and if found acceptable to the Bank, disbursement would be made for this component. The component will be used to draw resources from uncommitted project funds, as well as 5 percent of the aggregate undisbursed balances of Niger's portfolio of investment projects, and/or allow the Government to request the Bank to re-categorize and reallocate financing from other components to partially cover emergency response and recovery costs. In such case, the PDO would be revised and the scope of the project would be expanded to cover expenditures incurred under this component. It should be noted that this component will not be used to finance salaries. The safeguard assessment will be conducted and the safeguards policies triggered will be supported by the project. An "Immediate Response Mechanism Operational Manual" (IRM/OM) has been prepared by the country and it will be revised to integrate the proposed project. The manual will be updated with details including financial management, procurement, safeguards and any other necessary implementation arrangements. Detailed procedures are included in Annex 3.

B. Project Financing

44. **The proposed lending instrument is Investment Project Financing (IPF)**. The IPF will be executed using a hybrid structure with a DLI component (1) complemented by traditional investment components (2 and 3). The US$103 million equivalent cost of the Project will be financed by an IDA grant of US$94 million equivalent and a credit of US$9 million equivalent and its implementation period will be 6.7 years, from May 2015 to December 2021.

C. Project Cost and Financing.

45. Table 4 below presents a summary of the project costs by component.

Table 4: Project Costs and Financing by component in US$

Project Components	Project cost	IDA Financing	% Financing
1. Improving the provision of high quality RHN services	**66.6**	**66.6**	100
2. Increasing the demand of RHN services	**30.0**	**30.0**	100
2.1. Promote social and behavior change	9.5	9.5	100
2.2. Women's and adolescent girls' empowerment.	17.2	17.2	100
2.3. Mobilizing opinion leaders	3.3	3.3	100
3. Improving capacity to manage, coordinate, monitor and evaluate	**6.4**	**6.4**	100

RHN services and demand-side activities			
4. Contingent Emergency Response	**0**	**0**	
Total Financing Required	**103.0**	**103.0**	

46. **Disbursements under Component 1 are based on the achievement of pre-specified results, as measured by DLIs.** Component 1 is composed of 8 DLIs. Components 2 and 3 finance essential activities to generate demand for RHN and enable the MOH to work towards meeting the disbursement conditions under the DLIs, respectively.

D. Lessons Learned and Reflected in the Project Design

47. **The proposed project design utilizes results-based, demand generation and technical assistance/capacity building approaches, taking into account the lessons learned from implementation of the previous projects in Niger,** including: (i) the population agenda needs to be anchored at the highest level of government; (ii) ownership of project design and implementation by the government is key for successful implementation; (iii) linking health and nutrition SBCC efforts with women's empowerment activities can have a synergistic effect on women's economic conditions; (iv) interventions can benefit from being designed and implemented through a bottom-up approach, using decentralized and community-based distribution of information, commodities and services; (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; (vi) greater allocation of financial resources for coordination and implementation; and (vii) technical and operational capacity building through technical assistance at multiple levels to increase country ownership. Contracting NGOs for implementation at the community level has been successfully implemented both in Niger and neighboring countries. NGOs have been used to expand community-level interventions to overcome demand-side barriers, and to improve education outcomes for boys and girls while addressing gender gaps.

- **The results-based financing approach using DLIs is new to Niger's health sector, though it is being used in the Public Sector Capacity and Performance for Service Delivery Project (P145261).** By providing expertise and implementation capacity through Component 3 to meet disbursement conditions in Component 1, the project keeps the focus on results rather than inputs.
- **Lessons from other projects indicate that the use of community agents (CA) such as "*Relais communautaires*" at the village level and Community Health Workers (CHW) at health post/huts should be based on the country specific conditions and build on the lessons learned from the ongoing interventions in the village**. The recruitment conditions of the CA and their status in the village are critical to the success of the intervention. Moreover, successful CA&CHW utilization requires a careful selection of the agent and realistic and appropriate levels of expected services, taking into account cultural context; high quality training, regular remuneration, and a reliable supply chain.[24] Technical supervision is also a key element in the process.
- **Rapid Results Approach (RRA) can provide country learning to advance DLI targets and health outcomes.** For example, in Sierra Leone, a flagship Public Sector Reform Program (Improving Productivity through Management and Pay Reforms) used 90-100

[24] WHO (2007) *Community Health Workers: What do we know about them? The state of evidence on programs, activities, costs and impact on health outcomes of using community health workers*, WHO 2007. Geneva, Switzerland.

day RRA to advance DLIs for Pay and Performance. The RRA provided new solutions for the ministries involved to advance targets for the previously slow moving or stopped reforms.[25] Good results were also achieved to advance health outcomes in Rwanda[26] and Burundi.[27]

- **The complementarity and collaboration with ongoing projects will be crucial.** As indicated above and in Table 12, strong synergies exist with the SWEDD (P150080), SSNP (P123399), SDGP (P126049), and PSCPSD (P145261) that can support the implementation of the project, including targeting poor and vulnerable communities.
- **Capacity building is an essential element of project implementation, especially when new concepts are being used.** The activities in Component 3 are critical to the successful implementation of Components 1 and 2. Innovative capacity building approaches can be used, such as the India Integrated Child Development Services Project (P121731) which builds incrementally on small amounts of learning at a time, until all skills, understanding and actions have been put into regular practice, and internalized by those trained.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

48. **The project will be implemented by two ministries: MOH and MOP**. Based on the lessons learned from the implementation of the previous project[28] in the two sectors, a PIU will not be established for the proposed project. The Ministry of Health will be responsible for the overall management as well as the monitoring and evaluation of the project. The Secretary General (SG) of the MOH will be responsible for oversight and strategic coordination of the Project. The SG will coordinate the overall functions and responsibilities of the technical directorates. The SG of the MOP will have the same responsibility for Component 2 of the project. Detailed implementation arrangements are included in Annex 6.

49. **The project will rely on existing institutional and implementation arrangements for the HDP and the GDPP**. The implementation of the two strategies follows Niger's decentralized structure of administration. The implementation responsibility has been shared between the central level (policy regulation), the regional directorates (technical support), and the departmental level (operational activities). Each ministry will be given the responsibility to execute specified activities in line with its mandate. The responsibilities of the MOH include the national health policy formulation, health services expansion, establishment of the standard norms and operational protocols, regulating service delivery and ensure the distribution of the staff in the different regions of the country. The MOP has the same role and responsibility by focusing its intervention on social and behavior change, social protection, child protection and the promotion of women. The central level supports the regions in system development and mobilizes resources

[25] World Bank (2014) *Reforming Civil Service in Sierra Leone through Collective Leadership. WBI 2014, Washington DC.*
[26] Rapid Results Institute. Project *Report, Health – Increasing Assisted Births, Rwanda. http://rapidresultsinstitute.info/what-we-do/projecthighlights/rwanda-2.*
[27] World Bank (2014) *Leadership for Results: Developing Capacity and Delivering Results toward Public Sector Reform in Burundi. WBI 2013, Washington DC.*
[28] Institutional Strengthening and Health Support project (P083350) and the Multi-sectoral Demographic project (P096198). Examples: (i) SWAp seeks to achieve sector leadership, financial flow and harmonization; (ii) Ownership of design by the government through a full appropriation of the project design and the integration of the project team within the government officials in charge of implementing, etc.

to improve population and social and health service delivery on the ground. The MOH will implement Components 1 and 3 while the MOP will implement Component 2. If required, the MOH will implement Component 4. Modalities of collaboration between the MOP and the Social Safety Net Project (SSNP) Unit has been discussed and agreed during the preparation. The SSNP will implement PHSP activities related to SBCC and the schooling intervention. Details of these arrangements are included in Annex 6.

50. **A Steering Committee (SC) will be established to oversee project implementation and coordination**. The steering committee will approve the project related annual work plan and review annual budgets and audit reports. The committee will be chaired by a representative from the Ministry of Planning, Land Management and Community Development (MPLMCD) and will be composed of the representatives from the Ministry of Finance (MOF), MOH, MOP, MOSS, other key ministries and ongoing projects (SSNP, SDGP, PSCPSD) involved in implementation. The steering committee will function during the full project implementation period of six years, and will meet at least twice a year.

B. Results Monitoring and Evaluation

51. **A comprehensive description of the Project's results framework and the arrangements for monitoring and evaluation (M&E) are described in Annex 1 (Results Framework and Monitoring)**. The Directorates of Planning of the MOH and the MOP will be responsible for monitoring Project implementation and results. The agreed PDO indicators and a set of key intermediate outcome indicators, including DLIs for Component 1, will be monitored during the life of the Project. A third party will be in charge of the verification of data reported on DLIs and will be financed under Component 3.

52. **The data sources for the PDO indicators will be the DHS and HMIS.** During the project implementation period, one "mini" DHS[29] will be undertaken in 2018 and financed by the project. This will provide additional data to assess if PDO indicators are advancing as targeted. The national health management information system (HMIS or "*SNIS*") will be used to collect monitoring data on the number of women 15-49 and children under 5 using the basic RHN service package scaled-up through the project, as well as data on beneficiaries reached in Component 1. Information on the number of beneficiaries reached in Component 2 will come from NGO records and school management committees. The HMIS is the responsibility of the MOH Directorate of Statistics, with support provided by the National Institute of Statistics (*INS*). The data collected for all project indicators will be monitored for the five targeted regions and data will be disaggregated by region, such that differing progress can be analyzed to inform efforts to strengthen results.

53. **Data sources for monitoring the intermediate results in Component 1 are primarily the HMIS, supervision and financial reports of the MOH and the independent verification agent for the DLIs**. This is to strengthen existing country information systems. HMIS data is reported annually by health facilities and aggregated nationally by the MOH, with support of INS. The report of data for the previous year is expected to be available in February of the next year.

[29] "Mini" DHS because of the sample size.

The DLI verification will validate the HMIS data and data from MOH reports for the DLIs. The data sources are identified in the results framework.

54. **There are several data sources for monitoring the social and behavior change communication and empowerment interventions**. The intermediate results of Component 2 will be monitored using data reported by the NGOs contracted for implementing the interventions, as well as reports from the School Management Committees in the villages and districts that are receiving the family support for girls' education. The MOP will be responsible for the annual collection of this data.

C. Sustainability

55. The project is expected to be sustainable because of the leadership and commitment shown by Government, and the strong joint ownership of: (i) the MPLMCD to implement and monitor the PDES; (ii) the MOH to implement an RHN program developed with the support of the H4+ partners[30]; and (iii) the MOP to pursue the implementation of the population strategy. Although the base is still low, the Government has also shown increasing willingness to finance health and social welfare cost from its own resources, effectively leveraging available donor resources.

56. The Project will support improvements in both the demand for and supply of a comprehensive package of RHN services. The project will enhance the capacity of community agents, health workers, and community leaders through the implementation of the SBCC activities and RH commodity distribution which will increase the use of health services at the decentralized level. Community empowerment will be a major contributor to better basic health and nutrition care, especially in under-served areas. Nevertheless, in a context of macro-economic volatility, it is clear that in Niger, sustainability of sector efforts will take time to materialize. Donors should agree to articulate their interventions around the overall sector strategy and to continue to have a candid dialogue on sector challenges and to provide support in the implementation of the strategies.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Risk Category	**Rating**
1.Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of project or Program	Substantial
5. Institutional Capacity for implementation and sustainability	Substantial
6. Fiduciary	High

[30] H4+ partners: WHO, UNICEF, UNFPA, WB and UNAIDS.

7. Environment and Social	Moderate
8. Stakeholders	High
9. Other	
Overall Risk	**Substantial**

B. Overall Risk Rating Explanation

57. **The overall project risk is rated as substantial**. The multi-sectoral project is very complex because of the existing capacity gaps within the two sectors involved in its preparation and implementation. The MOH has the capacity to implement the project with the ongoing SWAp, while this capacity has to be built in the MOP. To mitigate the high risk of Stakeholders, an extensive policy dialogue and technical assistance will be used to ensure that those who will be implementing the project understand the activities that are to be financed. Dialogue with development partners will be undertaken to ensure proper coordination in support of the overall government objectives.

58. **Macroeconomic risks are substantial.** These risks stem from Niger's vulnerability to volatile commodity prices, its unpredictable climate, and the region's fragile security situation. A drought would exacerbate the threat of food insecurity and potentially require emergency food imports, and increase budgetary pressures. A new and significant deterioration of security situation would challenge the fiscal stability, by both diminishing public revenues, and increasing spending on security and on supporting refugees. The World Bank is collaborating with other UN agencies and bilateral partners to closely monitor the security situation. The improvement program of the country irrigation systems will help to mitigate the impact of weather-related shocks on livelihoods and food security.

59. The risk to security will remain a challenge and it will likely affect World Bank implementation support to the project. In order to reach some target areas, the Bank Group will use third parties, including CSOs and NGOs to help monitor and provide effective implementation of the project in insecure areas.

60. **Implementation and sustainability risks are substantial because of the use of the new approach with DLIs.** The use of the DLIs will require capacity which is currently being developed through the Public Sector Capacity and Performance for Service Delivery Project (P145261), which will help mitigate the risk. The experience of the MOH with Bank-financed projects will also help to mitigate the risk since the team is familiar with World Bank procedures, and has demonstrated the ability to monitor project results with a unique M&E plan. The annual process evaluation and integrated use of the Rapid Results Approach to define the annual work plan will support progressive integration of new lessons and innovations to strengthen results. Additional TA will be mobilized to support the implementation of the DLIs and to conduct sector performance verification vis-à-vis the agreed indicators.

61. **Perception of corruption is still high in the country**. Niger was ranked 103 of 175 countries surveyed in Transparency International's 2014 corruption ranking. There are risks of

leakage, misappropriation and fraud in the provision and use of inputs because of weak detection of fraud and corruption. As such, the fiduciary risks are high. The capacity building efforts included in project design and strengthening of the sector accounting and auditing systems should mitigate the risk. Procurement and financial management arrangements are designed also to mitigate fiduciary risks through regular financial and procurement planning and reporting, following Bank and Government of Niger guidelines and practices, and a qualified fiduciary team is in place within the pooled fund management unit. The project will fund technical assistance and training for identified gaps in knowledge and practices related to the project's objectives.

62. The overall risk to achieving the PDO is assessed as **Substantial**.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

63. Economic analysis plays a crucial role in informing the choice of project alternatives, especially in resource-constrained environments, and is often used to make decisions on how a project could enable efficient and equitable use of resources. The economic analysis of the project (Annex 10) provides an overview of the macro-fiscal and health financing context of the country, an economic rationale for investing in the health sector in Niger, and an analysis of the costs and benefits of the proposed project's components and activities, through a Cost-Benefit Analysis (CBA).

64. **Health financing in Niger: limited resource mobilization for health.** Population and health are key determinants of economic growth and development. Health in Niger has not benefited much from recent economic growth. The sources of finance for health are based mainly on household out-of-pocket spending (48 percent). The state mobilizes modest resources for health (32 percent of total health expenditure), while external aid accounts for about 20 percent. Total health spending represents 5.2 percent of GDP, about US$17-18 per capita (in current US$). This situates the country far below the regional average, which spends approximately US$150 per capita for health. Niger is estimated to spend about half of what low-income countries spend on average for health. Due to a disproportionate financial burden assumed by households, financial protection remains limited, despite the removal of user fees for children under five (curative care) and pregnant women in 2006.

65. **Economic rationale for investing in the health sector in Niger.** Improving health outcomes and access to health services is critical to building all citizens' capabilities and enabling them to compete for jobs and opportunities generated through inclusive and sustainable development. Investing in women's and children's health services is critical to improve access to quality services for direct beneficiaries. The economic justification relies on the disproportionate burden of maternal and neonatal deaths in Niger and the fact that affordable and cost-effective interventions to prevent these avoidable deaths are well-established. Evidence for low-income countries suggests that improved coverage with a package of interventions directed to mother and child is extremely cost-effective (US$82-US$142 per disability adjusted life year (DALY)

averted)[31]. The interventions and support proposed under this project are all considered global "best buys" in this respect.

66. **A Cost-Benefit Analysis (CBA) was conducted to measure the project's economic performance** and to ultimately assess its net returns against alternatives (e.g., status quo). The analysis focused on the DLI project component consisting of 64 percent (or US$66.6 million) of the total project budget. The CBA analysis shows a net present value of US$6.5 million, with a rate of return of approximately 18.2 percent.

67. By boosting the system's reliance on existing health facilities and delivery mechanisms, the project will be directly contributing towards the sustainability of the sector. By spending US$3.5 per capita, per year (including overhead costs), the cost is likely to be affordable and sustainable in the long term for the country.

B. Technical

68. The technical approaches proposed in this project are the main drivers for the progress expected in the health sector. The national health development plan 2011-2015 reflects the Nigerien government's vision to achieve the health sector goals which are closely aligned with the MDGs. The project will use a results-based approach through the use of DLIs, which should help to demonstrate good results. The relative innovation of the project interventions may pose some technical challenges. As a mitigation measure, the project will support technical assistance (international and local) to increase the capacity and knowledge of local counterparts. Further, the combination of encouraging demand for nutrition services at the community level and increasing the capacity of the health sector to provide quality nutrition services at the health facility aims to: (i) create a sustainable approach to nutrition counseling; and (ii) focus the attention of both the community and the health sector on promoting child growth to *prevent* malnutrition instead of only treating malnutrition among children which has been the focus in Niger for the past decade.

C. Financial Management

69. Financial Management (FM) responsibilities will be carried out for components 1 & 3 by the MOH through the Pooled Fund Unit (*Fond Commun – FC*) under the coordination of the Secretary General (SG), and for Component 2 by the MOP under the coordination of the SG. These ministries will thus ensure adequate FM arrangements are in place through the project life, financial reports are prepared in an accurate, reliable and timely manner, and auditing (internal and external) arrangements acceptable to IDA are in place. The FM team has conducted an assessment of the implementing entities to ensure that their FM capacity meets minimum requirements under OP BP10.00. The assessment complied with the Financial Management Manual for World Bank-Financed Investment Operations that became effective on March 1, 2010 and AFTFM Financial Management Assessment and Risk Rating Principles. As a result of the identified constraints, the following measures will be taken :

[31] Disease Control Priorities, Second Edition, 2006.

a) At Pooled Fund Unit level, the internal control system will be reinforced by a stronger involvement of the internal audit unit, and the Pooled Fund Unit will ensure internal audit reports will be systematically communicated on a quarterly basis to the World Bank. The Pooled Fund Unit has already taken appropriate measures to correct the internal control weaknesses including: (i) the recruitment of a second internal auditor which is underway; (ii) the update of the project FM procedures manual before the effectiveness, and (iii) the accounting software is customized to fit the new project needs not later than two months after effectiveness. The Pooled fund Unit will recruit an external auditor, not later than five months after effectiveness in order to mitigate the weakness of the national audit arrangements;
b) At MOP level, the coordination unit that is being set up under the Sahel Women's Empowerment and Demographics Dividend Project (SWEDD) will be relied on to take charge of the FM activities of the project. In addition, (i) a well experienced accountant will be recruited and be dedicated to the Project activities, and (ii) the accounting software will be customized to include Component 2 activities.

70. **Disbursement will be report-based for Component 1 following the Disbursement Link indicators (DLI) mechanism**. In the first year, MOH will receive DLI-zero advances as reflected in the DLI Matrices (Annex 2). At the end of each year, MOH will prepare a report justifying the corresponding value of each DLI as agreed with the Bank in the DLI matrices. The report will be supported by a financial report on the Eligible Expenditure Programs (EEPs). Funds will be disbursed annually from the IDA Credit/Grant Account to the Designated Account (DA-A) within the existing pooled fund arrangements and with among others, the evidence of achievement of agreed indicators substantiated in the report validated beforehand by the MOH and IDA. Achievement will be assessed by an independent verification agent. Payments of DLIs will be in proportion to the targets met, and the unutilized funds will be carried forward. The funds then transferred will be used to finance eligible government expenditures in the Annual Work Plan.

71. **Disbursement under Component 2 and 3 will be transactions based**. A Designated account B (DA-B) will be opened at a commercial bank, on terms and conditions satisfactory to the Bank for related activities under the responsibility of the MOH Pooled Fund Unit (for Component 3) and a sub account for the activities under the responsibility of the MOP through SWEDD Coordination Unit (for Component 2). Funds will flow from the DA-B to the sub-account at MOP and to suppliers, contractors and beneficiaries for the eligible expenditures.

72. Based on the Bank's assessment, the FM residual risk for the Project is deemed **Substantial**. It is therefore considered that the proposed FM arrangements for the project will satisfy the requirements under World Bank OP 10.00 once the mitigation measures are implemented. The implementing entity will ensure that the *Bank's Guidelines: "On Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants dated October 15, 2006 (revised January, 2011)* are followed under the project.

D. Procurement

73. Procurement activities will be carried out respectively (i) for Component 3 by the MOH through the Unit managing the Pooled fund (*Fond Commun – FC*) under the coordination of the SG, and (ii) for Component 2 by the MOP under the coordination of the SG.

74. The MOH and MOP will carry out the following activities in close collaboration with the respective beneficiaries: (i) preparation and updating of the procurement plan; (ii) preparation of the bidding documents, draft requests for proposals (RFP), evaluation reports, contracts in compliance with World Bank procedures; (iii) monitoring the implementation of procurement activities; (iv) development of procurement reports; and (iv) seeking and obtaining approval of national entities and then IDA on procurement documents as required. The procurement activities in the respective Ministries will be supported by the Procurement Directorate (*Direction des marchés publics - DMP*) and the Technical directorates in their respective area of competency.

75. A preliminary assessment of the capacity of the respective Ministries to implement procurement activities of the project was carried out in October 2014 and finalized during appraisal. The overall Project Risk for procurement is rated **Substantial**. The residual risk is assessed as Moderate after adopting the following measures including:

a) Appointing a qualified and experienced Procurement specialist to support all procurement activities for this Project in the Ministry in charge of Population;
b) Appointing qualified Procurement assistants to be located at the central and if needed at regional levels of MOH, depending of the volume of activities;
c) A procurement plan (PP) for the first 18 months of program implementation was prepared during appraisal, and was approved during negotiations. The PP will be updated at least annually to reflect changing implementation needs capacity improvements;
d) A manual of administrative, financial and accounting procedures will be prepared to clarify the role of each team member involved in the procurement process of the project, and the maximum delay for each procurement stage;
e) A workshop will be organized at the beginning of the Project to train /update all key stakeholders involved in procurement on World Bank procurement procedures and policies;
f) Recruiting competitively as needed NGOs to implement activities related to communications in the Ministry in charge of Population.

E. Social (including Safeguards)

76. The project will not finance any activities necessitating involuntary land acquisition resulting in: (i) involuntary resettlement of people and/or loss of (or access to) assets, means of livelihoods or resources; and (ii) the involuntary restriction of access to legally designated parks and protected areas resulting in adverse impacts on the livelihoods of the displaced persons.

77. In terms of ensuring community engagement and buy-in for the activities, the project will put emphasis on the importance of training, and increasing awareness, based on understanding community needs and concerns. Communities will benefit from the support of NGOs which will be hired to work and interact with communities throughout implementation.

F. Environment (including Safeguards)

78. The project will fund drugs, medical supplies, and some equipment, as well as consulting, communication costs, and training services. No civil works are contemplated or envisaged directly with the project funds. However, since the project activities are expected to increase the use of health services, as a result, the project is likely to increase the generation of biomedical waste. Consequently the project is classified as category B.

79. A Medical Waste Management Plan (MWMP, 2011-2015) is under implementation with the Second STI/HIV/AIDS Support project (P116167). It has been updated to serve as the safeguards instrument for this proposed project. This latest version includes the progress made so far in implementation and the experiences gained in the management of infected materials. The updated MWMP was disclosed in-country (February 17, 2015) and the World Bank InfoShop on February 23, 2015. Key mitigation measures with an implementation schedule, adequate budget, and clear institutional responsibilities are outlined in the action plan of the MWMP. The proposed project will contribute to the implementation of the action plan.

80. The team conducted the Climate and Risk Screening for the project as part of IDA 17 commitments. The results of the Screening for the project are: (i) low potential impact from extreme temperature, and (ii) high potential impact from extreme precipitation and flooding. As mitigation measures, through contributing to improved basic health care, the project will help reduce flood-induced diseases by distributing bed nets, commodities, improving access to health facilities and monitoring the health conditions of vulnerable groups. The implementation of the health waste management plan will also contribute to mitigate the risks.

G. Other Safeguards Policies Triggered

81. Due to the "soft" (non-physical) nature of the activities under the proposed project, no other safeguards policies besides OP 4.01 on Environmental Assessment are triggered by this project.

82. In case of emergency, an assessment of the safeguards would be conducted and reflected in the project restructuring document. If the category changes, the policies triggered by the new activities would be reflected in the project paper.

H. World Bank Grievance Redress

83. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World

Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

Table 5: Results Framework

Project Development Objectives

PDO Statement

To increase the utilization of reproductive health and nutrition services in Targeted Areas

These results are at Project Level

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	Cumulative Target Values[32]						Frequency	Data Source/ Methodology	Responsibility for Data Collection
				YR1	YR2	YR3	YR4	YR5	YR6			
(i) Women 15-49 years using modern contraceptive methods [33]	☐	%	12.76 (2012)	14	-	18	-	-	22	Every two years for five regions	DHS, mini DHS	MOH&INS
(ii) Skilled birth attendance at delivery for women 15-49	☒	%	25.6 (2012)	33	-	44	-	-	55	Every two years	DHS, mini DHS	MOH&INS
(iii) Exclusive breastfeeding for children under 6 months	☐	%	23.3 (2012)	26	-	33	-	-	38	Every two years	DHS, mini DHS	MOH&INS
(iv) Women 15-49 and children (<5) using the basic package of reproductive health and nutrition services (number), of which girls 15-19 (percentage)	☐	Cumulative Number, %	0	592,264 (30%)	1,480,661 (30%)	2,369,058 (30%)	3,553,588 (30%)	4,738,117 (30%)	5,922,647 (30%)	Annual	HMIS	MOH&INS
(v) Direct project beneficiaries (number), of which female (percentage)	☒	Number, %	0	1 922 665 (60%)	2 883 997 (60%)	2 883 997 (60%)	3 845 329 (60%)	3 845 329 (60%)	3 845 329 (60%)	Annual	HMIS, NGO and School management committee reports	MOH, MOP&INS

			Target Values							Data Collection and Reporting		
	Intermediate Outcome Indicators	**Baseline (2014)**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**Frequency and reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
Improving the provision of high quality RHN	**DLI 1:** Increase in women utilizing modern contraception (Number and percent) [34]	(397000)	18 (468000)	39.2 (553000)	64.3 (652000)	93.9 (769000)	128.8 (908000)	128.8 (908000)	128.8 (908000)	Annual	HMIS, DLI level verification	MOH&INS
	DLI 2: Increase in women	(277000)	9	18.8	29.5	41.2	53.9	53.9	53.9	Annual	HMIS, DLI	MOH&INS

[32] MOH, Monitoring and Evaluation Manual of the National Health Development Plan 2011-2015, June 2011.

[33] Indicators will be monitored for 5 regions – Maradi, Zinder, Tillaberi, Tahoua, Dosso. For the indicators exclusive breastfeeding and women 15-49 who have received at least 4 antenatal care visits. The regional breakdown is not available in 2012 DHS (Percent).

[34] The baseline HMIS data available is for 2013.The baseline values for the indicator new accepters (adolescent girls <20) using modern contraceptives was estimated as it is being collected by the government HMIS for 2016. The modern contraception was 3.7% in 2012 for this group (<20). All baseline and target data for DLI indicators will be reviewed following the facility level verification of the numbers.

services	delivered by a trained health professional (Number and percent)		(302000)	(329000)	(359000)	(391000)	(426000)	(426000)	(426000)		verification	
	DLI 3: Increase in new accepters (girls <20) using modern contraceptives (Percent)	0	-	18	36	54	72	72	72	Annual	HMIS, DLI verification	MOH&INS
	DLI 4: Increase in children <1 year of age having received nutrition counseling and an updated growth chart (Percent)	0	3.5	7.0	10.5	14.0	17.5	17.5	17.5	Annual	HMIS,DLI verification	MOH&INS
	DLI 5: Increase in children 0-11 months immunized with measles (Number and percent)	(587,000)	3.7 (609000)	7.5 (632000)	11.5 (655000)	15.6 (679000)	19.9 (704000)	19.9 (704000)	19.9 (704000)	Annual	HMIS, DLI verification	MOH&INS
	DLI 6: Health facilities receiving payments from the central government for their revolving fund on time (Percent)	0	15	30	45	60	75	75	75	Annual	MOH financial reports, DLI verification (Survey)	MOH&INS
	DLI 7: Training of health workers to deliver RH and nutrition services (Number)	0	Course designed	300	650	1000	1400	1400	1400	Annual	HMIS, DLI verification)	MOH&INS
	DLI 8: Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)	0	15	30	45	60	75	75	75	Annual	MOH supervision reports, DLI verification (Survey)	MOH&INS
	Service delivery sites providing tailored RH services for adolescents (Percent of planned annual target)	0	20	40	50	60	70	80	80	Annual	MOH Report	MOH
	Updated guideline for the delivery of community-based RHN services (Y/N)	N	N	Y	Y	Y	Y	Y	Y	Annual	MOH Report	MOH
	Rapid Results Approach implemented to support the annual work plan (number)	0	3	3	3	3	3	-	-	Annual	MOH Report	MOH
Increasing the demand of RHN services 2.1. Promote Social and Behavioral Change 2.2. Women's and Adolescent Girls' Empowerment 2.3. Mobilizing opinion leaders.	Households visited by *Relais Communitaire* (Number)	0	-	114000	228600	457200	457200	457200	457200	Annual	NGO Report (Community register)	MOP
	Women (15-24), who have increased their knowledge on defined areas of RHN (Percent)	0	-	60	70	80	80	80	80	Annual	NGO Report (Survey)	MOP
	Community and religious leaders who have improved acceptance of RH policies and programs (Percent)	0	-	15	20	25	30	35	40	Annual	NGO Report (Survey)	MOP&MOH
	Men in the *Ecole Des Maris* who are supportive of their partners' reproductive health practices (Percent)	0	-	50	60	70	75	75	75	Annual	NGO Report (Survey)	MOP&MOH
	Adolescent girls registered in school annually (Number)	0	-	0	6800	7440	7700	7700	7700	Annual	School management committee report	MOP, Ministry of Secondary

												Education& Ministry of Primary Education
	School Management Committees submit monthly reports on adolescent girls school registration (Percent completeness)	0	-	50	60	70	80	85	85	Annual	School management committee report	MOP, Ministry of Secondary Education& Ministry of Primary Education
Improving capacity to manage, monitor and evaluate RHN services	Participatory process evaluation conducted and lessons are integrated in the annual work plan [Y/N]	N	Y	Y	Y	Y	Y	Y	Y	Annual	Evaluation report including lessons learned	MOP&MOH
	Alignment of annual work plan to support results of project (Y/N)	Y	Y	Y	Y	Y	Y	Y	Y	Annual	Qualitative review	MOP&MOH
	Health facilities reporting health management data on time (Completeness rate).	72%	75	75	75	80	80	82	85	Annual (February)	Health facility reports for HMIS	MOH/HMIS

Table 6: Definition and Interpretation of PDO and Intermediate Indicators

Indicator Name	**Description (Definition etc.)**
PDO indicators	
(i) Women 15-49 years using modern contraceptive methods	This is the contraceptive prevalence rate for women 15-49, modern method. The percentage of currently married women 15-49 years who currently use any method of contraception. Numerator: The number of women 15-49 who say they use any specific method. Denominator: Number of currently married women ages 15-49 in the same area in the five years preceding the survey.
(ii) Skilled birth attendance at delivery for women 15-49	Numerator: The number of women 15-49 years who had births attended by skilled health personnel for women 15-49 years (doctors, nurses or midwives). Denominator: Number of deliveries expected in women ages 15-49 in the same area in the five years preceding the survey.
(iii) Exclusive breastfeeding for children under 6 months	Numerator: Infants 6 months of age who received only breast milk during the previous day. Denominator: Infants under 6 months (0-5 months) of age in the same area in the five years preceding the survey.
(iv) Women 15-49 and children (<5) using the basic package of reproductive health and nutrition services (number), of which girls 15-19 (percentage)	Cumulative number of women, adolescent girl and children (<5) who have received services included the basic RHN package at a health facility. The package includes family planning, pregnancy, newborn and child nutritional services in the country's list of basic services. The number is cumulative. The percentage will specify what percent of those using the services are adolescent girls 15-19.
(v) Women 15-49 years using modern contraceptive methods	Direct beneficiaries are people or groups who directly derive benefits from an intervention. Supplemental value will be collected for the indicator: Female beneficiaries. The percentage will specify what percent of the beneficiaries are female 15-49 years and pregnant and lactating.
Intermediate outcomes indicators	
Component 1	
DLI 1: Increase in women utilizing modern contraception (Number and percent) [35]	Increase in the number (percent) of women 15-49 years (above the baseline value) who receive any method of modern contraception at health facilities in the target area.

[35] The baseline HMIS data available is for 2013.The baseline values for the indicator new accepters (adolescent girls <20) using modern contraceptives was estimated as it is being collected by the government HMIS for 2016. All baseline and target data for DLI indicators will be reviewed following the facility level verification of the numbers.

DLI 2: Increase in women delivered by a trained health professional (Number and percent)	Increase in the number (percent) of deliveries (above the baseline value) in the health facilities for women 15-49 years in the target areas, which are attended by a trained health professional.
DLI 3: Increase in new accepters (girls <20) using modern contraceptives (Percent)	Percentage increase in the number of adolescent girls <20 who accept for the first time in their lives any (program) contraceptive method; to be reported for a defined reference period of one year. Data collection for this indicator only started in CY15, so the baseline will only be available at the end of 2015. This will be used as the basis for calculating the percentage increase.
DLI 4: Increase in children <1 year of age having received nutrition counseling and an updated growth chart (Percent)	This is a composite indicator. The indicator is the percentage increase in the number of children under 1 year who have received nutritional counseling from a trained health worker in health facilities in the targeted areas, and have an updated growth chart. The status of the growth chart will be confirmed through a verification assessment. The verification of the baselines will set the actual baseline for this indicator. This is a proxy indicator of quality of nutritional counseling to assess adequate child growth and subsequent action taking.
DLI 5: Increase in children 0-11 months) immunized with measles (Number and percent)	The increase in the number (percent) of children under 1 year (above the baseline value) who have received immunization for measles in a one year period in health facilities in the targeted regions.
DLI 6: Health facilities receiving payments from the central government for their revolving fund on time (Percent)	The numerator is the number of health facilities receiving payments from the central government for their revolving fund on time. The denominator is the number of health facilities scheduled to receive funds during the same time period and for the same facility type x 100.
DLI 7: Training of health workers to deliver RH and nutrition services (Number)	This is the number of health workers who have successfully completed additional in-service professional training from the MOH to deliver RHN services. In year 1, this indicator will determine with the training course was developed (Y/N).
DLI 8: Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)	Numerator: Number of health workers in regional health centers with supervisory contact during the reporting period which involved an observation of care using a quality checklist. Denominator: Number of health workers employed in the facility type during the same time period x 100.
Service delivery sites providing tailored RH services for adolescents (Percent of planned annual target)	Numerator: Number of service delivery sites (health centers, posts, other) providing tailored reproductive (RH) services for adolescents. Denominator: Number of service delivery sites for which adolescent tailored services were planned in the same region and time period x 100.
Updated guideline for the delivery of community-based RHN services (Y/N)	This is an indicator to determine if the guideline is developed.
Rapid Results Approach implemented to support the annual work plan (Number)	This is the number of Rapid Results Approach implemented each year to support the government to define the annual work plan for the scaled-up RHN service delivery.
Component 2	
Households visited by *Relais Communitaire* (Number)	This is the number of household visits conducted by *Relais Communitaire* annually.
Women (15-24), who have increased their knowledge on defined areas of RHN (Percent)	The numerator is the number of women 15-24 who report they have increased their knowledge on defined areas of RHN following participation in community-based interventions. The denominator is the total number of women surveyed x 100.
Community and religious leaders[36] who have improved acceptance of RH policies and programs (Percent)	The numerator is the number of leaders who report they have improved acceptance of RH policies and programs following participation in community discussions. The denominator is the total number of leaders surveyed x 100.
Men in the Ecole Des Maris who are supportive of their partners' reproductive health practices (Percent)	The numerator is the number of men who participate in the Ecole des Maris interventions who support their partners' reproductive health (RH) practices. Denominator: Total number of men in the Ecole des Maris surveyed) x 100.
Adolescent girls registered in school annually (Number)	This is the number of girls aged 11-18 registered in primary school grade 6 and Secondary School grades 7-8 reported by School Inspection Committees at municipality and village level.
School Management Committees submit monthly reports on adolescent girls school registration	Numerator: The number of monthly reports submitted by the School Management Committees. Denominator: Number of School Management Committees multiplied by the number of months for which reporting is required x

[36] Community and religious leaders will be define in the implementation Manual and the Monitoring and Evaluation Manual.

(Percent completeness)	100.
Component 3	
Participatory process evaluation conducted and lessons are integrated in the annual work plan (Y/N)	This indicates whether an annual qualitative assessment of lessons was conducted with project participants, and whether these lessons were then integrated in the project's annual work plan to improve implementation. (Yes or No).
Alignment of annual work plan to support results of project (Y/N)	This is a qualitative review of the annual work plans developed by the MOH and MOP for the project to confirm the plan aligns with the intended project results.
Health facilities reporting health management data on time (Completeness rate).	Numerator: The number of annual reports submitted by the health facilities by the end of year time line. Denominator: Number of health facilities for which reporting was required x 100.

Annex 2: Disbursement linked indicators, Verification Protocols and Disbursement Arrangement

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

Disbursement Linked Indicators – Matrix[37]

	Total Financing Allocated to DLI	*As % of Total Financing Amount*	*DLI Baseline*	*Indicative timeline for DLI achievement*				
				2015	*2016*	*2017*	*2018*	*2019*
DLI 1: Increase in women utilizing modern contraception (Percent and number)			(397000)	18 (468000)	39.2 (553000)	64.3 (652000)	93.9 (769000)	128.8 (908000)
Allocated amount:	**US$13 m**	**20%**		**1.82**	**2.14**	**2.53**	**2.99**	**3.52**
DLI 2: Increase in women delivered by a trained health professional (Percent and number)			(277000)	9 (302000)	18.8 (329000)	29.5 (359000)	41.2 (391000)	53.9 (426000)
Allocated amount:	**US$13 m**	**20%**		**2.17**	**2.37**	**2.58**	**2.81**	**3.07**
DLI 3: Increase in new accepters (girls < 20 yrs) using modern contraceptives (Percent)[38]			0		18	36	54	72
Allocated amount:	**US$4 m**	**6%**		**0.00**	**1.00**	**1.00**	**1.00**	**1.00**
DLI 4: Increase in children < 1 year of age having received nutrition counseling and an updated growth chart (Percent)[39]			0	3.5	7.0	10.5	14.0	17.5
Allocated amount:	**US$10 m**	**15%**		**2.00**	**2.00**	**2.00**	**2.00**	**2.00**
DLI 5: Increase in children 0-11 months immunized with measles (Percent and number)			(587000)	3.7 (609000)	7.5 (632000)	11.5 (655000)	15.6 (679000)	19.9 (704000)
Allocated amount:	**US$10 m**	**15%**		**1.86**	**1.93**	**2.00**	**2.07**	**2.15**
DLI 6: Health facilities receiving payments from the central government for their revolving fund on time (Percent)			0	15	30	45	60	75
Allocated amount:	**US$6 m**	**9%**		**1.20**	**1.20**	**1.20**	**1.20**	**1.20**
DLI 7: Training of health workers to deliver RH and nutrition services (Number)			0	Courses Designed	300	650	1000	1400
Allocated amount:	**US$5.5 m**	**8%**		**0.30**	**1.11**	**1.30**	**1.30**	**1.49**
DLI 8: Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)			0	15	30	45	60	75
Allocated amount:	**US$5.1 m**	**8%**		**1.02**	**1.02**	**1.02**	**1.02**	**1.02**
Total Financing Allocated:	**US$66.6 m**	100%		**10.37**	**12.77**	**13.63**	**14.39**	**15.44**

[37] Data will be reviewed only for the 5 target regions.
[38] Indicator included in new HMIS which has started data collection in CY15. Baseline will be set based on year-end data.
[39] Baseline will be verified during initial verification process.

DLI Verification Protocol Table

#	*DLI*	*Definition/ Description of achievement*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification*		
				Data source/agency	*Verification Entity*	*Procedure*
1	Increase in women utilizing modern contraception (Percent and number)	Increase in the number (percent) of women 15-49 years (above the baseline value) who receive any method of modern contraception at health facilities in the target area.	Yes	Routine administrative data. Existing Health Management Information System (*Système National d'Information Sanitaire -SNIS*)	Contracted verification agency	An annual technical audit will be carried out by the independent verification agency, based on a review of the documentation available centrally, and on-site verification in a representative sample of areas of the targeted Regions. An initial verification will be done to review the baseline data and appropriate adjustments will be made once that verification is complete. Since all indicators are taken from the SNIS, the same verification procedure will be used for each indicator. For indicator #4, the initial verification will also determine the baseline for the proportion of counseling visits where the growth chart has been updated, and this will be used to as the baseline. SNIS will collect this information in subsequent years.
2	Increase in women delivered by a trained health professional (Percent and number))	Increase in the number (percent) of deliveries (above the baseline value) in the health facilities for women 15-49 years in the target areas, which are attended by a trained health professional.	Yes			
3	Increase in new accepters (girls <20) using modern contraceptives (Percent)	Percentage increase in the number of adolescent girls <20 who accept for the first time in their lives any (program) contraceptive method; to be reported for a defined reference period of one year. Data collection for this indicator only started in CY15, so the baseline will only be available at the end of 2015. This will be used as the basis for calculating the percentage increase.	Yes			
4	Increase in children under 1 year having received nutrition counseling and an updated growth chart (Percent)	This is a composite indicator. The indicator is the percentage increase in the number of children under 1 year who have received nutritional counseling from a trained health worker in health facilities in the targeted areas, and have an updated growth chart. The status of the growth chart will be confirmed through a verification assessment. The verification of the baselines will set the actual baseline for this indicator. This is a proxy indicator of quality of nutritional counseling to assess adequate child growth and subsequent action taking.	Yes			
5	Increase in children 0-11 months immunized for measles (Percent and number)	The increase in the number (percent) of children under 1 year (above the baseline value) who have received immunization for measles in a one year period in health facilities in the targeted regions.	Yes			
6	Health facilities receiving payments from the central government for their revolving fund on time (Percent)	The numerator is the number of health facilities receiving payments from the central government for their revolving fund on time. The denominator is the number of health facilities scheduled to receive funds during the same time period and for the same facility type x 100.	Yes			
7	Training of health workers to deliver RH and nutrition services (Number)	This is the number of health workers who have successfully completed additional in-service professional training from the MOH to deliver RHN services. In year 1, this indicator will determine with the training course was developed (Y/N).	Yes			
8	Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)	Numerator: Number of health workers in regional health centers with supervisory contact during the reporting period which involved an observation of care using a quality checklist. Denominator: Number of health workers employed in the facility type during the same time period x 100.	Yes			

Bank Disbursement Table

#	DLI	Bank financing allocated to the DLI (million)	Deadline for DLI Achievement	Expected timing of achievement each year for verification	Minimum DLI value to be achieved to trigger disbursements of Bank Financing	Maximum DLI value (s) expected to be achieved for Bank disbursements purposes	Determination of Financing Amount to be disbursed against achieved and verified DLI value (s)
1	Increase in women utilizing modern contraception (Number and percent)	13	June 30, 2021	Annual	421,000	128.8% increase (908,000 women in total) (18% increase expected each year)	$100,951 per percentage point improvement = [Allocation to the DLI ($13m)/(total percentage point improvement) At least 421,000 [or at least 6% more] women utilizing contraception must be reached to trigger disbursement
2	Increase in women delivered by a trained health professional (Number and percent)	13	June 30, 2021	Annual	285,000	53.9% increase (426,000 women in total) (9% increase expected each year)	$241,356 per percentage point improvement = [Allocation to the DLI ($13m)/(total percentage point improvement)] At least 285,000 [or at least 3% more] women delivered by a trained health professional must be reached to trigger disbursement
3	Increase in new accepters (girls <20) using modern contraceptives (Percent)	4	June 30, 2021	Annual	6% increase	72% increase 18% (increase expected each year)	$55,556 per percentage point improvement = [Allocation to the DLI ($4m)/(total percentage point improvement)] At least 6% increase in new accepters (girls < 20 years) using modern contraceptives must be achieved to trigger disbursement
4	Increase in children <1 year having received nutrition counseling and an updated growth chart (Percent)	10	June 30, 2021	Annual	1.2% increase	17.5% increase (3.5% increase expected each year)	$571,429 per percentage point improvement = [Allocation to the DLI ($10m)/(total percentage point improvement)] At least 1.2% increase in children < 1 year of age having received nutrition counseling and an updated growth chart must be achieved to trigger disbursement
5	Increase in children 0-11	10	June 30,	Annual	595,000	19.9% increase (704,000	$501,993 per percentage point improvement =

#	DLI	Bank financing allocated to the DLI (million)	Deadline for DLI Achievement	Expected timing of achievement each year for verification	Minimum DLI value to be achieved to trigger disbursements of Bank Financing	Maximum DLI value (s) expected to be achieved for Bank disbursements purposes	Determination of Financing Amount to be disbursed against achieved and verified DLI value (s)
	months immunized with measles (Number and percent)		2021			children in total) (3.7% increase expected each year)	[Allocation to the DLI ($10m)/(total percentage point improvement)] At least 595,000 [or at least 1.2% more] children < 1 year of age having received nutrition counseling and an updated growth chart must be achieved to trigger disbursement
6	Health facilities receiving payments from the central government for their revolving funds on time (Percent)	6	June 30, 2021	Annual	5%	75% of health facilities receiving on-time payments (15% increase expected each year)	$80,000 per percentage point improvement = [Allocation to the DLI ($6m)/(total percentage point improvement)] At least 5% of health facilities must receive their payments on time to trigger disbursement
7	Training of health workers to deliver RH and nutrition services (Number)	5.5	June 30, 2021	Annual	100	Varies by year to a maximum of 1400 workers trained	$300,000 once the course is designed, plus $3,714 per health worker trained = [Allocation to the DLI ($5.5m-$300k)/ (total number of health workers to be trained)] At least 100 health workers must be trained to trigger disbursement once the course is developed
8	Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)	5.1	June 30, 2021	Annual	5%	75% of health workers receiving supervision visits (15% increase expected each year)	$68,888 per percentage point improvement = [Allocation to the DLI ($5.1m)/(total percentage point improvement)] At least 5% of health workers must receive supervision to trigger disbursement
	Total Financing Allocated	**66.6**					

Annex 3: Detailed Project Description

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

Sector Background

1. **Niger has made progress in its health, nutrition and population outcomes, but the country still lags substantially behind other low-income countries and Sub-Saharan African (SSA) counterparts.** Both infant and child mortality have declined remarkably (Table 7), placing Niger in a position to achieve MDG 4 by 2015. Improved use of bed nets for children under five, immunization coverage of children under 12 months of age, and coverage of measles vaccination have been key factors in the progress on child health. But chronic malnutrition or stunting, which contributes to over one third of child mortality, remains very high despite its decline from 55 to 44 percent, due to difficult access to health centers, lack of proper sanitation and behavioral factors, all exacerbated by recurrent food shortages. Only 23 percent of children under 6 months were exclusively breastfed in 2012. Anemia is prevalent in both children and adults: 73 percent of children 6-59 months, 46 percent of women and 26 percent of men.

Table 7: Progress in key Health, Nutrition and Population

Indicators	DHS 2006	DHS 2012	Trend*
Health and nutrition Outcomes			
Under-five mortality rate (U5MR - ‰)	198	127	Improvement
Infant mortality rate (IMR - ‰)	81	51	Improvement
Stunting for children under five (%)	55	44	Improvement
Prevalence of anemia among children 6-59 months (%)	84	73	Improvement
Prevalence of anemia among women (%)	46	46	No change
Total fertility rate (TFR) (children per woman)	7.1	7.6	Deterioration
Health service utilization/Healthy behavior adoption			
Skilled birth attendance at delivery (% of deliveries)	17	29.3	Improvement
Fully immunized children (%)	29	52	Improvement
Exclusive breastfeeding (%)	14	23	Improvement
Children under five who slept under ITN (%)	7	20	Improvement
Contraceptive prevalence rate (CPR) (%)	5	12	Improvement
Unmet need for family planning (%)	16	16	No change
Wanted fertility (children per woman)	6.9	7.4	Deterioration

Data Sources: Niger Demographic and Health Surveys 2006 and 2012.
** No change refers to any difference that is less than 5 percent difference since the 2006 DHS.*

2. **The implications of poor reproductive, maternal, newborn child, adolescent health and nutrition (RHN) outcomes are substantial and negatively impact the well-being of Nigeriens.** Despite some improvements in maternal health, the maternal mortality ratio (MMR) remains high at 535 per 100,000 live births in 2012, higher than the SSA average of 500. Skilled birth attendance is only 29.3 percent, and the modern contraceptive prevalence rate (CPR) remains low at 12 percent[40]; or about half of the regional average. Niger's fertility rate (7.6 children per woman) is substantially higher than the SSA average of 5.1[41] and highest even in the

[40] Unmet need for family planning is 16% in 2012.
[41] High fertility is explained by early marriage and childbearing (partly due to cultural attitudes, religious beliefs, and gender inequity as evidenced by low socioeconomic status of women), inadequate availability and quality of reproductive health and family planning information and services, and high illiteracy rate.

Sahel sub-region. As a result, Niger[42] is unlikely to achieve MDG 5 on maternal health.

3. **Low coverage and utilization of RHN services are attributed to both supply and demand side constraints.** On the supply side, service utilization is low due to inadequate provision of quality health services, including challenges with respect to the geographic distribution, the quality and the skills-mix of human resources, despite the recruitment of 2,410 additional health workers in 2011. In 2012 there was only 1 doctor per 21,232 inhabitants. The ratios for nurses and midwives are quite good (nurses: 1/5,203 and midwives 1/4,418), reflecting closely the ratios recommended by the World Health Organization (WHO) for Africa. However, despite the incentive measures adopted by the country, the spatial distribution shows regional disparities, particularly in favor of Niamey, which has 8 percent of the total population but about 50 percent of health staff (doctors, nurses and midwives), including one-third of the doctors. The doctor density in Niamey is 17 times greater than in Tillaberi and 13 times greater than in Dosso, two of the poorest regions of Niger.

4. **Another supply-side constraint in the provision of health services is the unavailability of affordable drugs across health facilities.** Niger has put in place a fee exemption policy in 2006 for specific vulnerable groups and priority services (services for children under 5, prenatal consultations, family planning commodities, cesarean sections, and female cancer). With the financial support from donors, the Government has made an effort to pay on time, in order to help health facilities purchase drugs and others commodities. However, reimbursements for the selective free health care policy are generally late, incomplete and unpredictable; leading to the inability of health facilities to maintain their drug revolving funds, and have led to debts with drug suppliers notably with the private purchasing agencies and the national "*Centrale d'achat*" (ONPPC: *Office National des Produits Pharmaceutiques et Chimiques*).

5. **Quality of care is poor with untimely and inappropriate care being provided to clients.** Among children with diarrhea and acute respiratory infection, only 43 percent and 53 percent, respectively, received appropriate care. Another 15 percent of children received anti-malarial drugs in case of fever, but only 12 percent received them in a timely manner. Although 59 percent of pregnant women received anti-malaria drugs, only 35 percent received the two recommended doses of Sulfadoxine Perimethamine/Fansidar for the Intermittent Preventive Treatment of Malaria. Use of health services is limited among adolescents: 16.4 percent of pregnant adolescents aged 15-19 do not receive any antenatal care; two thirds deliver at home with no assistance and only 7 percent use contraception (2012 DHS). A quality survey conducted in 2013 by the MOH also reported inadequate providers' practices and behaviors toward women's and adolescent health including: lack of privacy, inconsistency of clinical practices, staff absenteeism, and absence of adolescent-friendly approaches.[43] In medical practices, provider behaviors remain largely influenced by cultural and religious norms that condemn sexual activity before marriage for women and prescription of family planning commodities before marriage (IntHEC 2010)[44].

[42] INS, Demographic and Health Survey 2012, Report of September 2013.
[43] Services delivery Indicators survey (SDI) will be conducted after the project approval.
[44] IntHEC (2010-2014) : intégrer la santé, l'éducation et les aspects communautaires : stratégies factuelles pour accroitre l'équité, l'intégration et l'efficacité des services de santé de la reproduction pour les communautés pauvres en Afrique Sub-Saharienne. LASDEL, UNFPA Niger, MSP.

6. **Niger has successfully scaled up the treatment of severe acute malnutrition among under-five children, covering up to 400,000 children each year. However, chronic malnutrition and underlying determinants have not been similarly addressed.** In response to food security crises, international aid organizations have taken the lead to address both acute and chronic malnutrition, with collaboration from local non-governmental organizations (NGOs). In 2011, the Presidential 3N initiative (Nigeriens Nourish Nigeriens) was adopted and structured as a High Commission, with a mandate to coordinate nutrition activities for a more sustainable multi-sectoral approach. Since 2013, interventions to prevent chronic malnutrition and promote healthy nutrition behavior such as exclusive breastfeeding and appropriate complementary feeding as part of the Essential Family Practices package are being successfully implemented at the community level, mainly by NGOs. However coverage is low, and a key challenge is to scale up such interventions. As part of the strategic program under the Health Development Plan (HDP), nutrition activities are mainstreamed in the reproductive health activities under which they can be scaled up. This will require strong collaboration between the different departments at MOH as well as with the community based organization involved in providing nutrition services at the community.

7. **On the demand side, the health services are fraught with inequities of all types – geographic, cultural, structural, and financial.** Only 49 percent of the population has access to a health facility within five kilometers of their home, and the poor availability and high cost of transportation presents additional challenges to accessing care for 41 percent of women. As shown in Table 8 below, the disparities in health outcomes per wealth quintiles are substantial. In the 2012 DHS, 60 percent of women faced financial barriers to using a health service with a higher proportion in rural areas (62 percent rural versus 49 percent urban). In addition, lack of education for women and girls (only 22.4 percent of women between 15-24 years old are literate) and socio-cultural barriers both constrain women's use of reproductive health services (including modern contraceptives) and increase the likelihood of early marriage and early pregnancy. Cultural factors also constrain women's ability to use health services: 21 percent of women stated that the need to get the permission of their husbands created problems in seeking care.

Table 8: Inequities in Health Outcomes for Maternal and Child – DHS 2012 (Percentage)

	Lowest quintile	Highest Quintile
Full immunization for Child	34.9	66.8
Treatment of Diarrhea	33.3	47.6
Medical treatment of ARI	46.5	71.2
Skilled antenatal care	71.2	96
Skilled birth attendance	11.8	71
Contraceptive prevalence (use of modern method)	8.7	23.7

8. **Niger has low levels of education, which is the cornerstone of building human capital.** This is true especially for girls. Primary school enrollment is below the regional average, and girls in particular are lagging behind – only 57 percent of girls are enrolled in primary school (Table 9). Secondary school enrollment is substantially lower, at just 10 percent for girls and 14 percent for boys. Youth literacy figures are also alarming, especially for girls. These trends greatly constrain Niger's capacity to progress in human development in all its key dimensions.

Table 9: Percentage of Boys and Girls enrolled in School and Literate in comparison with regional and income-group averages

	Niger	SSA	Low Income
Primary school net enrollment (boys)	70	79	84
Primary school net enrollment (girls)	57	75	80
Youth literacy rate (male)	52	76	76
Youth literacy rate (female)	23	64	65

Data Sources: Most recent data available 2008-2012 from UNICEF (UNESCO, including the Education for All Assessment) and World Development Indicators.

9. **Early marriage and early childbearing are common, and despite national support for adolescent reproductive health, young people experience high levels of unplanned pregnancies, unsafe abortions, sexually transmitted infections and maternal mortality and morbidity.** The median age at first marriage is 15.7 years, the lowest in the Sahel, and age at first birth follows a similar pattern with the majority of first births occurring during adolescence: the median age at first birth is 18.6 years and the adolescent fertility rate is high at 206 births per 1,000. 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 with early sexual activity and childbearing. Adolescent childbearing affects not only the health of these young women and their children but also the mothers' long-term education and employment prospects.

10. **The low demand specifically for RHN services results from additional factors, including social barriers to access (religious and male opposition to family planning[45]), high desired fertility[46], low perceived need for RHN services, low levels of women's empowerment, and weak leadership on implementation of relevant policies.**[47] According to the UNDP's Gender Inequality Index (GII), Niger ranked 146th out of 148 countries, with a score of 0.707. This is well below the regional index value of 0.577 for SSA. Low levels of women's empowerment are correlated with high fertility in Niger. Women's and girls' empowerment is correlated with social and cultural norms, and the demand for children remains high in Niger. According to the 2012 DHS, women still reported that they wanted to have an average of 7.4 children, higher than in sub-regional neighbors such as Mali, Burkina Faso, Benin and Nigeria. Evidence indicates that some key factors affecting women's desire to limit or space births include: (i) insufficient knowledge and understanding of 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 for women and girls including educational and economic resulting in low bargaining power.

11. **While child mortality has been declining, the prevalence of child morbidity has remained high, suggesting that the quantity-quality tradeoff in terms of child mortality and fertility has not been fully realized.**[48] In other words, parents may continue to have more children due to uncertainty either over child survival (from multiple episodes of childhood illness) or whether the surviving children will be healthy and able to support them in their later

[45] WB, Sahel Demography Study (ESW), 2014.
[46] For example, in Niger, the ideal number of children is over 9 (2012 DHS). Moreover, the ideal number of children has actually been increasing in Niger since 1992 DHS. In Mali, the ideal number of children was over 6 (2006 DHS).
[47] WB, Sahel Demography Study (ESW), 2014.
[48] Aksan A-M. 2014. Childhood Mortality and Morbidity in sub-Saharan Africa's Fertility Transition. Presented at Population Association of America Annual Meeting 2014 (Boston).

years. Cultural and traditional values also favor early marriage, early childbearing and large families. In Niger, adolescent fertility is not only high, but it also contributes significantly to total fertility rates, and a decline of 50 births per 1,000 women aged 15-19[49] would be associated with a decline in total fertility of 1.2 children per woman.

12. **Government's interventions for adolescents so far have mostly focused on strengthening the supply of healthcare services, while insufficiently addressing the demand-side.** On the supply side, efforts to increase national capacity to provide user friendly reproductive health services for adolescents have been developed. A total of 48 health centers (8 in each Region) have been labelled adolescent-friendly, with staff trained on adolescent specific health issues and provision of adequate services and commodities[50]. On the demand-side, three main types of interventions have been developed at small scales: (i) life skills development; (ii) peer education; and (iii) behavior change activities. Life skills development programs (e.g., "tontines" with youth participation) have helped strengthen both individual (adolescents) and collective life skills within several communities. Such activities (e.g., sexual education in youth centers) are typically conducted on a voluntary basis and many peer-based interventions lack consistency and sustainability. Other communication strategies are being introduced, relying on multiple channels, including mass media, traditional community-based media and innovative solutions (interactive plays, mobile cinema and self-videos). Seeking to strengthen both the individual potential of each person, and collective forms of organizing, as well as female social and institutional networks, has been an effective way to empowering girls and communities. Through this holistic process used by civil society organizations (CSOs), female adolescents can acquire the tools that help them have more control over their socioeconomic environment and ability to make choices. They are then better equipped to be involved in decision making, and defend their rights.

13. **Overall financing for the health sector is a major challenge, underlying many of the supply and demand-side barriers.** Niger's health sector suffers from chronic under-funding. Only 2.4 percent of Niger's GDP is allocated to the health sector.[51] Given the reliance on out-of-pocket expenditures as the main source of health financing, the cost and unaffordability of health services remain the leading barriers for poor people who represent 48.2 percent[52] of the population. Annual per capita health spending is US$8, which is far below global health care financing benchmarks. Due to declining donor contributions, government expenditures on health declined significantly between 2008 and 2010, from XOF 55.4 billion to XOF 29.6 billion (US$92.9 million to US$49.6 million), which represents a decline of 47 percent during this period.[53] Between 2010 and 2011, health expenditures increased to XOF 40.5 billion (US$67.9 million), which is a significant improvement but still less than the amount in 2008. As a share of total government expenditure, health expenditures have also fallen, declining from 12.4 percent in 2008 to 7.1 percent in 2011. The total contribution of health expenditures of bilateral and multilateral agencies including NGOs also dropped drastically from 33.5 percent in 2005-2006 to 20 percent in 2009. Spending on goods and services declined by 11 percent, and spending on

[49] From an African average of 115 births per 1,000 adolescents (UN 2011).
[50] Specific guidelines have been developed with the support of development partners, mainly WHO and UNFPA, to define standards and norms for adolescent-friendly services, and train health personnel accordingly. Training reached over half of the health personnel in the country.
[51] MOH, National Health Accounts (NHA) 2011, December 2013.
[52] INS, National Survey on Household living conditions and Agriculture - ECVMA – 2011.
[53] World Bank, PER 2012.

transfers and subsidies fell by 3.6 percent, while personnel costs increased drastically after 2011. Capital expenditure continued to decline, representing only 8.4 percent of total public expenditure in the sector.

14. **The Government, by endorsing the national COMPACT[54] with its development partners, has committed to concerted efforts to tackle the bottlenecks hampering the delivery and scaling up of RHN services.** The implementation of the HDP is supported by the sector wide approach (SWAp) which helped to harmonize and align donor's funds with national budget contribution on the district health plan financing. Donors support the sector through (i) stand-alone projects implemented by an independent unit, and (ii) a pooled funds (see Annex 6), which has been set up by a number of partners; Spain, France, United Nations Children's Fund (UNICEF), Global Alliance for Vaccines and Immunization (GAVI), United National Population Fund (UNFPA), and the World Bank. Annex 9 shows the current activities of various partners in the health sector, while Annex 11 shows the memorandum of understanding (MoU) signed by the pooled funds donors.

15. **Niger has committed to address the challenges noted above through a number of strategic documents**:

- the 2011-2015 HDP[55] to improve maternal and child health with a strategic focus on delivering essential health services to children, women and most vulnerable groups of the population;
- the Government Declaration of Population Policy (GDPP)[56], adopted in 2007, to decrease population growth by addressing contraception and early marriage, with the overall objective of contributing to poverty reduction. The policy seeks universal access to safe, effective, affordable and acceptable reproductive health services by 2015. There are four priority programs which are under implementation: (1) advocacy and awareness on population and development issues; (2) information, education and communication program for behavior change (IEC/BCC) in reproductive health and prevention of chronic malnutrition; (3) promoting access to and use of reproductive health services, particularly around birth spacing; and (4) women's economic advancement;
- the Government Nutrition policy linked to the 3N initiative to address malnutrition comprehensively in a multi-sectoral approach. In 2012 the "3N" Strategy, "*les Nigériens Nourrissent les Nigériens*" (Nigeriens Nourish Nigeriens) was created with a focus on food security, malnutrition prevalence and chronic malnutrition. Nutrition-specific guidelines under the "3N" strategy mainly target pregnant and lactating women, infants and young children. The initiative established a steering committee (*Comité de pilotage)*, composed of representatives of different ministries, and provided a new platform for coordination;
- the adolescent-friendly policies which have been increasingly mainstreamed in national strategies for poverty reduction, health, education and jobs. The adoption of the Reproductive Health law in 2006 marked a milestone in acknowledging sexual and reproductive health rights, especially for young women, as a top priority for government

[54] COMPACT: Country compact is written commitments made by government and development partners that describe how they will work together to improve health outcomes through the International Health Partnership (ihp+).
[55] New Health plan for 2016-2020 will be available at the end of 2015.
[56] The revision of the policy planned at the end of 2015 under the support of the SWEDD project.

action. A specific National Plan for Adolescent Sexual and Reproductive Health was also adopted in 2011 in Niger. The Action Plans relies on four main strategic pillars: (1) improve access to information responsive to needs; (2) improve adolescents and youth access to, and use of health services; (3) promote an environment supportive of adolescent and youth health; and (4) improve management of operations targeting adolescents and youth.

Project Description

16. The project is organized around four components: (i) improving the provision of high quality RHN services; (ii) increasing the demand for RHN services; (iii) improving capacity to manage, coordinate, monitor and evaluate RHN services and demand-side activities; and, (iv) establishing a contingent emergency response mechanism. The theory of change describing how these components address particular constraints and are expected to advance results is in Annex 5.

17. The first three components will work together in a mutually supportive way to address the key issues highlighted above: (a) inadequate funds and incentives to provide services; (b) insufficient demand for services; and (c) inadequate capacity for high quality service delivery. The first of these issues will be addressed by Component 1, the second by Component 2 and the third by Component 3. Component 4 is designed to allow the project to quickly address emergency situations if they arise. There are also strong links between the activities under this project and those of ongoing projects within and outside of the health sector, in terms of both complementary efforts and implementation synergies. The Sahel Women's Empowerment and Demographic Dividend Project (SWEDD – P150080), the Social Safety Nets Project (SSNP – P123399), the Skills Development and Growth Project (SDGP – P126049) and the Public Sector Capacity and Performance for Service Delivery Project (PSCPSD – P145261) are of particular relevance. The areas of complementarity are included in Annex 3. The areas of complementarity are included in Table 12 of this Annex.

18. **Component 1: Improving the provision of high quality RHN services (DLI-based financing) (US$66.6 million equivalent).** This component aims to strengthen the delivery of health and nutrition services for women of reproductive age (including young women, pregnant and lactating women) and children under age five through improvements in the quantity and quality of services. For direct nutrition interventions, children under two years of age are the main target population. Component 1 will be implemented using a disbursement linked indicator (DLI) approach, which pays for achievement of results defined by key performance indicators and triggered by independent verification. DLIs are a series of outcomes, outputs and process indicators against which funds will be disbursed to MOH on an annual basis upon the achievement of indicators and targets listed in the DLI matrix (Annex 2). The process indicators are designed to focus attention on key bottlenecks in the effective achievement of the outcome and output indicators, specifically: (a) the timely release of funds to health facilities so that they can procure required medications; (b) the training of staff to provide higher quality care; and (c) the effective monitoring and supervision of staff to ensure that these new and improved skills are being applied.

19. The component will support the existing pooled funds (through a SWAp) managed by the Ministry of Health which harmonizes resources of the government and donors around an agreed-upon annual work plan (AWP) of activities and financing. This annual work plan is focused on the following 8 output areas: (1) increase access to services and improve the quality of care, including upgrading, and equipping health facilities, maintaining health facilities and equipment, and developing other strategies to improve access to care; (2) develop services for reproductive health, including family planning services, services for adolescents and youth; health and nutrition services for infants and children and services for the health of the mothers and the newborns; (3) provide competent and motivated human resources for health facilities including additional training on nutrition counseling; (4) ensure the continuous availability of medicines, vaccines, supplies, and therapeutic inputs, reagents, quality blood and derivatives; (5) step up the fight against diseases that are the subject of the integrated surveillance; (6) strengthen governance and leadership of the health system, including strengthening management and devolution/ decentralization, improving quality assurance, and enhancing the monitoring and evaluation system (*SNIS*); (7) develop health sector funding mechanisms; and (8) promote health research. The Bank financing will support government expenditures related to the work plan in the target regions, based on an Eligible Expenditure Program (EEP), as described in the table 10 below. The MOH has confirmed that government expenditures related to the EEP should be between
US$16 million and US$23 million per year.

Table 10: Eligible Expenditures Program (Based on AWP 2015)

OUTPUTS OF THE AWP[57]	CODE	PRODUCTS	EXPENDITURES
1. Increase access to services and improve the quality of care, including upgrading, and equipping health facilities, maintaining health facilities and equipment, and developing other strategies to improve access to care	**1.4**	Maintenance of equipment and health center buildings	*Maintenance and operating costs*
	1.5	Health services access strategies	*Outreach activities for children health including immunization*
2. Develop services for reproductive health, including family planning services, services for adolescents and youth; health and nutrition services for infants and children and services for the health of the mothers and the newborn	**2.1**	Family planning	*FP services supply at village and community level, Outreach activities, products distribution, health personnel training*
	2.2	Health services for Youth and Adolescents	*Services supply, training, sensitization, operating costs*
	2.3	Children health care including Nutrition (including under five age child health)	*Services supply, training, sensitization, operating costs*
	2.4	Maternal health care, Emergency obstetrics and Newborn care and integrated Management of Childhood illnesses (IMCI)	*Services supply, training, sensitization, operating costs*
3. Provide competent and motivated human resources for health facilities including additional training on nutrition counseling	**3.1**	Initial training for HR and hands one training	*Workshop, scholarship*
	3.2	HR management	*Training and supervision*
	3.4	Carrier Management and development	*Training*
	3.5	HR incentives program	*Performance financing (RBF)*

[57] Output areas 7 and 8 of the AWP are supported by other donors.

OUTPUTS OF THE AWP[57]	CODE	PRODUCTS	EXPENDITURES
4. Ensure the continuous availability of medicines, vaccines, supplies, and therapeutic inputs, reagents, quality blood and derivatives	**4.1**	Supply Chain management of drugs	*Training on supply chain management*
	4.2	Improvement of Laboratories and blood transfusion centers	*Training, operating costs*
	4.3	Drugs law	*Sensitization and health staff awareness improvement, and Law dissemination*
5. Step up the fight against diseases that are the subject of the integrated surveillance	**5.3**	National health programs implementation	*Coordination meeting, workshop and supervision*
	5.5	Promotion of hygiene and sanitation	*Sensitization and dissemination of law and training*
6. Strengthen governance and leadership of the health system, including strengthening management and devolution/decentralization, improving quality assurance, and enhancing the monitoring and evaluation system (SNIS)	**6.1**	Management and decentralization	*Workshop, Supervision, Coordination and operating cost(National Budget)*
	6.2	Quality Assurance strengthening	*Training*
	6.3	Mainstreaming Gender dimension	*Sensitization and dissemination of law, Training of staff on gender*
	6.4	Development of communication	*Training, communication and sensitization*
	6.5	Monitoring and Evaluation – Data management (HMIS - SNIS)	*Supervision, Support data collection, operating cost, training of staff*

20. Rapid Results Approach (RRA) would be used to support the Ministry of Health to collaborate with health facilities to define and advance the implementation of the AWP activities related to the DLIs. This will be particularly important to advance DLI results where there are delivery constraints that require new innovative solutions to facilitate change. Rapid results initiative support for the AWP also links to Component 3. It will help the Government to identify new implementation lessons to incorporate in the AWP (refer to Box opposite). The RRA support will help strengthen problem-solving and leadership abilities within the MOH. The use of DLIs and the payment for results should facilitate the improvement of high impact RHN services by providing funding linked to the achievement of specific performance targets in the five regions.

21. The component through the payment of results, will aim to address constraints related to service delivery by paying for the scaled-up delivery of a package of high impact RHN services,

The Rapid Results Approach *is an instrument to enhance client capacity and accelerate project implementation. It is implemented using a series of cyclical Rapid Results Approach or RRA to tackles large-scale change efforts through a series of small-scale, results-producing and momentum-building initiatives. It enables leadership groups and implementation teams to begin to tackle an inherently complex multi-sector challenge. The focus of the process is less on "what" to do, and more on how to get the results done. The approach will help to improve the AWP by focusing on results in the country context instead of activities, and ensuring the plan includes tested implementation strategies. It will also help the leadership group create a sense of urgency around achieving specific results toward DLIs within the 90-120 day time frames.*

Rapid Results Approach (RRA)
Tool used by leaders to learn how to accelerate a defined result in a strategy or work plan and reduce implementation risk by developing local capacity and know-how to achieve the result:

- *Involves a small (8-15 person)implementation team committed to achieving challenging, stretch goal to advance a DLI related result, typically within 100 days*
- *Structured process including launch event, and mid-point and final reviews*
- *Supported by Rapid Results Coach who help reinforce management and implementation disciplines during the 100-day life cycle of the team*
- *Each RRA or portfolio of RRAs (several RRAs can run at once) can be designed with a specific purpose in mind (a specific result to help advance a DLI in a region or district):*
- *Each RRA team will implement a new process to advance outcomes toward the DLIs in a health center, for example. The team's learning will identify a range of innovative activities or implementation strategies to advance results which after the 100 day cycle will be used to update the AWP such that it can support progress more effectively.*

with a focus on the five underserved regions. Among the key constraints to be addressed are: weak RHN outcomes and poor uptake of services among young women, young child growth faltering and chronic malnutrition (often unrecognized), insufficient resources to scale-up the delivery of services; shortage of essential RHN commodities in health facilities; inappropriate care provision to women and children, limiting health service effectiveness; and poor numbers and knowledge and skills of community health workers to deliver RHN services in facilities and outreach posts. Facilities will also improve service delivery in priority areas of the MOH annual work plan such as Emergency Obstetrics and Newborn Care, Integrated Management of Childhood Illnesses (IMCI), referral systems and linkages across levels of care. Other efforts in the MOH work plan include improving health facilities to offer "Adolescent-friendly facilities". Complementary support from the SWEDD project will help to improve the supply chain management through harmonization of registration and quality control of RHN commodities as well as basic investments in the national laboratory. The PHSP will also benefit from the ongoing Public Sector Capacity and Performance for Service Delivery Project which is supporting the strengthening of the health management information system (HMIS/SNIS), management of human resources for health, and data collection to assess quality of service delivery performance.

22. The achievement of DLIs is the basis for disbursements under Component 1. The indicators need to be tangible, transparent, and verifiable, and will have been generated by expenditures supported by the project. An agreement has been reached between the Bank team and the MOH on choice of indicators, timeline and amounts to be linked to each DLI. DLIs will be driven by achievement of results. The DLIs are independent of one another, meaning that if one is missed, it does not affect the payment of others that were met. Each DLI is individually priced at the capped amount of the maximum payment available, and each DLI is scalable, meaning that a payment will be made for partial achievement of the DLI target. However, for the first year, a minimum level of achievement has been set, equivalent to one-third of the difference between the baseline and the first DLR. The Project Implementation Manual will provide more details on the means of verification. The initial advance payment will allow the MOH to mobilize the necessary resources to achieve the expected DLRs in the first year. Given the nature of the services involved, a higher advance is provided for the first 2 DLIs, as well as for the last 3 process related DLIs.

23. In order to ensure that the DLI targets are achievable, the MOH and the Bank team reviewed data on the historical rate of change of these indicators using both the Demographic and Health Surveys and Health Management Information System (HMIS) statistical reports (Table 11). The proposed DLIs focus strongly on services proven to contribute to improved reproductive health and nutrition outcomes as well as reduced population growth in the long term. The DLIs are specifically applied to the priority regions (Maradi, Zinder, Tillaberi, Tahoua, and Dosso) and will motivate and encourage the MOH, the regional entities and the district health management team to find innovative solutions to address low levels of service utilization, especially by these disadvantaged populations.

24. **Disbursement Arrangements and Verification Protocols**. The total amount of the credit proceeds for Component 1 will be divided among the eight DLIs. These allocations were determined by the nature and importance of each of the DLIs. The financing amount for each DLI will be further broken down into sub-allocations, corresponding to years and sub-targets.

Scalable disbursement will be applied to all DLIs. This means that partial payment will be provided for partial achievement of the results. Disbursement will be made for each service provided over and above the baseline for a given year. The level of achievement for a given year will become the baseline for the subsequent year, although if the achievement is less than the previous year's, the previous highest value will remain the baseline.

Table 11: Annual Rate of Change based on Previous Performance

	Indicators	Change 2011-2013	Baseline (2013)	Proposed Target
1	Increase in women utilizing modern contraception (Percent and number)	22% increase between 2011 and 2013, higher growth desired	397,000	Increase of 18% per year
2	Increase in women delivered by a trained health professional (Percent and number)	31% growth in target regions between 2011 and 2013, slightly lower growth considered sustainable	277,000	Increase of 9% per year
3	Increase in new accepters (girls <20) using modern contraceptives (Percent)	n.a., will be available once 2015 HMIS data is finalized, growth expected to mirror DLI #1	0	Increase of 18% per year
4	Increase in children <1 year of age having received nutrition counseling and an updated growth chart (Percent)	current level of coverage is quite high, but may be adjusted once initial verification is completed (including whether growth chart was updated)	0	Increase of 3.5% per year
5	Increase in children 0-11 months immunized with measles (Percent and number)	DHS shows national coverage increased 4.6% annually between 1992 and 2012; since current level already quite high, a lower annual rate was considered appropriate	587,000	Increase of 3.7% per year
6	Health facilities receiving payments from the central government for their revolving funds on time (Percent)	Important delay has been noted in the reimbursement process of the user fees policy	0	Increase to 15% per year in the target region
7	Training of health workers to deliver RH and nutrition services (Number)	No indication that health worker training has taken place	0	Increase to 1400 workers trained in the target region (40%) by the end of the project
8	Health workers receiving supervision visits in the previous period including direct observation of their work (Percent)	Supervision has been conducted in the sector but the quality remain weak.	0	Increase to 75% of health workers in the target region at the end of the project. At least 5% increase in health workers receiving supervision

25. To support faster implementation of activities to achieve DLIs, an Advance of 16.4 percent (US$10.92 million equivalent) will be disbursed once the proposed project is declared effective. This potential Advance would be available annually throughout the project implementation on a revolving basis. If by the closing date the Advance, or some portion of the Advance, is still outstanding, and a DLI or a combination of DLIs are not met, the Government will need to refund the outstanding balance.

26. The verification of progress towards achievement of the project's objectives will be based on an annual technical audit that will be carried out by an independent organization procured

according to World Bank procedures. The technical audit will be based on a comparison between the documentation provided centrally by the MOH, including the HMIS data, and on-site verification in a representative sample of areas targeted by this component where health facilities will be randomly selected. The technical audit will verify the effective utilization of the HMIS system and procedures at health facilities, and regional directorate levels, and their aggregation at the central level via DHIS2; the accuracy of the *quantity* of services as reported in the HMIS/DHIS2 database, and the quality of the services provided, especially for DLI 4. There is a strong link to component three to strengthen the capacity of the health system to enable it to provide quality services in the above mentioned areas, including technical but also operation capacity such as supportive supervision of community level services.

27. The verification of the quantities and quality of services would include: (i) Desk review of the completeness of the reporting and the final data (by month) for each of the 5 target regions; (ii) Follow up on any major variations (annual increases or decreases of 10 percent or more); (iii) On-site review to check submitted reports against registers and other facility-based data for a random sample of facilities from each of the 5 target regions; and (iv) Random contact tracing via mobile phone (or physical visit) for a sample of patients on registers.

28. In addition to verifying the HMIS data, the technical audit will seek to explain any discrepancy found with the audit data, and make recommendations that will be used to improve the HMIS.

29. A discrepancy of up to 5 percent between the HMIS data and technical audit data will be accepted. In case of a higher discrepancy, disbursement will be adjusted, based on the technical audit data. The technical audit will be carried out annually, starting with the 2013 data which will be used as the baseline.

30. Upon achievement or partial achievement of a DLI, the MOH would provide the World Bank task team with evidence supported by the relevant documentation. Following the World Bank's review of the complete documentation, including any additional information considered necessary, the World Bank would send an official communication to the Ministries of Health and Planning as to the achievement of the DLI(s) and the level of project financing proceeds available for disbursement against each particular DLI, including any partial disbursement for the scalable sub-allocation.

31. Disbursement requests (Withdrawal Applications) would be submitted to the World Bank by the MPLMCD using the World Bank's e-disbursement system and standard disbursement form along with a Request for Advance signed by the Government's authorized signatory. During the project life, in addition to disbursement requests for the advance (US$10.92 million equivalent) maximum for not yet achieved DLIs, the MPLMCD would also be able to submit disbursement requests for already achieved DLI(s) for the amounts above the mentioned available advance. Such disbursement requests could be submitted individually on achievement of a single DLI or grouped together as a set of DLIs are achieved in a given period and submitted as a consolidated disbursement. A copy of the World Bank's official communications confirming the DLI achievement should be attached to the disbursement requests.

32. **Component 2: Increasing the demand of RHN services (US$30 million equivalent).** This component aims to increase demand for RHN services by promoting social and behavior change among the main stakeholders, empowering women and improving availability and accessibility of key RHN commodities in communities. This component will operate at the community level with interpersonal communication, social marketing, social dialogue and community mobilization. It is strongly linked with the health sector through Component 1. While Component 1 strengthens provision of services, Component 2 increases demand for these services. Components 1 and 2 will reinforce one another to increase utilization of services. The activities in this component will be implemented by NGOs, build on the activities implemented by the ongoing SSNP, and complement activities in the SWEDD Project (specific complementarities highlighted in Table 12 of this Annex).

33. **Sub-component 2.1: Promote Social and Behavioral Change (US$9.5 million).** The sub-component will support community-level SBCC activities on RHN, population, and development issues. SBCC will be used to increase the demand for RHN services by addressing knowledge, social, cultural and gender barriers. With technical support from the SWEDD Project, implementation support from the ongoing Social Safety Nets (SSN) Project, and contracting of NGOs, various SBCC approaches will be further developed and implemented. The SWEDD Project will contribute to a regional pool of experts who will provide technical assistance to develop a national SBCC strategy. Health and population sector staff would be represented at community mobilization events to ensure the link between the sector and community activities. Topics covered would include best practices during and after pregnancy (e.g., ANC visits, assisted deliveries and post-natal care visits), family planning, delayed marriage and childbirth, healthy birth intervals (birth spacing), exclusive breastfeeding and appropriate complementary feeding practices, child growth needs, hygiene and sanitation, and benefits of investing in children's health and education.

34. In the same targeted regions as the Population and Health Support Project (PHSP), the SSNP is currently implementing SBCC activities[58] (accompaniment measures) focused on early childhood development through the following approaches: (i) village assemblies open to the entire village; (ii) small group meetings of women (primarily the older first wives of beneficiary households); and (iii) household visits. The PHSP will develop an SBCC strategy that is comprehensive, complementary and integrated with the SBCC activities currently implemented by the SSNP, and will aim to: (a) expand the scope to include reproductive, maternal and adolescent health themes; (b) intensify delivery modes and possibly the number of community workers and scale up within the household to include all women (all wives) and children; and (c) improve availability and accessibility of key RHN commodities.

35. The PHSP will carry out a thorough review of the SSNP accompaniment measures' curriculum to identify the need to strengthen the existing modules and/or develop additional modules on maternal health (pregnancy and delivery care), family planning (delaying, spacing and managing pregnancies) and nutrition. The SBCC component (accompaniment measures) of the SSNP consists of parenting training modules built on UNICEF's "essential family practices"

[58] SBCC at the community level is being particularly targeted toward the most disadvantaged households. The SSNP project's beneficiary targeting system will be used for identification of households (poorest 30%) and implementation of intensive SBCC activities thereby contributing to equity.

package. These training modules suggest a holistic approach to children's development by promoting improvements in parenting practices on nutrition, psychosocial stimulation, health and sanitation. The SSNP has developed an implementation manual, which provides a basis for a fully structured and standardized intervention. The manual details the content of the curriculum, the implementation modalities, the supervision and quality control arrangements, as well as guidance on the related Management Information System (MIS) module. The content of the curriculum includes the following 14 core themes:

Topic	Core theme
Child Nutrition	Exclusive breastfeeding for the first six months Complementary feeding after six months Recognizing signs of malnutrition and referring malnourished children to health services Vitamin A supplementation, deworming and iron absorption
Health	Use preventive health services to protect children against diseases Hygiene and hand washing Family planning (managing pregnancies and spacing birth intervals)
Psycho-Social Stimulation	Language stimulation Stimulation through play School readiness Brain development and sleep management
Child Protection	Birth registration and maintaining children at school Discipline, punishment and conflict management Attachment and psycho-social development

36. During the PHSP set-up phase, a throughout review of the content of the modules will be carried out so as to identify any need to strengthen the content of the existing modules. As the SSNP, SBCC activities are anchored on children, adjustments will be needed to widen the focus to women and adolescent girls to address maternal and reproductive health. In particular, the "Health" module above would likely be reframed as follows:

Topic	Core theme
Health	Use preventive health services to protect children against diseases Use curative health services to treat child illness Hygiene and hand washing Maternal health: pregnancy and delivery care Antenatal care Delivery care (skilled birth attendance) Postnatal care Family planning Delaying pregnancy Spacing births Managing pregnancies

37. The PHSP will intensify the delivery modes for SBCC in the current SSNP[59] with more frequent interpersonal communication (e.g., more frequent household visits) and deepen the

[59] As part of the SSNP accompanying measures, each beneficiary household participates in 3 activities per month: a village assembly delivered by a NGO operator, a small-group meeting delivered by a community educator, and a home visit delivered by the community educator (*relais communautaire*). One village assembly is organized for 50 beneficiary households on average. The village assembly remains open to non-

counseling on complementary feeding and child growth. Currently, the first wives of each beneficiary household participate in the small group discussion and household visits. Given the importance of reaching women at younger ages, the PHSP will expand the group discussions and household visits to include all women (all wives) in the household. This will also ensure directly reaching all children in the household rather than only children of first wives.

38. Finally, the PHSP will improve availability and accessibility of key RHN commodities (e.g., contraceptives, oral rehydration salts (ORS), mosquito nets, micronutrients, soap) at the community level. Contracts will be signed with NGOs and private sector actors for social marketing and community-based distribution (CBD) of products and knowledge.

39. *Relais communautaires* are often mobilized by NGOs and play a complementary role to that of the community health worker, thereby strengthening the links between the health facility and the community[60]. The *relais* will receive additional training to strengthen her/his counseling skills and nutrition knowledge as he/she is responsible for one on one counseling and home visits to encourage caretakers to monitor their child's growth a regular intervals. He/she would also be available for follow up counseling after child well-being visits at the health centers where children would receive the tailored messages with regard to the growth of their child. Similarly, they will receive additional training on topics related to pregnancy care and family planning. The community health workers would establish a clear supportive supervision role vis-a-vis the *relais* with supervision taking place at regular intervals. In addition, further capacity building activities for community workers and NGOs in technical areas as well as communication methodology will be made available through Component 3.

40. Contracts established with NGOs under the scope of the SSNP will be replicated for the SBCC activities. Different (additional) contracts will be used for the social marketing activities (including Community Based Distribution - CBD). Given the current high variance in performance of NGOs, twinning arrangements between experienced NGOs and start up NGOs, needed for scaling up, will be promoted to facilitate capacity building. During the set-up phase of the PHSP, the suitability of the contractual agreements and ways of work established with NGOs in the context of the SSNP will be revised to take into account the change in scope and intensity of the activities. It is likely that implementation of the PHSP SBCC activities will require an increased number of operators and agency staff. Moreover, a thorough review of the SSNP evaluation documents will be conducted to understand how experienced NGOs have performed, and identify those that should be engaged in the PHSP as operators and those that should be considered to twin with start-up NGOs.

41. **Sub-component 2.2: Women's and Adolescent Girls' Empowerment (US$17.2 million equivalent).** The sub-component will improve community-level demand for RHN

beneficiary households in those villages as well. The community educator delivers one small-group meetings ("causerie") for a group of 25 beneficiaries each month. The community educator also delivers a household visit for each household in the group each month. The household visit is structured to last 2 hours and includes pedagogical content.

[60] In the scope of the SSNP, NGOs make operators available for the project and select 1 community educator for each 25 beneficiaries. Both NGO operators and *relais communautaires* receive a two-week training at the beginning of the activity, as well as another two-week refresher training after 6 and 12 months of implementation. NGO operators provide coaching to *relais communautaires* during their monthly visit to each community. Thorough quality control procedures are put in place, with quality controllers hired by the implementing NGOs, as well as quality controllers hired directly by the project. Each NGO operator covers 10-15 villages, and there is one quality controller for every five NGO operators. In addition to quality control, beneficiary participation in program activities is registered in the project Management and Information System (MIS).

services by empowering women and adolescent girls with the knowledge and skills needed to make informed use of RHN services coupled with economic incentives for participation in key initiatives. Initiatives aimed at empowering adolescent girls (Age 10-24) will be focused on: (i) life skills; (ii) schooling; and (iii) skills development.

42. Life skills training will include modules on reproductive health (especially family planning), health and nutrition, hygiene, self-esteem, and financial literacy. The approach will be to give adolescent girls (14-19) a safe space where they can meet and learn under the support of a female mentor. A guide on the key modules has been developed by UNFPA. This curriculum adopts an interactive approach, using various games, role-play, small group activities and discussions to enhance learning and strengthen participants' competences. The modules will be implemented over a period of ten months. The participants (adolescent girls 14-19) will receive a kit including items such as sanitary pads, toothbrush, hair brush, soap, and bath slippers. PHSP will link out-of-school adolescent girls in the project areas to skills development training opportunities offered by the SDGP (see description below). Furthermore, the reproductive health and nutrition module developed for the PHSP will be shared with the SDGP for use in the skills development trainings.

43. Sub-component 2.2 will *utilize the existing cash transfer arrangements of the Social Safety Nets Project (SSNP)* to provide additional family support to poor households with adolescent girls to motivate them to keep their daughters in school. In Niger, there are two main points of school drop-out for girls: after primary school and after the first year of secondary school. After these points, attendance is relatively stable (i.e. if a girl continues to the second year of secondary, she is likely to complete the remaining years). Some of the barriers for poor households (demand side) to send their daughters to school are economic; others are related to cultural issues, health problems of the girls, and overall poor consideration for education. Financial support to poor households to maintain their adolescent girls at school is expected to contribute to the reduction in the drop in enrollment between primary and secondary school. Therefore, to maximize impact and retention of girls in school, there will be ***three eligibility criteria*** for the family support*: (i) poverty; (ii) age; and (iii) grade.* Since the two projects are being implemented in the same geographic areas, the already established beneficiary targeting and payment system will be used, which is administered by the SSNP implementation unit.[61] The poverty status of eligible families will be determined according to the SSNP targeting methodology. Information available in the SSNP register will be used. The SSNP targets 30 percent of chronically poor households in selected villages. A first screening based on three criteria: (i) household income; (ii) social status (profession); and (iii) length of residence in the village, is used to determine households' eligibility for the SSNP. A Proxy Means Test (PMT)[62] is then carried out to rank eligible households at municipality level and select the poorest 30 percent. Within the SSNP eligible households, girl's age 11-18 who are enrolled in grades 6-8[63] will be eligible for the family support. Enrollment will be voluntary and parents committing to maintaining their daughters at school for the entire school year will receive the family support,

[61] The identification of households eligible will be mostly based on administrative and categorical information from the SSNP register.
[62] PMT approximates households' wealth to variables correlated to their level of consumption (based on the survey ECBM 2007). The PMT includes variables that are observable, measurable and relatively stable. This allows verifying the reliability of answers and approximating wealth differences between households.
[63] Grade six corresponds to the last year of primary school (CM2), while grades 7 and 8 are the two first years of secondary school ('*sixième*' and 'cinquième'). Girls would reach the sixth grade at the age of 13, but statistics show that students in Niger lag behind the expected schooling age.

which will be paid to the mother of the enrolled adolescent girl. In a departure from the SSNP, not only the first wife but rather all wives in the household will be able to receive the family support if her daughter is enrolled in school (according to the above criteria). Beneficiary households will receive the family support for each girl enrolled in grade 6 (primary school), grade 7 and grade 8 (secondary school). Thus, eligible families can received more than one school incentive, according to the number of adolescent girls aged 10 to18 enrolled in the 6th, 7th or 8th grade in the family.

44. The amount will be different for primary school and for secondary school to account for the higher costs (financial and otherwise) of secondary school. Furthermore, to take into account higher costs of some secondary school girls staying with host families, a budget allocation has been made to cover up to 20 percent of secondary school students who may need to live with hosting families. Thus, there will be ***three tiers of payments:*** (i) primary school; (ii) secondary school; and (iii) secondary school living with host families. The number of adolescent girls expected to benefit will be approximately 7,400 per year. The family support will be transferred to the mothers of the adolescent girl students in ***three installments over the course of the school year upon verification of enrollment*** with the School Management Committee involved in monitoring and reporting of enrollment. The first transfer will be at the beginning of the school year in September, and the following two in December and April. School Management Committees[64] at village level will provide regular monitoring of girls' enrollment in, attendance to and performance at school and may provide support to adolescent girls during their stay outside their home. School Management Committees and the entire community will be strengthened and supported to have influence over the fulfillment of these commitments. Figure 3 below illustrates the flow of responsibilities and conditionalities of the family schooling support.

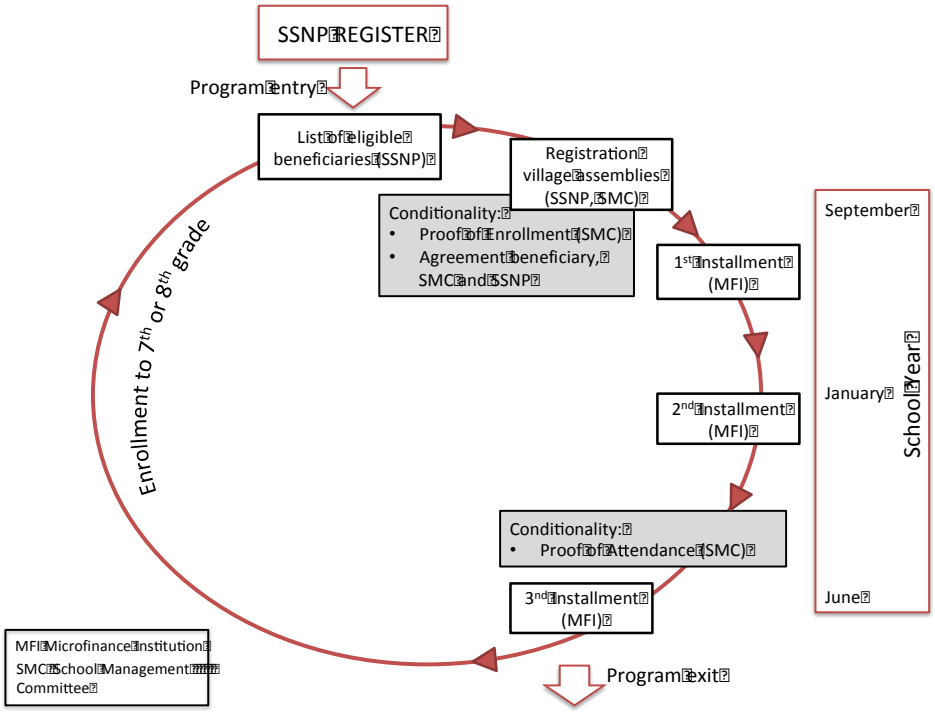
> ***Hosting Families.*** *Due to poor secondary school coverage in rural areas, many girls have to move to other villages to continue their studies. In these cases, their families pay for their stay at a hosting family's place. The question of whether cash should be given to the family of origin or the hosting family was discussed with the relevant authorities and stakeholders. A decision was taken to target families of origin based on their poverty status.*

45. Skills development trainings for out-of-school adolescent girls will be developed in collaboration with UNFPA, and implemented through local NGOs. The modules will be tailored to livelihood opportunities specific to each region and may include sessions on: agriculture, cooking, agro-business, handicraft, sewing, etc. Skills development interventions will be implemented after the life skills activities extending the period of support for out-of-school adolescent girls to two years. Productive kits will be distributed to either individuals or groups of adolescent girls at the end of the training. In addition, the PHSP will establish synergies with the SDGP by linking out-of-school adolescent girls in the project areas to short-term apprenticeship opportunities offered by the SDGP. This will be done through village level communication. Other synergies between the PHSP and the SDGP will include: (i) the PHSP will make available the SSNP register, including the list of out-of-school adolescent girls in the geographical areas where the two projects overlap; (ii) the PHSP will reinforce the

[64] School Management Committees include representatives of local authorities, community and religious leaders, women groups, parents and students.

empowerment of girls enrolled in short-term apprenticeship schemes through SBCC and life skills activities; and (iii) the PHSP will share the reproductive health and nutrition modules with the Fund for Continuing Professional Development and Learning (FCPDL) for use in the skills development trainings of the SDGP.

Figure 3 Annual Activity flow with Responsibilities and Conditionalities



46. **Sub-component 2.3: Mobilize opinion leaders (US$3.3 million equivalent).** The sub-component aims to expand the SBCC strategy to 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. A peer-education program in the form of discussion groups of men led by men from within the community – *Ecole des Maris* (EdM – Husband Schools) – was being piloted in two health districts in Zinder. The PHSP will support scaling up this initiative in the other four priority regions.

47. This sub-component will additionally benefit from the SWEDD Project's establishment of a network of religious leaders across the Sahel – participation of religious leaders in the Sahel network of peers will strengthen ownership and leadership at the community level. The PHSP will support knowledge transfer from the Sahel regional network to a broader network of religious leaders within Niger. The project will support knowledge exchanges and peer-to-peer capacity building across the five priority regions and especially at the local level. It is anticipated that the sub-component activities will also re-activate discussions on the legal age of marriage for women, reproductive health challenges, and health and development issues among the youth. Past attempts to introduce new regulations about age of marriage have faced strong opposition by religious and traditional leaders.

48. **Component 3: Improving capacity to manage, coordinate, and monitor and evaluate RHN services and demand-side activities (US$6.4 million equivalent)**. The component aims to support project management, implementation, monitoring and evaluation. It will strengthen the capacity of MOH, MOSS, MOP and MPLMCD in management, monitoring and coordination through the provision of: (i) administrative, management and fiduciary support; (ii) leadership and skill building at the central, regional and local levels to support implementation, particularly through the use of Rapid Results Approach (RRA); (iii) technical support to enhance the design of policies and strategies and the revision of training programs to improve the quality of care (for reproductive health and nutrition); and (iv) implementation monitoring and evaluation. The component will finance goods, consultants, training, Rapid Results Approach, evaluation assessments (including a qualitative process evaluation of Component 1 and 2) and operating costs. Technical assistance will be appointed as an independent verification agent to verify the project results, including baseline information. For the disbursement-linked indicators, payments will be made after an independent verification exercise is conducted. The verification process has to ensure the accuracy and consistency of reporting on qualitative and quantitative performance indicators before funding is released. Application of the DLI approach (under Component 1) will require the establishment of functional monitoring and evaluation systems (under Component 3) to routinely collect analyze and verify health data. While an independent monitoring firm will be hired to further validate progress and achievement of DLIs as well as project objectives and milestones, capacity strengthening and monitoring tools will be developed within the MOH to generate timely and accurate reporting. The component will also develop broader capacity to improve data quality and use the M&E information from RHN services for decision-making. The project will also support TA for capacity building of MOH and MOP in nutrition, SBCC and demography. Project management can also make skill building and other capacity development support available on a needs-basis for NGOs and CBOs supporting Component 2 of the project especially as the MOP will have the responsibility of hiring, management and performance management of a number of NGOs with varying experience and capacity.

49. **Component 4**: **Contingent Emergency Response (US$0).** The objective of this component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by OP/BP 8.00 (Rapid Response to Crisis and Emergencies). Niger is experiencing serious environmental problems including land degradation, desertification, soil erosion, water pollution, floods and droughts, leading to epidemics of communicable diseases such as meningitis and cholera, as well as other health problems such as malnutrition which are related to these environmental issues. There is a moderate to high probability that during the life of the project, environmental or other factors could lead to a major epidemic or other disaster which causes a major adverse economic and/or social impact (e.g., Ebola), which would result in a request from the country to the Bank to support mitigation, response, and recovery in the region(s) affected by such an epidemic. In anticipation of this, an emergency component is proposed.

50. The request would be appraised and reviewed, and if found acceptable to the Bank, disbursement would be made for this component. The component will be used to draw resources from uncommitted funds and/or allow the Government to request the Bank to re-categorize and

reallocate financing from other components to partially cover the emergency response and recovery costs. In such case, the PDO would be revised and the scope of the project would be expanded to cover expenditures incurred under this component. It should be noted that this component would not be used to finance salaries, nor any expenditures that could trigger any of the Bank's safeguard policies.

51. An "**Immediate Response Mechanism Operational Manual" (IRM/OM)** has been prepared by the country and it would be revised to integrate the proposed project. The manual should be subjected to no-objection by the Bank, in line with the flexibility provided under paragraph 14 of OP 10.00. Should funding be reallocated within the project through IRM, the PDO and/or project results framework, as required, will be adjusted to capture use of these funds through a level one restructuring. Safeguards will be addressed when/if a crisis happens. The component will be implemented by the MOH. Disbursements would be made against a positive list of eligible expenditures critical for the sector recovery. The list will consist of goods, maintenance and repairs operating costs, and consultant services needed to deal with the emergency.

52. **Procedures for triggering the Contingent Emergency Response (CER)**. In order to activate this component in the event of an emergency, the MOH shall: (a) prepare and furnish to the Bank for its review and approval, an operations manual which shall set forth detailed implementation arrangements for the CER, including: (i) designation of, terms of reference for and resources to be allocated to, the entity to be responsible for coordinating and implementing the CER ("Coordinating Authority"); (ii) specific activities which may be included in the CER component, and any procedures for including them; (iii) financial management arrangements for the CER; (iv) procurement methods and procedures for expenditures to be financed under the CER; (v) documentation required for withdrawals of expenditures; (vi) environmental and social safeguard management frameworks for the CER, consistent with the Association's policies on the matter; and (vi) any other arrangements necessary to ensure proper coordination and implementation of the CER; (b) give the Bank a reasonable opportunity to review said proposed operations manual; (c) promptly adopt an IRM Operations Manual; (d) ensure that the CER is carried out in accordance with this manual; and (e) not amend, suspend, abrogate, repeal or waive any provision of the manual without prior approval by the Bank.

53. Throughout the implementation of the CER, the MOH will maintain the Coordinating Authority, with adequate staff and resources satisfactory to the Bank, and the MOH will not undertake activities under the CER unless and until: (a) the Government has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Bank a request to include relevant activities in the CER in order to respond to the identified crisis or emergency, and the Bank has agreed and accepted the request and notified the Government thereof; (b) the MOH has prepared and disclosed all safeguards instruments required for the relevant activities, in accordance with the IRM Operations Manual, the Bank has approved all such instruments, and the Government has implemented any actions which are required to be taken under said instruments. Procurement for the CER will be done in accordance with the procurement methods and procedures set forth in the IRM Operations Manual, and prior to disbursements: (a) a request should be made for using the CER component and this should be accepted by the Bank; (b) safeguards instruments should be prepared and disclosed and any necessary safeguard actions

should be implemented; (c) adequate staff and resources should be in place to implement the CER activities; and (d) the IRM Operations Manual is adopted.

Table 12: Complementarities between the SWEDD, SSNP, SDGP, PSCPSD and PHSP

COMPONENT 1: Improving the provision of high quality RHN services					
Priority area	**Regional Sahel Women's Empowerment and Demographic Dividend (SWEDD) Project**	**Niger Social Safety Nets Project (SSNP)**	**Niger Skills Development for Growth Project (SDGP)**	**Public Sector Capacity and Performance for Service Delivery Project (PSCPSD)**	**Niger Population and Health Support Project (PHSP)**
	P150080 [Approved]	**P123399 [Effective 11/11/11]**	**P126049 [Effective 11/28/13]**	**P145261 [Effective 9/29/14]**	**P147638**
Service delivery	Regional harmonization of registration, quantification and quality control of RHN commodities Establishment of rural midwifery training institutions; incorporation of family planning education in midwifery training curriculum			Strengthening of health management information system (HMIS/SNIS) Management of human resources for health	Use of results-based mechanism (DLIs) to improve the quantity and quality of RHN service delivery Procurement, distribution and supply chain strengthening for RHN commodities Improved capacity of health workers to deliver quality RHN services
COMPONENT 2: Increasing the demand of RHN services					
Social and behavior change communication (SBCC)	Establishment of a regional pool of experts on social mobilization, marketing, mass communications, and knowledge management Launch of a regional media campaign (edutainment: radio, TV) for behavior change	Development and implementation of SBCC strategies for early childhood development (Essential Family Practices) Targets first wives in beneficiary households			Development and implementation of high intensity community-level SBCC strategies for RHN Targets all women and children in beneficiary households Information dissemination and commodity distribution at community level using social marketing Contracts with NGOs under SSNP will be replicated using a performance-based approach, including twinning arrangements between new and experienced NGOs

Empowering adolescent girls	Evaluation of adolescent girls' interventions and dissemination of results to other countries	Unconditional cash transfer to beneficiary households	SDGP skills development training for girls 15-19 (e.g., apprenticeship, on demand trainings)		Implementation of adolescent girls' interventions covering: 1) Life skills training for girls 15-19 (health and nutrition, family planning, hygiene, self-esteem, and financial literacy) 2) Schooling for girls 11-18 (implemented in same geographic areas as SSNP; uses SSNP targeting and payment mechanism to provide family support to beneficiary households conditioned upon girls enrolled in grades 6-8; SSNP management unit directly involved; payment agencies in SSNP contracted for payment of family support transfer in PHSP)
Reaching opinion leaders	Establishment of a regional network of religious and other opinion leaders for RHN and demographic dividend				Engagement of religious leaders and other opinion for community-level SBCC and knowledge exchange across the country
COMPONENT 3: Improving capacity to manage, coordinate, and monitor and evaluate the RHN services and demand-side activities					
Monitoring and evaluation				Development of Service Delivery Indicators (SDI) Survey on the performance of health facilities on quality of service delivery	Additional SDI survey at end of project – SDI surveys will be used to assess progress on quality of health service delivery throughout the project

Annex 4: Global Evidence on Social and Behavior Communication Change and Adolescent Girls' Empowerment

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

Social and Behavior Change Communication

1. **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. The evidence on SBCC shows that different types of communication can be used to promote and facilitate healthy behaviors and behavior change. SBCC works on the behavior or action taken by groups, social and cultural structures, and the enabling environment. At its core is social change. SBCC activities can be categorized into two primary types – mass media and community-based approaches:

(a) ***Mass media approaches*** can be in the form of edu-tainment or social marketing campaigns. Edu-tainment is characterized by radio and television messages, dramas aired on radio or television, songs containing relevant messages. Social marketing campaigns have been commonly used for family planning but can also go beyond that to include a broader set of RHN commodities (e.g., oral rehydration salts, water purification tablets, insecticide-treated bed nets, etc.). Mass media approaches are a good way of using entertainment and strategies to reach large numbers of people to change knowledge, behaviors and attitudes. Mass media approaches have been implemented and evaluated in a number of countries, including Ethiopia, The Gambia, Tanzania, Mali and Côte d'Ivoire. These programs have increased knowledge and improved attitudes about family planning, approval of family planning, family planning self-efficacy use of modern family planning methods, and use of reproductive health services. For example, in Tanzania, Radio Tanzania produced and aired a radio soap opera about family planning and about HIV/AIDS. The messages and storylines were developed following formative research with religious and youth groups. The program aired twice per week during primetime for 30 minutes. Certain areas of Tanzania did not receive the broadcast, so served as a control group for comparison. An evaluation indicates that the program resulted in improvements in self-efficacy about family planning, ideal age of marriage, approval of family planning, spousal discussion about fertility and family planning and contraceptive prevalence rate in the areas that received the radio broadcasts compared to areas that did not. Furthermore, within the areas where the radio messages were broadcasted, there were people who reported listening to the radio and people who did not. Prevalence of spousal discussion and adoption of family planning was significantly higher among those who reported listening to the radio compared to those who did not.

(b) In contrast, ***community-based approaches*** leverage social networks to promote community-level discussion with an aim to influence utilization of services and behaviors via norms and information exchanges. These approaches can be delivered in the form of community discussion groups, peer groups, or one-on-one exchanges and are often

targeted at specific sub-populations (e.g., women, men, adolescents, religious leaders, etc.). Global evidence indicates that leveraging community groups to promote discussion of family planning can influence utilization via norms and information exchanges. Rigorous evaluations of programs in Senegal, Bangladesh and India indicate that community-based approaches have been effective and have resulted in increases in: awareness of family planning and reproductive health, use of modern family planning methods, discussions with husbands about family planning and continuation of method use. The Bangladesh intervention, for example, identified so-called "link persons" within social networks to facilitate regular peer group discussions about contraception and to provide supplies as needed. Community-based interventions have also targeted intra-household communication, including specifically gearing communication toward men. Evidence from Ethiopia, Zambia and Vietnam have shown these programs have resulted in higher rates of initiation and continuation of modern family planning, increases in concordance with wives' readiness to adopt family planning, and increases in perceived benefits of using family planning and reproductive health services. The *Tostan*[65] program in Senegal focuses on community education and mobilization, and engages communities to pledge public declarations against harmful practices such as early marriage.[66] *Tostan* claims a large number of converted communities through documented pledges, results on actual declines in child marriage are less conclusive[67]. There is also a potential for testing a regional effort in Islamic advocacy, as showed by promising experiences from Mauritania.

2. The evidence on SBCC offers a number of common lessons that have been learned from implementation in different settings. SBCC and social marketing strategies have been more effective when developed in partnership with NGOs and the private sector. Launching media campaigns (radio, TV) about reproductive health issues are effective, and facilitating community-level communication campaigns and ensuring involvement of men are important. Finally, SBCC has been most effective when paired with community-based distribution (by healthcare workers or members of the community) of reproductive health services and products.

Adolescent Girls' Empowerment

3. **The global evidence base indicates that interventions aimed at adolescent girls and their communities can be effective in improving outcomes both within and beyond the health sector**, including:

a) Health: age of marriage; pregnancy; risky sexual behaviors; use of condoms and other contraceptives; sexual and reproductive health knowledge and attitudes;
b) Beyond health: school attendance, retention & achievement; employment and income; financial literacy; savings behavior; experience of violence; social capital and social networks; agency (self-efficacy, self-esteem, decision-making power, aspirations, etc.).

[65] Tostan's Community Empowerment Program (CEP) uses a non-formal, human rights-based approach to education wherein it aims to empower communities with the knowledge and tools that will enable them to develop their own futures.
[66] Diop N, M Faye, A Cabral, H Benga, F Mane, I Baumgarten, and M Melching. 2004 The TOSTAN Program Evaluation of a Community Based Education Program in Senegal. Washington DC: USAID.
[67] Malhotra A, A Warner, A McGonagle, and S Lee-Rife. 2011. Solutions to End Child Marriage: What the Evidence Shows. Washington DC: International Center for Research on Women.

4. The types of interventions that have been effective in improving the above outcomes can be categorized into three broad categories:

a) Strengthened provision of reproductive health education and life skills;
b) Economic empowerment interventions; and
c) Enhanced access to secondary education for girls.

5. **There is growing evidence that life skills interventions[68] targeting the poorest girls early, both out-of-school and in-school, can have tremendous impact.** These interventions are designed to teach a broad set of social and behavioral skills including decision-making, community living, and personal awareness and management with the aim of developing young peoples' abilities and motivations to make use of all types of information. These interventions are often delivered in the form of "girls' clubs", and topics of discussion can include legal rights, gender, relationships, communication and decision-making, health, puberty, sexual and reproductive health, self-esteem, leadership, early marriage and pregnancy, Female Genital Mutilation (FGM), and education. Life skills interventions can also be aimed at other members of the adolescent girl's community. These interventions tend to focus on topics such as early marriage, early childbirth, birth spacing, female genital mutilation, and girls' education. For example, the Berhane Hewan program for girls age 10-19 in Amhara, Ethiopia resulted in substantially greater increases in age of marriage and use of family planning in program areas than comparison areas.

6. **Economic empowerment interventions have been proven to be effective in both health and non-health outcomes but with stronger results in non-health outcomes.** Job skills training and follow-up placement support can be in targeted fields based on labor market demands for wage employment. Business or livelihood training focuses on building skills for self-employment and follow-on business advisory services. These interventions can be designed for entrepreneurship generally or targeted to specific sectors (e.g., agriculture). Financial asset management training has included financial literacy as well as access to credit and saving services. One example of a successful economic and livelihood intervention is the Economic Empowerment of Adolescent Girls and Young Women (EPAG) program in Liberia. Impact evaluation results showed very large economic impacts: employment increased by 47 percent and incomes by 80 percent. In Uganda, an intervention combining life skills training (on sexual and reproductive health), livelihood training, savings and microfinance had impacts on both health and non-health outcomes in program areas compared to non-program areas: increases in employment, earnings and consistent condom use as well as decreases in incidence of sex against their will and fertility rates.

7. **Finally, schooling interventions have been shown to result in lower rates of adolescent marriage, school dropouts and HIV.** The most rigorous evidence comes from interventions that provide financial incentives to delay marriage and childbearing, including unconditional cash transfers (UCTs), conditional cash transfers (CCTs) and in-kind transfers. UCTs have been transfers of cash to eligible households with no conditions attached. CCTs transfer cash conditioned on certain behaviors of recipient households or individuals (e.g.,

[68] These can also be considered as a type of community-level SBCC approach.

attending 80 percent of school days, staying unmarried, achieving learning outcomes). Finally, in-kind transfers of uniforms, school canteens, food rations, etc. have been used to encourage school enrollment and attendance. Programs in Kenya, Burkina Faso, Bangladesh, Mexico, Brazil, Malawi, Ethiopia, and Egypt have employed a mix of interventions at primary and secondary school levels. Rigorous evidence indicates reduced drop-outs; higher school enrollment and attendance rates; better test scores; decreased prevalence of child marriage; delayed onset of sexual activity; increased use of contraception; lower adolescent pregnancy rates; smaller desired family size; and lower overall fertility. For example, a female secondary school stipend program (which functioned as a CCT) in Bangladesh showed improvements in secondary school enrollment as well as a reduction in the proportion of married adolescent girls. In-kind transfers of free uniforms in primary schools in Kenya resulted in greater improvements in dropouts, teenage marriage and teenage pregnancy in school enrolled in the program compared to those not enrolled in the program.

Table 13 : Design Options and Lessons Learned for Demand-side Interventions

Type of Intervention	Design Options	Description	Complementary Interventions/Approaches
SUB-COMPONENT 2.1: PROMOTE SOCIAL AND BEHAVIORAL CHANGE			
Social and Behavior Change Communication (SBCC)	Mass media	• Radio or television messages, dramas aired on radio or television, songs containing relevant messages → also known as edu-tainment; • Social marketing campaigns for family planning, including pills and condoms that were marketed through advertising campaigns, radio programs and short films aimed at behavior and attitude changes; social marketing can also go beyond family planning to other health commodities (oral rehydration salts, water purification tablets, mosquito nets, etc.). • **<u>Take-away:</u> A good way of using entertainment and mass outreach – shown to produce results on change in knowledge, attitudes and behaviors.**	• Any of the others in this table – but can also be stand-alone
	Community-based approaches	• Leverages social networks to promote community-level discussion with an aim to influence utilization of services and behaviors via norms and information exchanges; • Can be delivered in the form of community discussion groups, peer groups, or intra-personal communication (one-on-one exchanges) – when targeting adolescent girls, often delivered as life skills intervention (see below row). • Includes interventions geared toward improving intra-household communication, including specifically tailoring communication to reach men in the household. • **<u>Take-away:</u> Although the results are somewhat mixed, this approach has produced higher rates of initiation and continuation of family planning; better agreement between husband and wife; and increased perceived benefits of reproductive health services.**	• Any of the others in this table – but can also be stand-alone

SUB-COMPONENT 2.2: WOMEN'S AND ADOLESCENT GIRLS' EMPOWERMENT			
Life Skills Interventions	Community-level intervention targeting adolescent girls	• Designed to teach a broad set of social and behavioral skills including decision-making, community living, and personal awareness and management with the aim of developing young peoples' abilities and motivations to make use of all types of information. • Can be considered a Social and Behavior Change Communication (SBCC) community-level approach with targeting toward adolescent girls; • Topics can include legal rights, gender, relationships, communication and decision-making, health, puberty, sexual and reproductive health, self-esteem, leadership, early marriage and pregnancy, FGM, education, etc.; • Often delivered through mentoring by older females, including community health workers, trained teachers and peers; • Can be school-based but also reach girls not in school, such as through social clubs that also provide safe spaces for other group activities; • Can include making health services adolescent girl and women friendly, including related referrals, availability of information, and guidance; • **<u>Take away:</u> Adolescent girls most often do not have sole decision-making power over their actions and development outcomes. It helps to include family- and community-level mobilization and sensitization within broader programming. Non-cognitive skills developed in these programs have been proven to be important to health and labor market outcomes.**	• Economic and livelihood interventions • Schooling
	Community-level intervention targeting other members of the community	• Mobilizing and educating parents and community members through SBCC approaches (group discussions, interpersonal, mass media, etc.); • Topics can include early marriage, early childbirth, birth spacing, FGM, girls' education, etc.; • Considered Social and Behavior Change Communication (SBCC) community-level approach with targeting toward other members of the adolescent's community; • **<u>Take away</u>: Interventions should be targeted and personalized as much as possible, involving key authority figures and champions.**	• Economic and livelihood interventions • Schooling
Economic and Livelihood	Literacy training	• **<u>Take away:</u> Can encourage drop-outs to re-enroll in school.**	• Life skills • Economic and livelihoods interventions

Interventions	Jobs skills training	• Job skills training and follow-up placement support in targeted fields based on labor market demands for wage employment; • **<u>Take away:</u> Programs encouraging girls into non-traditional trades have proven successful in variety of contexts. Basic entrepreneurial skills should be included where wage employment opportunities are limited. Should consider in-school and out-of-school girls.**	• Life Skills • Mentoring/Coaching • Financial Literacy • Access to services (e.g., Health or Financial Services) • Community Engagement
	Business or livelihood training	• Business or livelihood skills for self-employment and follow-on business advisory services. Can be designed for entrepreneurship generally or targeted to specific sectors (e.g., agriculture); • **<u>Take away</u>: Pairing technical skills (either job or business skills) with life skills seems to be important for improving adolescent girls' development outcomes.**	• Life Skills • Mentoring/Coaching • Financial Literacy • Access to services (e.g., Health or Financial Services) • Community Engagement
	Financial assets	• Financial literacy, access to credit and saving services; • **<u>Take away:</u> Programs are likely to be more successful where the lack of financial services or knowledge is a binding constraint for young women. As with all AG programs, it is important to monitor for unintended consequences of increasing young, and work with communities as needed. Programs should consider the greater risk aversion of young borrowers.**	• Life Skills • Mentoring/Coaching • Financial Literacy • Access to services (e.g., Health or Financial Services) • Community Engagement
Schooling Interventions	Unconditional Cash Transfer	• Cash transfer to the poorest households with an adolescent daughter (identified through beneficiary targeting system) or to a host family of an adolescent girl who is in school; • **<u>Take away:</u> Evidence of lower marriage and pregnancy rates, and lower HIV rates. Mechanisms of change in regards to fertility outcomes and empowering women are not well understood. Transfers should be integrated with other sectors and programming to address gender equality.**	• Access to other services (e.g., Health) • Community Engagement • Life Skills
	Conditional Cash Transfer	• Stipend to adolescent girl or her family for meeting certain conditions (e.g., attending a minimum percentage of school days; attaining a minimum score on an achievement test; remaining unmarried until finishing school; regular health checks, remaining STI-free, etc.); • Could include economic targeting to prioritize poor households; • **<u>Take away:</u> Evidence of reduced dropouts, and lower HIV rates. Longer term impacts unclear, and links to fertility and empowerment are**	• Access to other services (e.g., Health) • Community Engagement • Life Skills

		unclear.	
	In-kind Transfer	• Provision of uniforms, school canteens, food rations, household goods (e.g., rice, oil, etc.) • **<u>Take away:</u> Some evidence for reduced dropouts. Should involve careful communication to avoid negative social impacts for recipients. Unclear fertility and empowerment linkages.**	• Access to other services (e.g., Health) • Community Engagement • Life Skills
SUB-COMPONENT 2.3: MOBILIZE OPINION LEADERS			
Community-level interventions targeting leaders of the community		• Mobilizing and educating parents and community members through SBCC approaches (group discussions, interpersonal, mass media, etc.); • Topics can include early marriage, early childbirth, birth spacing, FGM, girls' education, etc.; • Considered Social and Behavior Change Communication (SBCC) community-level approach with targeting toward other members of the adolescent's community; **<u>Take away</u>: Interventions should be targeted and personalized as much as possible, involving key authority figures and champions.**	• Economic and livelihood interventions • Schooling

Annex 5: Theory of Change

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

Increase the utilization of reproductive health and nutrition services in Targeted Areas.

PDO indicators

(i) Women 15-49 years using modern contraceptive methods
(ii) Skilled birth attendance at delivery for women 15-49
(iii) Exclusive breastfeeding for children under 6 months
(iv) Women 15-49 and children (<5) using the basic package of reproductive health and nutrition services (number), of which girls 15-19 (percentage)
(v) Direct project beneficiaries (number) of which female (percent).

Overall change description:

Improving the provision of RHN services and the community demand to use the services will lead to improved utilization of the services in the five regions. Component 1 of the project will improve the provision of RHN services by addressing delivery constraints to scaling-up RHN service. The project financing is anchored in achieving results in key areas of the MOH work plan to promote innovations and incentives to accelerate outcomes.

Component 2 will link RHN services to increasing demands in the community. The component will influence **changes in behaviors and attitudes to address social, cultural and gender constraints which can impede** RHN health service utilization. Health facilities will be directly involved in the community activities.

Component 3 will provide capacity building support to the MOH and MOP in areas such as technical skills, leadership and evaluation. Participatory process evaluation will iteratively incorporate lessons learned back into the annual work plan to strengthen components 1 and 2.

Constraints addressed	Actors	Description of change process	Intermediate results
Component 1: Improving the provision of high quality RHN services • Weak impact of available health services on challenges of chronic malnutrition, high fertility, high child morbidity, and high maternal and child mortality • Limited uptake of services by young women, despite policies to engage adolescents in health services • A systematic shortage of essential drugs and supplies in health centers • Poor numbers and skills of health workers to deliver services • Insufficient public health financing to deliver services to population	*Change agents* Health care platforms (district hospitals, health centers and outreach post) Health workers MOH *Beneficiaries* Children under 2 and under 5 years Adolescent girls Women of	The MOH will scale-up a package of high impact RHN interventions by addressing constraints related to service delivery. Financing is anchored in results and key areas of the MOH work plan to promote new country-led innovations and incentives to accelerate service delivery targets. Improving delivery will emphasize quality and quantity to benefit more women and children. Increasing the knowledge and number of health worker in the five regions will enable better RHN services to meet needs of young women and	• DLI 1: Increase in women utilizing modern contraception (Percent and number) • DLI 2: Increase in women delivered by a trained health professional (Percent and number) • DLI 3: Increase in new accepters (girls <20) using modern contraceptives (Percent) • DLI 4: Increase in Children < 1 year of age having received nutrition counseling and an updated growth chart (Percent) • DLI 5: Increase in Children 0-11 months immunized with measles (Percent and number) • DLI 6: Health facilities receiving payments from the central government for their revolving funds on time in accordance with the guidelines (Percent)

• Inappropriate health care and very poor quality nutrition counseling provided to children and young women reduces quality of services	reproductive age	children. Rapid Results Approach will be used to define the work plan in key areas and develop new solutions. Some areas of the work plan include improving commodities availability at health centers, nutritional services, adolescent RH services, and pregnancy related services for women.	• DLI 7: Training of health workers to deliver RH and nutrition services (Number) • DLI 8: Health workers receiving supervision visits in the previous period including direct observation of their work (Percent) • Rapid Results Approach implemented to support the annual work plan (Number) • Service delivery sites providing tailored RH services for adolescents (Percent) • Updated guidelines for the delivery of community based RHN services (Y/N)
Component 2: Increasing the demand of RHN services • Social-cultural factors limit schooling and opportunity for young girls, resulting in early marriage and early childbearing • Cultural and religious norms do not allow sexual intercourse before marriage and use of family planning • Limited access to health information to make choices about reproduction and nutrition • Low perceived need for RHN services, and women may need permission to use the services, and be unable to access services in remote areas • Malnutrition is often invisible and not recognized timely • Weak stakeholder commitment to policy reforms, such as age of marriage • Gender norms and women's status limit women's roles in decision-making power	*Change agents* Relais communautaires or Community agents Ecole des Maris discussion groups of male community leaders NGOs Network of religious leaders Women Health facilities *Beneficiaries* Children under 2 and under 5 years Adolescent girls Wives Mothers	Demand for RHN services will increase through SBCC, outreach services, re-activating dialogue on key issues among leaders, and empowering girls (e.g., life skills and schooling). This will improve knowledge, and change behaviors and attitudes to address social, cultural and gender barriers, and better link communities to health facility and outreach services (in Component 1). The interventions will intensify and scale-up achievements of the SSNP project.	• Households visited by *Relais Communautaire* (Number) • Women (15-24), who have increased their knowledge on defined areas of RHN (Percent) • Community and religious leaders who have improved acceptance of RH policies and programs (Percent) • Men in the Ecole Des Maris who are supportive of their partners' reproductive health practices (Percent) • Adolescent girls registered in school annually as reported by the School Management Committees (Number) • School Management Committees submit monthly reports on adolescent girls school registration (Percent completeness)
Component 3: Improving capacity to manage, coordinate, and monitor and	MOH Nutrition	Capacities to coordinate decentralized RHN services will be	• Participatory process evaluation conducted and lessons are integrated in the annual work plan

evaluate RHN services and demand-side activities • Weak government coordination for decentralized implementation nutrition services, which have been led by NGOs • Weak capacity to management services, oversee quality and use date and information for decision making	Directorate of MOH MOSS School Management Committees Health facilities	developed, including in financing for results, leadership, designing strategies, and evaluating progress. Monitoring and evaluation including DLI verification will improve quality of data and use for decision-making. Re-integration of lessons learned from process evaluation and rapid results into the annual work plan will strengthen implementation and scale-up successes.	(Y/N) • Alignment of annual work plan to support results of project (Y/N) • Health facilities reporting health management data on time (Completeness rate).

Annex 6: Implementation Arrangements

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

Project Institutional and Implementation Arrangements

1. **The project will be implemented by two ministries: MOH and MOP**. Based on the lessons learned from the implementation of the previous project[69] in the two sectors, a PIU will not be established for the proposed project. The Ministry of Health will be responsible for the overall management as well as the monitoring and evaluation of the project.

2. **The project will rely on existing institutional and implementation arrangements for the Health Development Plan (HDP) and the Government Declaration of Population Policy (GDPP)**. The implementation of the two strategies (HDP – GDPP) follows Niger's decentralized structure of administration. The implementation responsibility has been shared between the central level (policy regulation); the regional directorates (technical support); and the departmental level (operational activities). Each ministry will be given the responsibility to execute specified activities in line with its mandate. The respective Secretary General in each ministry will be responsible for the management and the implementation of the project. The responsibilities of the MOH include the national health policy formulation, health services expansion, establishment of the standard norms and operational protocols, regulating service delivery and ensure the distribution of the staff in the different regions of the country. The MOP has the same role and responsibility by focusing its intervention in social and behavior change, social protection, child protection and the promotion of women. The central level supports the regions in system development and mobilizes resources to improve population and social and health services delivery on the ground.

3. **The MOH has a long track record in implementing Bank-financed projects.** Its pooled funds[70] demonstrates strong capacity to coordinate project implementation, and the arrangements in the key areas of financial management (FM), procurement and monitoring evaluation (M&E) remain in compliance with Bank's fiduciary and reporting requirements. It will: (i) coordinate the project activities including those implemented by the MOP; (ii) carry out financial management for project activities under the four components; and (iii) prepare consolidated annual work plans, budgets, M&E report, and the project execution report for submission to the Steering Committee and the Association (IDA). Additional staff will be recruited with the necessary qualifications to ensure appropriate fiduciary control and project monitoring and evaluation. In addition, given the interest in the development of PBF in the sector, technical assistant will be hired to ensure: (i) an adequate implementation arrangements; and (ii) a capacity building for staff at different level of the health system especially in the area of Performance Based Financing (PBF) and DLIs. The proposed Project Preparation Advance (PPA) would be used in part to provide such capacity building.

[69] Institutional Strengthening and Health Support project (P083350) and the Multi-sectoral Demographic project (P096198).

[70] The MOH has operated a pooled account into which all contributions from donors (UNICEF, AFD, Spain, GAVI and UNFPA) participating in the pooling arrangements are paid to finance the agreed upon Annual work plan. The pool account has been established in a commercial bank, which received funds disbursed based on periodic Financial Monitoring Reports (FMRs). Accounts at different levels (each Health District and each Regional Directorate) will receive funds from the Pool account.

4. **The MOH will implement Components 1 and 3**. Component 1 will be implemented by the MOH through the existing pooling arrangements supported by UNICEF, GAVI, UNFPA, Spain, and France. The project funds will be disbursed to the Designated Account A after a performance assessment of the DLIs carried out by a third party, allowing the financing of the eligible expenditures for the activities in the annual sector plan. The second Designated Account - B within the MOH will receive funds for traditional investment for the expenditures under Component 3.

5. **The Secretary General (SG) of the MOH will be responsible for oversight and strategic coordination of all actions foreseen under the project in general, and those under the SWAp, in particular.** The SG will coordinate the overall functions and responsibilities of the technical directorates. Technical implementation of the project will be assigned to organizational units within the Ministry according to their comparative advantage. A project management adviser has been hired and placed under the Secretary General. Technical directorates and units at the central, regional, and district levels have full and direct responsibility for implementing their activities according to agree upon AWP and priorities as set in the HDP. After the approval of the AWP, funds will flow from the central level to regional and district level so as to contribute to the implementation. A review of the AWP will be carried out annually and form the basis for the following year's work plan.

6. At the Central Level: (i) The **Planning and Studies Directorate (*Direction des Etudes et de la Programmation – DEP***) will be responsible for consolidating the planning and programming of MOH activities and will ensure adequate monitoring and evaluation. It will address issues that may arise during implementation and propose related corrective measures in consultation with the donors as necessary. The DEP will provide the link between the fiduciary and technical directorates to ensure that resources are made available in a timely manner to the technical directorates (at all levels). The DEP will report directly to the Secretary General. (ii) The **Financial Resource and Material Directorate (*Direction des Ressources Financières et Materielles - DRFM*)** will be responsible for overall administrative and financial management. The DRFM will manage the budget allocated to the MOH in the context of the HDP and will ensure financial coordination of the Project through regular supervision and audit of all administrative, financial, and accounting. The DRFM has been reinforced by the services of a Financial Controller Specialist, a Senior Accountant, and internal auditor. (iii) The **Procurement Directorate (*Direction des Marchés Publics - DMP)*** will manage procurement functions for goods, furniture, and consultant services in collaboration with the technical directorates that will benefit from these inputs. The DMP has been strengthened with an additional Procurement Specialist in order to carry out the procurement process according to the Bank's procedures and guidelines. (iv) **Technical Directorates** will be responsible for the development and technical implementation of their respective AWPs. They will also provide technical support to the decentralized levels on an ongoing basis. Specifically the Directorate for Nutrition will be responsible for nutrition interventions included in the sectoral plan implemented through contracts with NGOs. It will prepare annual plans to be financed and provide follow-up to the contracts with NGOs who would be implementing the behavior change activities. Specific attention will be paid to the strengthening of the capacity of the Directorate of Nutrition under MOH for its role in the supervision and coordination of the activities as well as stimulating inter and multi-sectoral coordination, in particular with the 3N initiative. Although the project would

not tackle all determinants of malnutrition (food security, water and sanitation, poverty) it would focus on its sectoral responsibilities of access to health and nutrition services and caretaking behavior while remaining vigilant about the other sectors.

7. At the Regional Level, as part of the process leading to the decentralization/ deconcentration of responsibilities in delivering quality services: (i) the **Regional Directorates of Public Health (*Direction régionale de la santé publique - DRSP*)** will ensure the technical and financial management of the project. It will provide technical supervision and support for activities carried out as part of its AWP and those of the districts; and (ii) The **Health District** (*District Sanitaire - DS)* is the first level of management and implementation of the Project as indicated in the agreed-to District Annual work Plan based on local needs and priorities. Service delivery and implementation at the district levels are the responsibility of the health district team, who are accountable to local authorities.

8. **The MOP will implement the Component 2 and will receive funds for eligible expenditures based on traditional investment.** The ministry will prepare regular annual work plans which will be included in the project work plan consolidated at the end by the MOH before its submission for review and approval. It will have its own sub account to which it will receive funds for the eligible expenditures. The SBCC activities will be implemented through contracts with NGOs and through transfers for girls schooling and women's empowerment. The transfers for girls will be made through the mechanism used by the Safety Nets project in the same targeted regions. Women and adolescents empowerment activities will be completed by an entrepreneurship training program provided by the skills development for growth project. Qualified staff in financial management and procurement will be hired to ensure appropriate fiduciary control and management. The hired staff will also strengthen the capacities of the sector's staff directly involved in the implementation of the project.

9. The MOP has the same implementation arrangement as the MOH without pooled funds. The Secretary General (SG) of the MOP will be responsible for oversight and strategic coordination of all actions foreseen under the project Component 2. The SG will coordinate the overall functions and responsibilities of the technical directorates in charge of the implementation of the activities supported by the project. The **Planning Directorate** (DEP) will be responsible for consolidating the planning and programming of MOP's activities and will ensure adequate monitoring and evaluation of the project. **The Financial Resource and Material Directorate** (DRFM) will be responsible for overall administrative and financial management. It will manage the budget and will ensure financial coordination of the project through regular supervision and audit of all administrative, financial, and accounting. The DRFM will provide technical support to the decentralized levels (regions) when carrying out their budgetary, administrative, financial, and accounting functions. The directorate will be reinforced before the project effectiveness with the services of a senior Accountant. **The Procurement Directorate** (*Direction des Marchés Publics - DMP)* will manage procurement functions for goods, furniture, and consultants services in collaboration with the technical directorates that will benefit from these inputs. The DMP will be reinforced before the effectiveness of the project by a Senior Procurement Specialist in order to carry out the procurement process according to the Bank's procedures and guidelines. **Technical Directorates** will be responsible for the development and technical implementation of their respective

activities and they will also provide on an ongoing basis technical support to the decentralized levels.

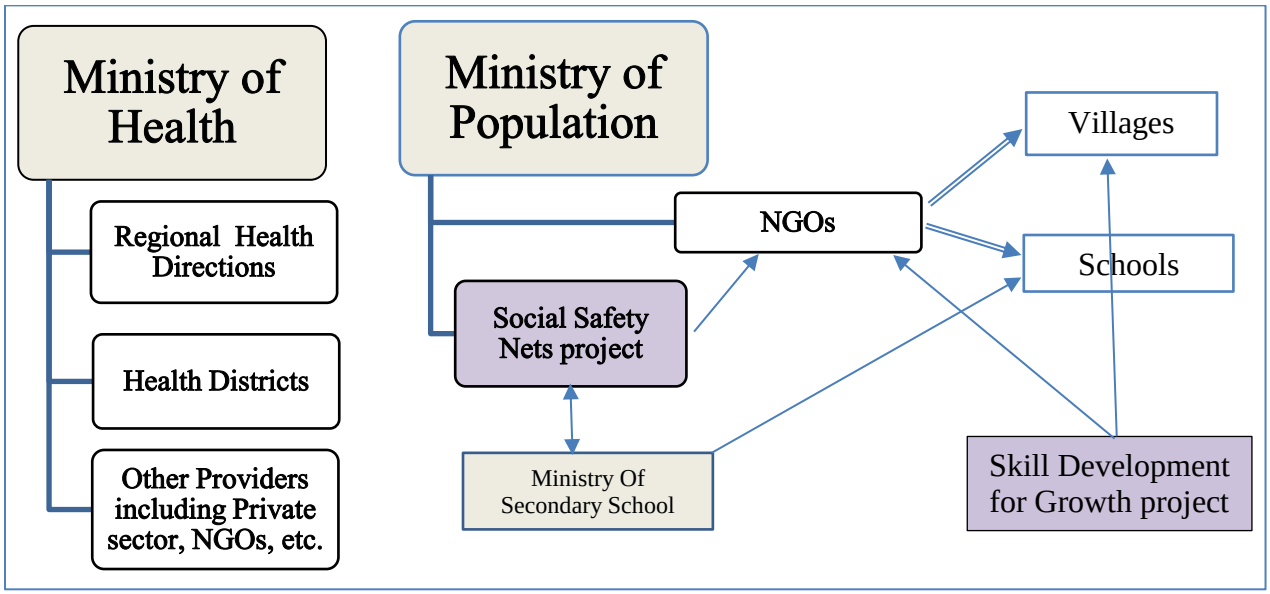
10. Modalities of collaboration between the MOP and the Social Safety Net Project (SSNP) Unit has been discussed and agreed during the preparation. The SSNP will implement PHSP activities related to SBCC and the schooling intervention. An operational account will be opened in the Safety Net Unit through which funds will be sent from the MOP to cover salaries for additional staff, top up salaries for expanded TORs of the SSNP's staffs, and any other overhead costs. The MOP and the Safety Net Unit will collaborate in the definition of the skills needs, development of TORs, and the recruitment process. Recruitment decisions will be made jointly between MOP and Safety Net Unit. Newly recruited staff will be managed by the Safety Net Unit. The Safety Net Unit will also extend the contracting of the microfinance institutions involved in the payment of the SSNP cash transfers so as to cover the PHSP cash transfers. The contract and management of the microfinance institutions will remain under the responsibility of the Safety Net Unit. The transfer fees of the financial service providers will be included in the implementation costs transferred to the operational account. The Safety Net Unit will be responsible for the following activities in the implementation of the schooling intervention:

a) Insert new variables that account for the level of education of adolescent girls in the data collection of the targeting exercise for the second cycle of the SSNP cash transfers;
b) Include information on adolescent girls education in the SSNP beneficiary register;
c) Identify poor households eligible to receive school incentives based on the procedures indicated in an operational manual;
d) Update TORs of existing staff, and recruit additional staff if needed;
e) Annually validate and register the beneficiaries of the school incentives in village assemblies;
f) Update yearly the beneficiary register, taking into account adolescent girls' entries and exits;
g) Contract microfinance institutions to conduct payments to the mothers of the adolescent girls in three installments according to the procedures defined in an operation manual;
h) Supervise payments and collect payment support documents (book and registries);
i) Conduct regular meetings with the school management committees responsible for the supervision of the enrollment, frequency and performance of the adolescent girls enrolled in the program;
j) Collect information on school enrollment from both the school management committees and the district offices of the ministries of primary and secondary education;
k) Conduct regular meetings with local partners and provide general supervision of the activities;
l) Prepare every quarter a report which will be sent to the MOP with information on the activities implemented for SBCC and girl's schooling in the five regions.

11. The two ministries are responsible for planning, budgeting and reporting funds released: (i) to the Designated Account (DA-A) within the Pooled Fund Unit[71] after the payment of the

[71] At the completion and evaluation of the current RBF pilot under the HIV/AIDS project (P116167), the MOH could use the designated account to transfer the payment to the targeted health centers after the performance carried out by a third party within the RBF framework. It was also agreed that the MOH pooled fund arrangements will also coordinate the Sahel Diseases of

DLIs under Component 1; and (ii) to the Designated Account (DA-B) for Component 3 and to sub-accounts for the eligible expenditures under Component 2 under the MOP.



12. **Implementation Readiness.** The successful implementation of the project will require a high level of coordination and oversight capacity within the two ministries. The status of the preparation, followed by the assessment completed for the project fiduciary arrangements, is the following:

Actions	Responsibilities	Due date	Observations
Recruitment of the key staff for the pooled fund management	MOH	April 30, 2015	The recruitment of the Internal auditor for the MOH has been completed.
Recruitment of Senior Accountant and Procurement Specialist for the implementation of Component 2	MOP	Effectiveness	Process underway.
Project Implementation Manual	MOH	Effectiveness	The revision of the Manual is ongoing with PPF financing. Final Document Expected in May 2015.
Monitoring and Evaluation Guidelines	MOH	3 months after effectiveness	The revision of the Manual is ongoing with PPF financing. Final document expected in May 2015.
The Administrative, Financial and Accounting Procedures Manual	MOH	Effectiveness	The revision of the Manual is ongoing with PPF financing. Final document expected in May 2015.

poverty project (P149526) implementation by providing the technical support and coordination to each directorate and vertical program involved in the project's activities.

Actions	Responsibilities	Due date	Observations
Recruitment of the external auditor	MOH	5 months after effectiveness	Auditor has been recruited. TOR will be revised to extend its mandate to Component 2 and 3 of the project
Sign the Memorandum of Understanding of the Pooled fund	MOH - IDA	3 months after effectiveness	

Financial Management and Disbursements

Staffing and Training

13. The project FM staffing will mainly consist of a senior accountant and an accountant at Pooled Fund Unit level and a dedicated accountant under the supervision of an FM Directorate at the MOP.

Budgeting arrangements

14. The project budgeting process will follow Bank procedures and be clearly defined in the Budget section of the FM section of the procedures manual. The budget will be adopted before the beginning of the year and monitored through the project accounting software. Annual draft budgets will be submitted to the Bank's non-objection before implementation. The consolidated Annual Work Plan and Budget approved by the Steering Committee will be submitted to the Bank no later than November 30 every year.

Accounting policies and procedures

15. Project accounts will be maintained and supported with appropriate records and procedures to track commitments and to safeguard assets. Annual financial statements will be prepared by the FM team of the coordination unit by using appropriate accounting software to generate automatically acceptable IFRs and financial statements. The accounting policies and procedures will be documented in the accounting procedures. The project through its administrative and financial management units will apply the OHADA (*Organisation pour l'Harmonisation en Afrique du Droit des Affaires*) accounting principles.

Internal controls and internal audit

16. FM procedures will be developed as part of the project implementation manual (PIM). It would include budgeting, accounting, consolidated reporting, disbursement and auditing arrangements. To maintain a sound control environment, the project team is expected to follow the control mechanisms that will be described in the manual of procedures. The said manual will ensure that adequate internal controls are in place for the preparation, approval and recording of transactions as well as segregation of duties and will be subject to updates as needed. The procedures identified in the FM section of the PIM will have to be closely followed by all parties involved in project implementation, including regular and on-time financial reporting. In addition, regular oversight by the project steering committee, periodic supervision missions by

the Bank's task team (which will include FM specialists) and annual financial audits by independent external auditors will serve as mechanisms for ensuring the project financial management systems function effectively.

17. As the project design will include the DLI mechanism, the internal audit team will ensure through ex posts reviews that all related transactions are in line with the DLI verification and disbursement arrangements. In that respect it will team up as appropriate with the external DLI independent verification agent who will be recruited by the coordination unit.

Reporting and Monitoring

18. The Pooled fund Coordination unit will prepare quarterly consolidated Interim Financial Reports (IFRs) during project implementation encompassing all components. The consolidated IFR includes the following statements: (i) Statement of Sources of Funds and Project Revenues and Utilization of funds; (ii) Statement of Expenditures classified by project components/activities (economic classification) showing comparisons with budgets for the reporting period and cumulative for the project life; and (iii) Note to the IFR providing reasons for the variances and any information on the statement of sources of funds and project revenues and utilization of funds.

19. The reporting arrangements will require MOP to submit to MOH for consolidation purposes its financial reporting and related notes early enough to allow said consolidation and transmission of the consolidated IFR on time to the Bank.

20. Consolidated annual financial statements will be prepared by the Pooled Fund Unit (including Component 2 activities) and will be subject to annual external audits. Such Financial Statements will comply with SYSCOHADA and World Bank requirements and will be comprised of:

a) A Statement of Sources and Uses of Funds which includes all cash receipts, cash payments and cash balances;
b) A Statement of Commitments;
c) Accounting Policies Adopted and Explanatory Notes; and
d) A Management Assertion that project funds have been expended for the intended purposes as specified in the relevant financing agreement.

Flow of funds and disbursement

21. ***Flow of funds.*** For Component 1, funds will flow from the IDA Grant Account to the Designated Account (DA-A) within the existing pooled fund unit. Applications for reporting eligible expenditures paid from the DA-A would be submitted to the Bank, with support of: (i) Statements of expenditure (SOE) and other records evidencing eligible expenditures as required; and (ii) evidence of achievement of agreed indicators substantiated by a report prior validated with the Pooled Fund Unit and IDA. Said achievement will be assessed by an independent verification agent. The funds then transferred will be used indifferently with other financing sources to finance eligible activities include in the Annual Work Plan following Bank guidelines (FM and procurement). As for previous operations, each funding will be affected a percentage

of cost sharing that will facilitate the tracking of use of funds per financing source. By the end of the project, any undocumented advances in DA-A are to be refunded to the Bank.

22. For Component 2 and 3, a second Designated Account (DA-B) and a sub account will be opened for related activities under the responsibility of the MOH through the Pooled Fund Unit (for Component 3) and the MOP through SWEDD Coordination Unit (for Component 2). Funds will flow from the DA-B to the sub-account at MOP and to suppliers, contractors and beneficiaries for the eligible expenditures.

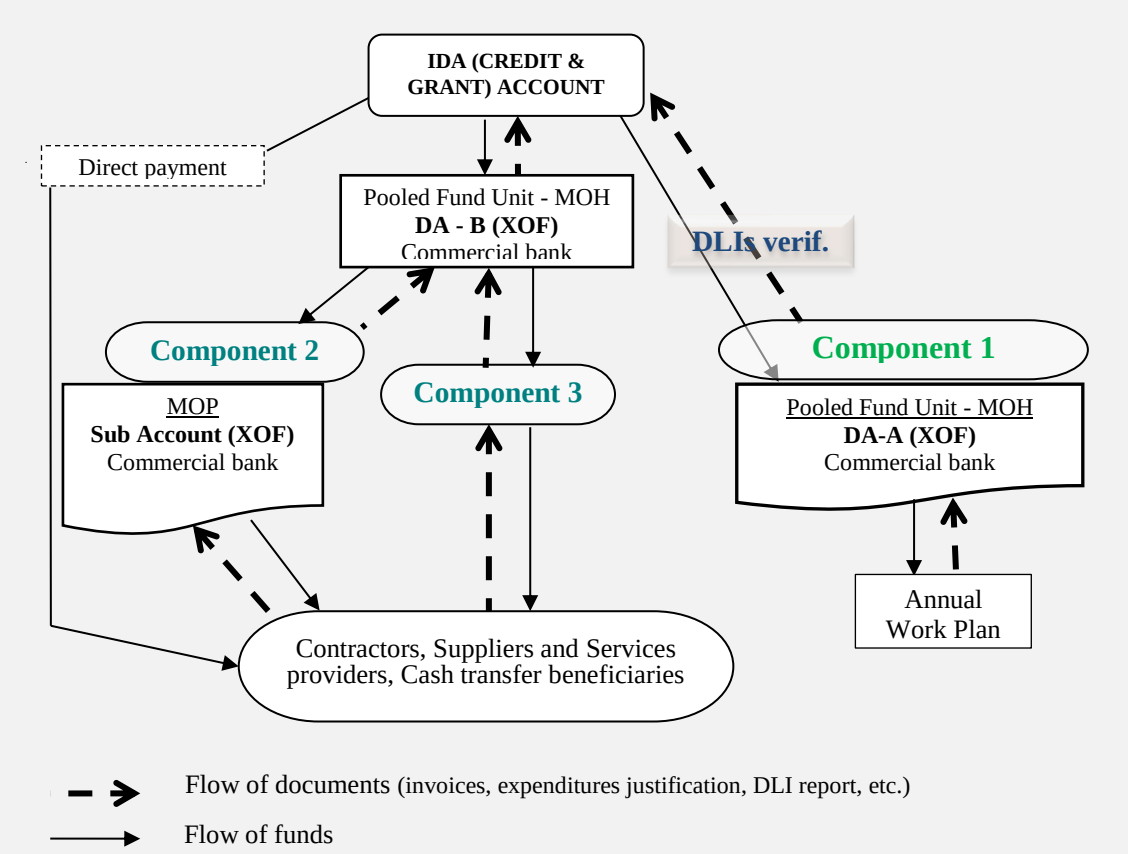


Figure 4: The Project Fund Flow Diagram

23. The Pooled Fund Unit within MOH will maintain and manage the Designated accounts (DA-A and DA-B) in XOF (FCFA) at a commercial bank, on terms and conditions satisfactory to the Bank, including appropriate protection against set-off, seizure and attachments. The DAs will be used for disbursing funds for eligible expenditures upon appropriate authorization by MOH. The ceiling for the DAs has been discussed and agreed during negotiations and specified in the disbursement letter for the project.

24. The project shall maintain ledger accounts (sub-accounts) to track eligible expenditures paid for each project component. Applications of reporting eligible expenditures paid from the DA-B and reimbursement for expenditures with DLIs (DA-A) would be submitted separately.

Authorized signatories for the sub account for Component 2 will be designated officials from the MOP.

25. Under the responsibility respectively of the MOH through the Pooled Fund Unit and the MOP through the SWEDD Coordination Unit (which will also provide project management and fiduciary services for Component 2), the project Financial Management staff will be responsible for conducting regular reconciliation of the DAs, and sub account.

Disbursement methods

26. **Disbursement will be report-based for Component 1** following the Disbursement Link indicators (DLI) mechanism. Funds will be disbursed annually from the IDA Grant Account to the DA-A within the pooled fund unit conditional on satisfactory achievement of agreed indicators substantiated by a report prior validated with the Pooled Fund Unit and IDA.

27. **Disbursement under Component 2 and 3 will be transactions based**. An initial advance up to the ceiling of the DA-B (FCFA 750 million or US$1.5 million) and representing 3 months forecasted project expenditures paid through the DA will be made into the Designated Account and subsequent disbursements will be made on a monthly basis against submission of SOE or records as specified in the Disbursement Letter (DL). In addition to the "advance" method, the option of disbursing the funds through direct payments to a third party, for contracts above a pre-determined threshold for eligible expenditures (e.g., 20 percent of the DA-B ceiling), will also be available for the DA. Another acceptable method of withdrawing proceeds from the IDA credit/grant account is the special commitment method whereby IDA may pay amounts to a third party for eligible expenditures to be paid by the Recipient under an irrevocable Letter of Credit (LC).

28. Component 2 will finance unconditional or conditional cash transfers to girls. The transfer mechanism could rely on what will be developed for the Sahel Women's Empowerment & Demographics Project (SWEDD).

29. Disbursement procedures will be detailed within the accounting, administrative and financial procedures and the disbursement letter.

Audit arrangements

30. The Financing Agreement (FA) will require the submission of Audited Financial Statements for the project to IDA within six months after year-end. The auditor will conduct an annual audit of the consolidated annual financial statements. A single opinion on the Audited Project Financial Statements in compliance with International Standards on Auditing (ISA) will be required. The external auditors will prepare a Management Letter giving observations and comments, and providing recommendations for improvements in small grant management, accounting records, systems, controls and compliance with financial covenants in the Financial Agreement.

Table 14: Major Weaknesses and FM Action Plan to reinforce the control environment

Significant Weaknesses or risks	Action	Responsible body	Completion
Existing Pooled fund FM manual does not fit the new project design	Elaborate the Project FM procedures as part of the Procedures manual including internal controls, budget process, assets safeguards, and description of roles and responsibilities of all stakeholders	MOH	Before effectiveness
The accounting and reporting requirement might not be fulfilled	Customize the accounting software to the Project specificities	Pooled Fund Unit and MOP	Not later than two (2) months after effectiveness
SWEDD accounting team would be overwhelmed by new project activities	Recruit an accountant to complement the MOP Project team	MOP	Not later than one month after effectiveness
	Customize the accounting software to include Component 2 activities	MOP	
Weak internal control environment revealed by last external audit report	Finalize the recruitment of the additional internal auditor	Pooled Fund Unit	Not later than four months after effectiveness
National audit arrangements are not adequate	Recruit an external auditor with TOR acceptable to the Bank (including fraud & corruption)	Pooled Fund Unit	Not later than five months after effectiveness

Implementation Support Plan

31. The Coordination unit will send to the Bank quarterly Interim Financial Reports in addition to annual audited financial statements. In addition, based on the project FM residual overall rating that is deemed **Substantial**, the Bank FM team will conduct supervision missions on a semester basis. The first FM review will thus be carried out within 6 months of project effectiveness. This detailed review will cover all aspects of financial management, internal control systems, and overall fiduciary control environment. Thereafter, the on-site supervision intensity will be based on risk - initially on the appraisal document risk rating and subsequently on the updated financial management risk rating during implementation.

32. Based on the outcome of the FM risk assessment, the following implementation support will apply:

FM Activities	Frequency
Desk reviews	
Interim financial reports review	Quarterly
Audit report review of the project	Annually
Review of other relevant information such as interim internal control systems reports.	Continuous as they become available
On site visits	
Review of overall operation of the FM system	Bi-annual (Implementation Support Mission)
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed
Transaction reviews (if needed)	As needed
Capacity building support	
FM training sessions	When needed.

Financial Covenants

a) A financial management system including records, accounts and preparation of related financial statements shall be maintained in accordance with accounting standards acceptable to the Bank.
b) The Financial statements will be audited in accordance with international auditing standards. The Audited Financial Statements for each period shall be furnished to the Association not later than six (6) months after the end of the project fiscal year. The Borrower shall therefore recruit an external auditor not later than five months after effectiveness.
c) The Borrower shall prepare and furnish to the Association not later than 45 days after the end of each calendar quarter, interim un-audited financial reports for the Project, in form and substance satisfactory to the Association.

Conclusion of the FM assessment

33. The FM residual risk at preparation is **Substantial**. It is therefore considered that the proposed FM arrangements for the project will satisfy the requirements under Bank OP 10.00 requirements once the mitigation measures are implemented. The implementing entity will ensure that the Bank's Guidelines*: Preventing and Combating Fraud and Corruption in Projects financed by IBRD Loans and IDA Credits and Grants* (revised January 2011) are followed under the project.

Procurement

34. ***Procurement Arrangements***. Procurement of the proposed project will be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers dated January 2011 (revised July 2014), and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank borrowers dated January 2011 (revised July 2014), and the provisions stipulated in the Financing and the Project Agreements.

35. ***Procurement of Goods.*** The procurement will be done using the Bank's SBD for all ICB and National SBD agreed with or satisfactory to the Bank. Procurement may be done under NCB and Shopping depending on the thresholds.

36. ***Procurement of non-consulting services.*** Procurement of non-consulting services will follow procurement procedures similar to those stipulated for the procurement of goods, depending on their nature.

37. ***Improvement of bidding procedures under national competitive bidding***. The Niger Procurement reform has led to the adoption of a new procurement law in October 2011 and the implementing decree on procurement Code in December 2011. Implementing texts are adopted in 2012 and 2013. Niger legal framework is now better aligned to the West African Economic Monetary Union (WAEMU) Directives and international standards.

38. Although the legal framework seems acceptable, the Recipient shall ensure that the following additional requirements are met under National Competitive Bidding :

a) Invitation to bid shall be advertised in at least one national newspaper with wide circulation, at least 30 days prior to the deadline for the submission of bids;
b) foreign bidders shall not be precluded from bidding and no preference of any kind shall be given to national bidders in the bidding process;
c) bidding shall not be restricted to pre-registered firms;
d) Qualification criteria shall only concern a bidder's overall capability and financial capacity to perform the contract, taking into account objective and measurable factors. All qualification criteria shall be clearly specified in the bidding documents;
e) bids shall be opened in public, immediately after the deadline for submission of bids;
f) bids shall not be rejected merely on the basis of a comparison with an official estimate without the prior concurrence of the Bank;
g) before rejecting all bids and soliciting new bids, the Bank's prior concurrence shall be obtained;
h) contracts shall be awarded to the lowest evaluated and qualified bidder;
i) no domestic preference shall be given for domestic bidders;
j) Fees charged for the bidding documents shall be reasonable and reflect only the cost of their printing and delivery to prospective bidders, and shall not be so high as to discourage qualified bidders;
k) any firm declared ineligible by the Bank, based on a determination by the Bank that the firm has engaged in corrupt, fraudulent, collusive, coercive or obstructive practices in competing for or in executing a Bank-financed contract, shall be ineligible to be awarded a Bank-financed contract during the period of time determined by the Bank; and
l) each contract financed from the proceeds of the Credit/Grant shall provide that the suppliers, contractors and subcontractors shall permit the Bank, at its request, to inspect their accounts and records relating to the performance of the contract and to have said accounts and records audited by auditors appointed by the Bank. The deliberate and material violation by the supplier, contractor or subcontractor of such provision may amount to obstructive practice.

39. ***Selection of Consultants.*** Consultancy services will be done using the Bank's standard Request for Proposals when required. Assignments estimated to cost the equivalent of US$300,000 or more would be advertised for expressions of interest (EOI) in Development Business (UNDB), and in at least one newspaper of wide national circulation. In addition, EOI for specialized assignments may be advertised in an international newspaper or magazine. Foreign consultants who wish to participate in national section should not be excluded from consideration. Shortlists of consultants for services estimated to cost less than US$200,000 equivalent per contract for supervising engineers and US$100,000 equivalent per contract for other consulting services , may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines

40. ***Capacity Building and Training Programs, Seminars, Conferences, Workshops, etc.*** All training and workshops will be carried out on the basis of the project's Annual Work Plans and Budget which will have been approved by the Bank on a yearly basis, and which will inter-

alia, identify: (i) the envisaged training and workshops; (ii) the personnel to be trained; (iii) the institutions which will conduct the training and selection methods of institutions or individuals conducting such training; (iv) the justification for the training, how it would lead to effective performance and implementation of the project and or sector; and (v) the duration of the proposed training; (vi) the cost estimate of the training. Report by the trainee upon completion of training would be required.

41. ***Operating Costs.*** Project operating costs would be procured using the implementing agency's administrative procedures, which have been reviewed and found acceptable to the Bank.

42. ***Fraud and corruption***. All procuring entities, as well as bidders, suppliers, and contractors shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraph 1.15 and 1.16 of the Procurement of the Procurement Guidelines and paragraphs 1.25 and 1.26 of the Consultant Guidelines. 'Guidelines on Preventing and Combatting Fraud and Corruption in Projects financed by IBRD loans and IDA Credits and Grants "dated October 15, 2006 and revised in January 2011, shall also apply to the project.

43. ***Procurement responsibilities and accountabilities***. Procurement activities will be carried out respectively: (i) for components 3 by the MOH through the Unit managing the Pooled fund under the coordination of the Secretary General (SG), and (ii) for Component 2 by the Ministry in charge of Population under the coordination of the Secretary General (SG).

44. The procurement activities in the respective Ministries will be supported by the Procurement Directorate (DMP) and the Technical directorates in their respective area of competency. All procurement requests will be sent by the SG to the World Bank.

45. The Ministries respectively in charge of Health and Population under the overall coordination of the SG will be responsible for all procurement related to the project and will carry out the following activities in close collaboration with the respective beneficiaries: (i) preparation and updating of the procurement plan; (ii) preparation of the bidding documents, draft requests for proposals (RFP), evaluation reports, contracts in compliance with World Bank procedures; (iii) monitoring the implementation of procurement activities; (iv) development of procurement reports; and (v) seeking and obtaining approval of national entities and then IDA on procurement documents as required.

46. ***Capacity Assessment and Remedial Actions***. A preliminary assessment of the capacity of the respective Ministries to implement procurement activities of the project was carried out in October 2014 and was finalized during appraisal. The assessment reviewed the organizational structure for implementing the Project, the procurement capacities of the agencies (past procurement experience, staff in charge of procurement, tools including manuals, procurement reporting, filing, use of software, etc.) and the interactions between the different agencies involved in the Project.

47. The assessment found that:

a) The MOH with the Pooled Fund Unit has gained satisfactory knowledge, technical expertise and experience in WB procedures during the implementation of previous projects. The Procurement Specialist has since left, and the Ministry has appointed notably two staff in charge of procurement, and equipment and infrastructure contract management. The audit report in 2013 has revealed weaknesses in procurement notably in the regions. The procurement officer oversees the procurement activities in close collaboration of DMP. He has received much training in WB procurement procedures; his experience in practicing seems acceptable. The procurement filing is acceptable;
b) The previous Multi Sectoral Demographic Project (PRODEM), closed in March 31, 2013, was implemented by the MOP. The project had difficulties at the beginning, but ended with a satisfactory ranking in procurement. The mobility of the staff and the insufficient competency transfer from consultants to the permanent staff has limited building appropriate procurement capacity at the Ministry. The staff currently in charge of procurement has limited experience in WB procedures procurement. The procurement filing needs to be improved and in compliance with bank procurement filing manual.

48. The overall Project Risk for procurement is rated Substantial prior to mitigation. The key risks for procurement are: (i) staff involved in the project who may not have experience with complex technical procurement; (ii) staff who will be responsible for process control and approval. This could cause misprocurements, possible delays in evaluation of bids and technical proposals leading to implementation delays, poor quality of contract deliverables and reputational risks to the Bank and the project. The residual risk is assessed as Moderate after adopting the following measures including:

a) Appointing a qualified and experienced Procurement specialist to support all procurement activities for this Project in the Ministry in charge of Population, notably to ensure quality control and compliance with World Bank procedures. The staff to be recruited through this project will support at the same time the procurement activities of the SWEDD Project (P150080- Sahel Women's Empowerment and Demographic Dividend Project) implemented by the MOP;
b) Appointing qualified Procurement assistants to be located at the central and if needed at regional levels of MOH, depending of the volume of activities, to fully support the team in all procurement activities related to the Project;
c) A procurement plan (PP) for the first 18 months of program implementation was prepared during appraisal. The final version of this PP was discussed and approved during negotiations. During implementation the PP will be updated in agreement with all the pooled fund donors as required - at least annually - to reflect actual program implementation needs and improvements in institutional capacity;
d) A manual of administrative, financial and accounting procedures will be prepared to clarify the role of each team member involved in the procurement process of the project, the maximum delay for each procurement stage, specifically with regards to the review, approval system and signature of contracts;

e) A workshop will be organized at the beginning of the Project to train /update all key stakeholders involved in procurement on World Bank procurement procedures and policies;
f) An adequate filing system will be set up for the project records at the level of the Ministry of Population. The Project will finance appropriate equipment and the procurement specialist will ensure compliance with Bank procurement filing manual;
g) Recruiting competitively as needed NGOs to implement activities related to communications in the Ministry in charge of Population.

49. ***Procurement methods***. For Niger, International Competitive Bidding (ICB) thresholds have been set at US$5 million for works and US$500,000 for goods. The table below summarizes the procurement and selection thresholds applicable to this project.

Table 15: Procurement Methods Thresholds

NO	Expenditure Category	Contract Value Threshold**(US$)	Procurement Method
1	Goods and Services (*other than Consulting Services)*	C>=500,000	ICB
		50,000= <C < 500,000	NCB
		C<50,000	Shopping
		All values	Direct Contracting
2	Consulting Services Firms	C>= 200,000 firms	QCBS, QBS
		< 200,000 firms	QCBS, FBS, CQS, LCS
		All Values	Single Source Selection
	Individual Consultant	All values	IC
		All Values	Single Source Selection
3	Training, Workshops, Study Tours	All Values	With the approval of the TTL
All TORs, regardless of the value of the contract and the selection method, are subject to prior review.			

ICB – International Competitive Bidding

NCB – National Competitive Bidding

QCBS – Quality and Cost-Based Selection method

IC – Individual Selection method

SSS – Single Source Selection

QBS – Quality Based Selection

FBS – Fixed Budget Selection

CQS – Consultants' Qualification Selection(for Contracts below 100 000 USD)

LCS – Least Cost Selection

50. ***Procurement prior review thresholds***. The procurement prior review thresholds are tied to the substantial procurement risk as shown in the table below and reflected in the procurement plan.

No	Expenditure Category		Amount in USD
1	Goods and Services (*other than Consulting Services)*		>=1 000 000
2	Consulting Services		>=500 000
3	All Direct contracting and Single Source contracts with consultant (firms)	*Works*	>=100 000
		Goods	
		Consultants services	
4	Individual Consultants (*Single Source contracts)*		>= 100 000
	Individual consultants (*based on comparison of CVs*)		>=200 000

51. Contracts estimated to cost above these thresholds for works and goods, consulting services will be subject to prior review by IDA.

52. Further, it was agreed on the following additional mitigation measures:

a) All TORs for consulting services will be subject to prior review by Bank.
b) At least once a year, the Bank and the Government will agree on a procurement plan which will detail the procurement methods to be used and specific contracts to be reviewed by the Bank.

53. ***Revision***. The prior review thresholds and other measures to be taken to mitigate the procurement risk should be re-evaluated once a year with a view of adjusting them to reflect changes in the procurement risk that may have taken place in the meantime and to adapt them to specific situations. In case of failure to comply with the agreed mitigation measures or Bank guidelines, a re-evaluation measure of both types of thresholds, ICB and prior review, may be required by IDA.

54. ***Additional Notes***:

a) The threshold for shopping is defined under para. 3.5 of the Guidelines and should normally not exceed US$50,000 equivalent for off-the-shelf goods and commodities, and for simple civil works.
b) Operating expenditures are neither subject to the Procurement and Consultant Guidelines nor prior or post reviews. Operating expenditures are normally verified by TTLs and FM Specialists.
c) Irrespective of the thresholds and category of risk, the selection of all consultants (firms or individuals) hired for legal work or for procurement activities are respectively cleared by the LEG VPU unit with the relevant expertise and the designated PS/PAS or RPM as required.
d) Prior Review Contracts for the Hiring of Individual Consultants: Apart from legal work and procurement assignments, irrespective of the thresholds and category of risk, which shall respectively be reviewed by LEG VPU Unit with the relevant expertise and the designated PS/PAS or RPM as required, review of the selection process for all other individual consultants (Technical Experts) shall be solely reviewed by the TTL and the relevant technical specialist within the Bank team.
e) Contracts below the threshold but falling within an exception as defined in clause 5.4 of the Guidelines: Selection and Employment of Consultants are also subject to prior review or require the Bank's prior no objection.
f) Special cases beyond the defined thresholds are allowed based on applicable market conditions.

55. ***Frequency of Procurement Supervision***. In addition to the prior review which will be carried out by the Bank, the procurement capacity assessment has recommended two supervision missions each year.

56. ***Post Review Procurement***: IDA will carry out sample post review of contracts that are below the prior review threshold for contracts implemented to ascertain compliance with the

procurement procedures as defined in the legal documents. The procurement post-reviews should cover at least 15 percent of contracts subject to post-review, as the risk rating is Substantial.

57. ***Procurement information and documentation – filing and database***. Procurement information will be recorded and reported as follows:

a) Complete procurement documentation for each contract, including bidding documents, advertisements, bids received, bid evaluations, letters of acceptance, contract agreements, securities, related correspondence, etc., will be maintained at the level of respective ministries in an orderly manner, readily available for audit;
b) Contract award information will be promptly recorded and contract rosters as agreed will be maintained;
c) Comprehensive quarterly reports indicating: (i) revised cost estimates, where applicable, for each contract; (ii) status of on-going procurement, including a comparison of originally planned and actual dates of the procurement actions, preparation of bidding documents, advertising, bidding, evaluation, contract award, and completion time for each contract; and (iii) updated procurement plans, including revised dates, where applicable, for all procurement actions.

Environmental and Social (including safeguards)

58. The social impacts associated with the project are expected to be largely positive given the scope of activities which consists of improving the awareness on population and the use of reproductive, maternal, newborn, child health and nutrition (RHN) services in selected regions with a focus on women and adolescent girl's empowerment activities.

59. No civil works are envisaged with the project funds. However, based on project activities to increase the use of health services which is expected to result in increased generation of biomedical waste, the project is classified as category B and only OP 4.01 on Environmental Assessment has been triggered.

60. A Medical Waste Management Plan (2011-2015) is under implementation with the Second HIV/AIDS Support project (P116167). It has been updated to serve as the safeguards instrument for this proposed project. Key mitigation measures with an implementation schedule, adequate budget, and a clear institutional responsibilities are outlined in the new action plan of the MWMP. The revised MWMP was disclosed in country on February 17, 2015 and in the Bank Info Shop on February 23, 2015.

61. The MWMP will be implemented by the Ministry of Health (Directorate of Public Hygiene and Health Education). The Ministry of Environment, through the Office for the Evaluation of Environmental Assessment Studies (BEEEI), will be responsible of ensuring that the project complies with the national legislation on environment. The Bank team will supervise the implementation of the updated Medical Waste Management Plan and provide guidance and advice to the Directorate of Public Hygiene and Health Education.

Project monitoring and evaluation

62. The monitoring of the PDO indicators will use DHS and HMIS data sources, including implementation of one "mini" DHS in 2018. The monitoring activities will be financed by the project. The smaller sample "mini" DHS will provide data to assess if key PDO indicators are advancing as targeted. The national health management information system (HMIS "*SNIS*") will be used to collect monitoring data on the number of persons using the basic RHN service package scaled-up through the project, as well as data on beneficiaries reached in Component 1. Information on beneficiaries of Component 2 will come from NGO records and school management reports. The use of HMIS data in the project is to strengthen existing country information systems. HMIS data is reported annually by health facilities and aggregated nationally by the MOH, with support of INS. The report of data for the previous year is expected to be available in February of the next year. The DLI verification will validate the MOH data for the DLIs.

63. In order to review lessons learned during implementation and re-incorporate these in the Government's work plan, the project has planned for an annual process evaluation. This assessment will use a participatory approach to engage key project stakeholders (from government, community groups and NGOs) and examine defined questions, successes or concerns of the project to improve implementation systematically. A mini evaluation will be conducted annually, with more in-depth evaluations for learning at project mid-term and completion. The process evaluation will identify lessons learned from both the supply side interventions in Component 1 and the demand-side interventions in Component 2. The project will monitor the incorporation of the findings into the work plan to build local capacity to utilize the lessons learned.

Role of Partners

64. Niger's health sector receives technical and financial support from many donors. Key donors in the health sector include WHO, UNICEF, UNFPA, EU, the French Cooperation/AFD, Belgium, Spain, the African Development Bank, Global Funds and the World Bank (IDA). NGOs are present in some health districts. Niger has tried to harmonize support in the health sector through a sector wide approach and pooled financing from UNICEF, UNFPA, Spain, AFD, and GAVI. (See box below).

65. The partners involved in the pooled fund have agreed to continue their support with the new IDA support within the same arrangements described in the MOU, dated May 19, 2006 displayed in Annex 11. To further strengthen ties between the Ministry of Health and development partners, the country joined the International Health Partnership (IHP+) Compact in May 2009 and adopted the country COMPACT in March 2011. Under the compact, donors have agreed to finance the HDP and to conduct a joint sectoral review twice a year. A full list of the activities of current donors is included in Annex 9.

66. Partners are the main financial contributors. In order to improve the sector budget

Health Sector Pooled fund arrangements

A Sector wide approach (SWAp) has been adopted in 2006 and it sought to: (i) enhance efficiency with increased predictability, flow, and use of sector financial resources; and (ii) strengthen program effectiveness with improved tools and processes to plan, budget and manage funds, and measure results.
A pooled fund has been established by AFD and Bank in 2006. The Spanish Development Agency joined in 2010, GAVI and UNICEF joined in 2011 and UNFPA in 2014. An agreed procedures and guidelines has been approved in a Memorandum of understanding (MoU) signed by the common fund partners. In addition, they also agreed with the MOH on the basic program documents: Medium term Expenditure framework (MTEF), Annual Work Plans (AWP) and Budgets, Biannual progress reports, and annual report. In accordance with the MoU and the legal documents, one manual of administrative and accounting procedures; one procurement plan and accounting tools have been used by the pooled fund. One monitoring and evaluation process is in place which included holding two sectoral reviews a year; a joint field visit; the production of the performance report and the production of financial reports and audits.
What distinguished the pooled fund (essentially a co-financed project) from other externally funded projects and was particularly appreciated by the Ministry were: (i) its institutional placement within the ministry; (ii) its transparency about the potential amounts and uses of the funds; and (iii) its availability to all eligible recipients at central, regional, and district levels.

execution, the pooled fund set up within the sector is the solution. The arrangements put in place within the sector with a dedicated skilled staff, has improved drastically the budget execution and the health service delivery indicators during the period. It allowed the sector to improve: (i) the skills of staff in the budget preparation, execution and monitoring, as well as resource management; (ii) the preparation of Annual work plan on time; (iii) the preparation of Procurement Plans, bidding documents, advertising, bid evaluation, signature, launching, implementation and monitoring of procurements; (iv) the transfer of cash from central to district level for the Annual work plan implementation. The inclusion of health interventions which are really recurrent expenditures under Part V "Investments", penalizes their execution in case of cash flow problems. Their inclusion in the regionalized component of the budget would provide health services with permanent resources for the implementation of interventions for the population

67. With the pooled fund, efforts have been made to improve the allocation and use of resources in the health sector through the following measures: (i) better translation of the sector Medium Term Expenditures Framework (MTEF) in the Finance Law; (ii) protection and securing of sensitive budget lines, particularly those for drugs and vaccines, free health care, grants to public administrative institutions and investments; (iii) improvement of the credibility of the budget and its execution; (iv) greater decentralization of the budget to regions and health districts, and the inclusion of credits for health interventions; and (v) capacity building for workers in budget preparation, execution and monitoring and in public procurement.

68. The sector continues to use the pooled fund, and it is expected to have the contribution of donors through the instrument.

69. The preparation of this operation is the result of strong coordination between the IDA team and key bilateral and multilateral donors involved in the implementation of the national Health development plan and the General Declaration of the Population Policy. This coordinated approach will be maintained throughout the implementation of the project. All donors have

welcomed the process and intend to articulate and pursue their support to the country program. They will also provide technical assistance and technical contribution in the supervision of the project in accordance with their comparative advantage. The implementation of the project will emphasize development of national health systems and the improvement of people's behavior on reproductive health.

Annex 7: Implementation Support Plan

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

1. **The strategy and approach for Implementation Support has been tailored to strengthen existing structures and build on ongoing programs rather than creating *ex nihilo* new ones**. To this end, the project builds on current ministries' program implementation units for the execution of components. A permanent dialogue has been established with ministerial departments in charge of the supply of health services and the creation of demand at the community level. The Implementation Support Plan (ISP) will specifically focus on the following areas and activities:

a. **Technical support**. The Government was advised to mobilize and to procure TA services and equipment required for the implementation of the project. From the inception of the operation, the MOH and the MOP's team will be coached and provided with the necessary training by the Bank project team in order to implement the RRA every year during the AWP preparation;

b. **Procurement implementation support by the Bank will include**: (i) providing training to the MOH and MOP, (ii) providing detailed guidance on the Bank's Procurement Guidelines, (iii) reviewing procurement documents and providing timely feedback to the MOH and the MOP, and (iv) monitoring procurement progress against the Procurement Plan;

c. **Financial Management implementation support by the Bank will include**: (i) providing training to the MOH/MOP's financial management unit; and (ii) reviewing the project's financial management system and its adherence to the Project Operations Manual, including but not limited to, accounting, reporting and internal controls;

d. **Environmental and Social Safeguards.** Safeguards specialists will conduct annual reviews to sample review projects under implementation and provide technical assistance to the MOH and ministries in charge of environment to monitor safeguards;

e. **General Supervision inputs**. There will be two formal missions per year complemented by sector specialist as needed. In addition, TTL and team members based in the country office will provide day to day support of all operational aspects, as well as coordination with the client and among Bank team members. Where possible, missions will be conducted jointly with development partners supporting the Health development Plan (HDP) and the National Population Policy;

f. **Mid-Term Review.** A mid-term review will be conducted 30 months after effectiveness of the project by the Bank team to assess the progress of the project and eventually adjust the project design (DLIs and Performance based financing);

g. **Fiduciary requirements and inputs.** Training will be provided by the Bank's financial management and procurement specialists before commencement of project implementation. The Bank team will continue to support the MOH and the MOP to identify capacity

building needs to strengthen overall project implementation, with an emphasis on fiduciary aspects; Formal supervision of project implementation and financial management will be carried out semi-annually or as needed, while procurement supervision will be carried out on a timely basis as required by the client;

h. **Monitoring and Evaluation.** Implementation support to the MOH and MOP will be required to ensure due diligence and technical quality of the M&E activities of the project components.

2. The main inputs and focus in terms of support to implementation is summarized below :

Time	**Focus**	**Skills Needed**	**Staff weeks estimate**
First twelve months	Procurement training (two sessions)	Procurement Specialist	2
	Technical and procurement review of the bidding documents	Procurement Specialist Health Specialist	2 2
	FM training and supervision	FM specialist	2
	Dialogue with Client & Team leadership	TTL	4
	Use of Civil Society Organizations	Social Specialist	2
	Environmental & Safeguards training and supervision	Technical specialist Environmental specialist	2
	RBF	Technical specialist	2
	SBCC	Technical Specialist (Communication)	2
	Rapid Results Approach	Technical specialist	2
	Gender	Gender Specialist	2
12-48 months	Financial management disbursement and reporting	FM specialist Disbursement specialist	4 2
	FM Supervision	FM specialist	2
	Environmental supervision	Environmental specialist	2
	Technical supervision		2
	Procurement Review	Procurement Specialist	2
	Team leadership		2
12-48 months	Project supervision coordination & technical and sector	TTL and Sector Specialists	12
	M&E	Technical Specialist	2

Time	***Focus***	***Skills Needed***	***Resource Estimate***	***Partner Role***
First twelve months	*Results Based financing and Disbursement linked Indicators* *Rapid Results Approach*	*RBF & DLI experts* *RRA*		
12-48 months	*RBF & DLI and adolescent girls Initiative*	*RBF and RRA*		
Other	*Monitoring and Evaluation*	*M&E*		

Partners

Name	***Institution/Country***	***Role***
	UNFPA *UNICEF*	*Reproductive health and adolescent girls initiative supervision* *Nutrition supervision*

Annex 8: Sector Strategies, their Content and Lessons Learned from Previous IDA Projects

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

1. **Health care production and organization is structured at three levels, which correspond to the administrative decentralization levels in the country.** It also overlaps with the organization of the regulatory function as follows:

a. At the first level, three (3) National Hospitals, one (1) referral maternity, and twelve (12) national referral centers provide tertiary care. Apart from the referral services, these facilities can also provide care at lower levels of mobile health care services. They receive strategic support from the MOH and four (4) research and support centers;

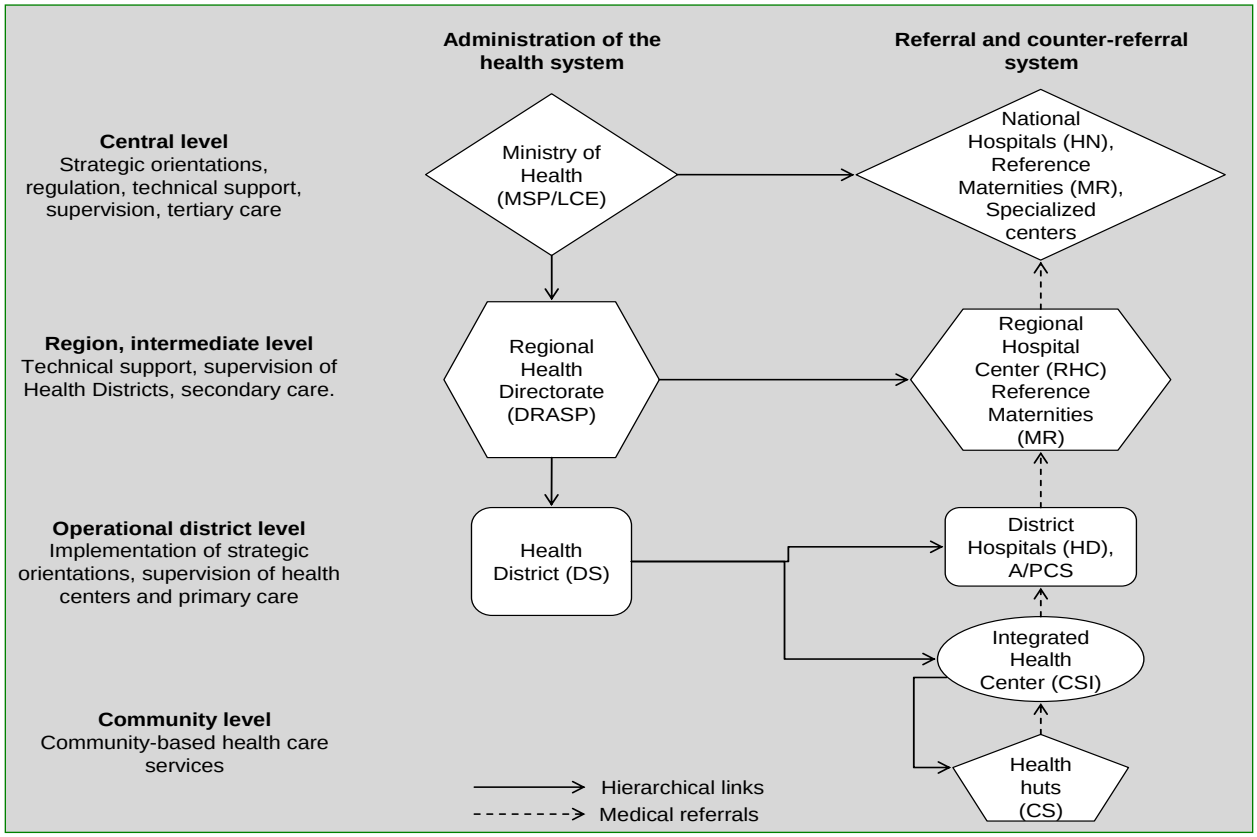
b. At the second level, also considered as the intermediate level, six (6) Regional Hospital Centers (CHR), seven (7) Mother and Child Centers[72], two (2) regional referral maternities, four (4) Regional Blood Transfusion Centers (CRTS), one (1) regional dental center, and five (5) private hospitals provide secondary care, and serve as referral facilities for the operational level. These service providers also organize mobile health care services outside the regional chief towns. They receive technical and strategic support from national referral facilities, as well as national and regional regulatory structures;

c. At the third level, also known as the operational level, thirty-two (32) District Hospitals (HD), 849 Integrated Health Centers, 177 private treatment rooms, 44 clinics and private practices, and 2,478 health huts, of which 2,305 are operational. The district hospitals serve as referral centers for the other health care facilities. They also provide mobile health care to populations outside the chief-towns of Health Districts. They provide technical support to health facilities in the health district, and receive support from the core teams of regions and health districts. The other health care facilities serve as first contact. Health huts are community facilities mostly managed by Community Health Workers who are, in principle, paid by the community;

d. About twenty national health programs and projects provide strategic support to service providers at all levels of care delivery.

[72] Not yet operational at time of preparation of this report.

Figure 5: Public Health System Organization



2. **The Health Sector Development Plan**. The PDS - ***Plan de Développement Sanitaire*** (2011 – 2015) seeks to contribute to improving the health of the Nigerien population and to the attainment of the MDGs related to health through the provision of quality health services, particularly vulnerable groups. The policy includes the following eight strategic programs:

a) Improved access to health: through the up-grade and expansion of infrastructure and mobile health services;
b) Enhanced reproductive health services: including family planning, adolescent and youth health services and the integrated management of maternal, newborn and child health;
c) Sufficient provision of competent and motivated human resources across health facilities: involves the implementation of a National Human Resources Policy and Plan to improve human resource management, strategic planning, training and skills development, career management and performance evaluation;
d) Availability of quality pharmaceutical supplies: through reform and regulation of the pharmaceutical sector, improved supply logistics, and the development of biological technologies;
e) Intensified campaigns against diseases under surveillance: through awareness-raising, integration of traditional medicine and improved efficiency of hospital responses;
f) Improved governance and leadership at all levels of the health system: through decentralization/deconcentration, improved financial management, supervision and

monitoring and evaluation, better management of health information, capacity-building and communications;

g) Effective health financing mechanisms: through the creation of partnerships with development partners, insurance schemes and alternative financing arrangements;
h) Promotion of health research: through a strengthened legal and regulatory framework, capacity building and improved coordination

3. **The Government Declaration of Population Policy**. In August 2006, the Government prepared a concise and action-oriented Declaration of Population Policy (GDPP) or *Déclaration du Gouvernement en matière de politique de population* which updates and summarizes the 1992 National Population Policy. The GDPP which was approved by the Cabinet in February 2007 provides operational directives for its implementation and covers the years 2007-2015 (one of the objectives of the GDPP is the reduction of the annual population growth rate from 3.3 percent to 2.5 percent by 2015).

4. A GDPP Strategic Framework along with an overall Work Plan is being prepared with the support of UNFPA. GDPP Annual Work Plans (AWP) will be prepared as well. A new law on Reproductive Health was passed in May 2006. The Government has also adopted legislation to provide free contraceptives in public health facilities, but sustainable funding remains an issue.

5. The overall objective of the initiatives to be implemented is to contribute to poverty reduction by developing attitudes and behavior toward reproduction that are likely to boost significantly contraceptive use by the population and reduce early marriage. The adoption of such behavior will set in motion a process for the gradual reduction of the county's demographic growth.

6. To achieve this overall objective, the Government intends, by 2015, to guarantee access by all interested persons to reproductive health services that are conveniently located, safe, effective, affordable, and acceptable and to make every effort to ensure that contraceptive use increases by at least one percentage point per year starting in 2007.

7. To this end, the following four priority programs have been implemented and supported by IDA projects from 2007 to 2013:

a) An advocacy and awareness-building program on population and development problems;
b) An information, education, and communication (IEC) program aimed at changing behavior in the reproductive health sphere;
c) A program to promote access to and use of reproductive health services, particularly in the context of birth spacing; and
d) A program to assign responsibility to couples and foster the economic advancement of women.

8. **Reproductive health Strategy**. The child and maternal health commitments in Reproductive Health (RH) program respond to the commitments by Niger for meeting the Millennium Development Goals (MDG), the Action Plan of the International Conference on

Population and Development (ICPD+10) and the Roadmap for Reducing Maternal Mortality. Niger has a young population with a broad based pyramid typical of countries that have not yet entered the demographic transition. The fertility is high (TFR of 7.6 children per woman) and the contraceptive prevalence rate is about 12 percent in 2012. While the population momentum is already set, there is urgent need to address the high fertility in the country dare to the known linkage with maternal and child health.

9. Niger has identified reduction of population growth, maternal and child mortality as the utmost health priority in the country. The right to health is enshrined in the Niger Constitution, and the HDP 2011-2015 reflects the desire to render effective this right through the interventions planned in its eight strategies areas.

10. In the last decade, Niger registered very modest improvements in child outcome, while the situation did not improve at all on maternal indicators. The underlying reasons are many and include - lack of knowledge of risks and illness, poor access to MCH services, poor quality of services, poor nutrition and gender disparities**.**

11. Following adoption of the Health Development Plan (HDP) for the period 2011-2015, the MOH prepared and updated the RH strategy which underlines the need to refocus attention on interventions of proven value in reducing maternal and child mortality. The RH strategy aims at:

a) Repositioning Family Planning as a priority component of health interventions;
b) Improving the availability and quality of the prenatal and postnatal services;
c) Increasing the access to skilled attendance at delivery and availability of emergency obstetric care;
d) Expanding post abortion care;
e) Improving the care provided for pregnant adolescents and promotes their sexual and reproductive health;
f) Strengthening the prevention and management of STIs (including complications such as HIV/AIDS, infertility and RH cancers);
g) Rehabilitating and designated health facilities to increase utilization;
h) Developing and implementing a comprehensive RH communication strategy;
i) Restarting the CCC/Counseling in health facilities and the communities;
j) Strengthening of the M&E system and use of data to monitor and improve services;
k) Establishing effective coordination between the units dealing with RH, nutrition, women and children;
l) Increasing male involvement in the promotion of RH.

Maternal health	Increasing attendance to focused antenatal care (at least four visits with appropriate assessments), including iron/folic acid supplementation and anti-malarial interventions (bed nets and Sulfadoxine-Pyrimethamine - *SP*), prevention to Mother to child transmission (MTCT); improved access to skilled attendance at delivery; increasing the proportion of health facilities capable of providing emergency obstetric care; increasing attendance and quality of post natal visits; caesarean and the promotion of foods consumption (leaves, green vegetables, fruits,...) or fortified with micronutrients (iron, vitamin A, iodine and Zinc).
Newborn care	Focusing on intervention of proven value both in the facilities and at community

	level, in line with the recommendations of the Partnership for Maternal Newborn and Child Health (PMNCH)**.** Cost-effective interventions for newborn health cover the antenatal period, the time around birth and the first week of life as well as care for small and sick newborns. Examples of high-impact, low-cost interventions for newborn health are breastfeeding support and kangaroo mother care, where the preterm baby is held skin to skin with its mother. Further reduction of neonatal mortality requires educated and equipped health care workers, especially those with midwifery skills, and the provision of essential commodities such as antenatal corticosteroids, resuscitation devices, injectable antibiotics and chlorhexidine for clean cord care. Most of these care packages are most effective when delivered to women and their babies at the same location by the same health care service providers.
Child Heath	Interventions on child survival focusing on nutrition, immunization, Integrated Management of Childhood Illness (IMCI)[73], MTCT, neonatal care, access to safe water, hygiene, and sanitation; promotion of the family essentials practices (*PFE*); use of the bed nets; Exclusive breastfeeding up to 6 months; deliver ORS and zinc in case of diarrhea; screening of the acute malnutrition in the villages and reference to health center.
Adolescent health	Requires a multisectoral approach, involving other ministries and communities through the following approaches: (i) Information and awareness will be expanding through targeted IEC and peer groups; (ii) Health services will also be made more user friendly for the youth.
Family planning	Contraceptive services will be expended through mobile outreach and other community based approaches. Integration of the FP in the health care package; expansion of the community based distribution; social marketing; outreach strategies for RH/FP services delivery.

12. **Gender perspectives and disparities.** Persistent poverty and high levels of gender inequality have hindered female participation in Niger's development processes. Given the importance of the traditional participation of Nigerien women in rural activities a gender-sensitive approach need to be strengthen, specifically: (i) participation of women in the consultations leading to decisions on family health and family size; (ii) engagement of women's labor force (e.g., cash-for-work); and (iii) scaling-up the successful experience of woman empowerment. Improvements in access to and the quality of family planning, health and nutrition services will have an immediate positive impact on the life of women. The integration of family planning, maternal and child health, and nutrition services will offer protection to mother and child and lay a solid foundation for healthy growth of newborns and the welfare of their mothers. Effective management and referral of high-risk pregnancies and complications at delivery would save women's lives and offer them a better chance of bringing up healthy children. Such improvements will free women's resources and enable them to pursue economic and social activities that fully integrate them into development activities.

13. **A new National Nutrition Policy is being finalized by the MOH**. The general objective of the Nutrition Policy is to guarantee that each Nigerien citizen, and the vulnerable population in particular, has a good nutritional status and is in good health to lead an optimal life. The new

[73] IMCI is an integrated approach to child health that focuses on the well-being of the whole child. IMCI aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age. IMCI includes both preventive and curative elements that are implemented by families and communities as well as by health facilities.

National Nutrition Policy developed for the period 2012-2021 has fixed the following targets for the reduction of malnutrition by 2021:

a) Wasting reduced to less than 10 percent;
b) Stunting in under-fives reduced from 51 percent to 35 percent;
c) Reduction in micronutrient deficiencies;
d) Reduction in morbidity and mortality associated with malnutrition.

14. The activities to achieve these objectives and targets need to be implemented in synergy with the other interventions in health (IMCI, Malaria, Immunization, HIV/AIDS, etc.) as well as those in other sectors, education, agriculture, irrigation, water and sanitation and with a particular emphasis on community participation.

15. The government-led 3N initiative (Nigeriens Nourish Nigeriens) aims at improving food production and securing livelihoods. It was announced as part of the electoral promises of the current president. The 3N initiative was approved in April 2012 and includes a US$96 million USD budget for nutrition of which 5 percent is intended for direct nutrition interventions. There are five specific objectives under the fourth strategic objective of the 3N initiative:

a) Promotion of balanced food consumption
b) Promotion of Essential Family Practices
c) Increase Capacity to treat acute malnutrition
d) Increase food safety
e) Strengthen the nutrition surveillance and M&E for nutrition activities.

16. **The project takes into account the lessons learned from the implementation of the**

Lessons learned from Institutional Strengthening and Health Sector support project (P083350) 2006-2011

1) ***Sector-wide approaches need to carefully balance expectations and forward momentum.*** *SWAps seek to achieve objectives which simultaneously address issues of sector leadership, predictable financial flows and allocations (incorporating the principles of equity and flexibility), harmonized disbursement procedures, and accountability for expenditures and results. And often, as was the case in Niger, these objectives are established in a context where fundamental constraints have not appreciably changed. The challenge, as the QAG noted, is to balance the management of expectations with the need to maintain the momentum of continued development of the approach: if expectations are too ambitious, then setbacks may discourage future developments; if expectations are not ambitious enough, then satisfaction with current achievements may produce complacency.*

2) ***Though good governance, continuity, and sustained commitment of both the Ministry and its partners are necessary conditions for a successful sector-wide approach, they are not sufficient.*** *Where SWAps have been particularly successful, vision and leadership must be continually present in order to maintain forward momentum. Where they are not (and this is currently the case among the partners in Niger), there is a significant risk for the future development of the SWAp.*

3) While the financial resources allocated by the Common Fund were important, equally so were the flexibility and decentralized procedures which accompanied these resources. *Not only did the Common Fund improve the response to local needs, the flexible and decentralized procedures used to channel the funds raised staff motivation (by allowing staff to program priority activities and implement them in a timely manner), promoted community participation (through priority setting, planning, and oversight), and improved the ownership of and accountability for the results achieved.*

previous projects supported by IDA. The following boxes have been drawn from the completion reports of the projects.

Lesson learned from the Health Sector Development Project (Credit No 2915) - 1996-2003

1) ***Health sector reform and the supporting donor interventions need to be driven by results****, a clear set of objectives, and performance benchmarks for service delivery institutions. A focus on inputs, activities and outputs does not provide sufficient guidance and incentives for achieving fundamental changes necessary for improved outcomes.*

2) ***The focus of health sector reform needs to be on removing systemic bottlenecks****. Such a focus requires flexibility and the adoption of action-learning principles during implementation.*

3) ***Increasing geographic coverage does not translate into increased utilization if the systemic bottlenecks are not addressed.*** *Expanding coverage needs to be carefully prioritized and driven by demand as well as long-term resource availability. In a resource constraint environment, donors need to be very cautious in increasing recurrent costs through financing the expansion of existing health care facilities and the construction of new infrastructures.*

4) ***Improving service quality is the key****, and qualified and committed health care staff is the most important contributor to this. In order to create a spirit of professionalism and motivation among health care staff, developing an appropriate incentive system to attract, maintain, and further qualify staff is crucially important. The provision of learning needs to be driven by the actual needs of staff and should take place, as much as possible, through "work-based" learning on the job.*

5) ***Cost recovery in its current form appears to be problematic*** *as it might dis-empower and exclude the poor. While the principle of contributions is important, it should not constitute a financial barrier to accessibility. Adequate mechanisms need to be put in place that ensure financial access of the poor. In particular, cost recovery for contraceptives in one of the poorest countries worldwide and the country with the highest fertility rate does not appear to be an appropriate solution.*

6) ***Donors need to significantly co-finance recurrent costs*** *of Niger's health system so that the country has at least a chance to come close to reaching the MDGs. This requires a long-term donor commitment. In order to allow reasonable external support, the health system needs to be set up and function in a cost-effective manner.*

7) ***A SWAp approach*** *as part of the country's PRSP under Government leadership and with donor-aligned support can turn the above mentioned lessons into reality. The Bank's approach should (i) foster donor alignment around the country's health sector priorities with common objectives and indicators linked to a medium-term expenditure framework; and (ii) strengthen MOH capacity in becoming a full actor in the PRSC process. Bank support needs to be delivered in an*

Lessons learned from Multisectoral Demographic Project (P096198) - 2007-2013

1) ***Addressing the population agenda needs to be anchored in the highest level of government:*** *The population agenda cannot be the sole responsibility of MOP while it is the coordinating responsibility of the MOP. As one of Niger's top development objectives and given its multi-sectoral nature, the population agenda should fall under the mandate of the Prime Minister who is responsible for managing all ministries ensuring their full exploitation of comparative advantages to contribute to the country's overall development. Also, the Prime Ministry should be responsible for advocacy and oversight, holding all ministries accountable for their parts in addressing the population agenda.*

2) ***Technical assistance to address the population challenge should be clearly devised at all levels of society for increased country ownership.*** *It is as important to strengthen and reinforce the need for permanent capacity building at central level as it is at the local level. Building capacity of members of regional and communal councils set up with the country's decentralization process should bring solutions adapted to the specificities of the region or commune. This would in turn, ensure the sustainability of the interventions toward the intended goal of decelerating population growth.*

3) ***Ownership of design by the government is key for successful implementation and impact on the ground:*** *While political will was a pre-requisite for the Bank to prepare the Project, it was not sufficient. Without a full appropriation of the Project design, we are faced with a poor integration between the Project team and the government officials in charge of implementing the Project. As a clear consequence, Project implementation is sub-optimal and impact on beneficiaries may be jeopardized.*

4) ***Awareness/sensitization approach:*** *The 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.*

5) ***Make the best of a decentralization system:*** *Design and implement through a bottom-up approach by using decentralization and community-based system.*

6) Culturally sensitive interventions: *There is a need for specialized IEC/BCC expertise and for the design and implementation of interventions to be cognizant of local culture, needs, and issues; it points to a need for joint design; local delivery with expert*

Annex 9: Activities of Other Development Partners in Health and Population Sectors

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

DONORS	PROJECTS	INTERVENTIONS	TOTAL COST (CFAF)	GEOGRAPHIC COVERAGE	PERIOD	COMMENTS
MINISTRY OF PUBLIC HEALTH						
AFD	Annual plan from 2011-2015	Interventions include : RH, Training, Civil works, coordination, audit, pharmaceutical supply chain, equipment, vehicles, etc.	9 178 million	National	2011-2015	Support through the basket funding (SWAp)
UNICEF	Annual plan from 2011-2015	Interventions include : RH, Training, Civil works, coordination, audit, pharmaceutical supply chain, equipment, vehicles, Women and child health etc.	500 million			Support through the basket funding (SWAp)
GAVI	Annual plan from 2011-2015	Child immunization, Vaccine, administration and logistics	4500 million	National	2011-2015	Support through the basket funding (SWAp)
SPAIN (AECID)	Annual plan from 2011-2015	Interventions include : RH, Training, Civil works, coordination, audit, pharmaceutical supply chain, equipment, vehicles, etc.	196 million	National	2011-2015	Support through the basket funding (SWAp)
GLOBAL FUNDS	Malaria Control project	Treatment and care for malaria	9000 million	National	2008-2013	Closed
GLOBAL FUNDS	Malaria control project	Treatment and care for malaria	8889	National	2014-2015	
UNFPA	Reproductive Health project	Reproductive health	1896 million	National	2009-2013	
European Union	MDGs acceleration project	Nutrition, child health, water and sanitation	6231 million	Zinder, Tahoua and Maradi.	2013-2015	
CHINA		Civil works and equipment	35 million	National Hospital of Niamey	2012-2015	
Italia	Training program for HR	Training for Health specialists, civil works and equipment	92 million	National	2011-2013	
Belgium (CTB)	Capacity development Program	Training for Health district management	2340 million	National (42 health district)	2010-2013	
Belgium (CTB)	Institutional support project	TA support for the MoH	1820 million	National	2011-2015	
Belgium (CTB)	Health system strengthening project	Civil works for district and health centers	8859 million	National	2011-2015	
Saudia Development Foundation	Building of Health centers	Civil works and equipment for Maternal and child health Centers	7200 million	National (7 regions)	2007-2012	Project not yet completed

Saudia Development Foundation	Health and Education sector	Civil works for 21 health centers	2410 million	Zinder and Diffa	2012-2014	Project start in 2014
MINISTRY OF POPULATION, WOMEN PROMOTION AND CHILD PROTECTION						
UNFPA		Capacities strengthening program in population, gender, youths, adolescent girls, communication and sensitization	US$762678	National	2014	
Belgium Technical Cooperation (CTB)		Institutional support for the gender policy implementation	Euro1692840	Zinder, Dosso and Diffa	2013-2015	

Annex 10: Economic and Financial Analysis

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

1. Economic analysis plays a crucial role in informing the choice of project alternatives, especially in resource-constrained environments, and is often used to make decisions on how a project could enable efficient and equitable use of resources. It also helps estimate the economic returns of sector-specific investments. The economic analysis of the proposed health project for Niger will: (i) provide an overview of the macro-fiscal and health financing context of the country; (ii) analyze the economic rationale for investing in the health sector in Niger; and (iii) investigate the costs and benefits of the proposed project's components and activities, through a Cost-Benefit Analysis (CBA). The analysis is informed by existing primary and secondary data sources, including a Public Expenditure Review (World Bank, 2013), National Health Accounts (World Health Organization, 2011), IMF reviews (Article IV, 2011), the Health and Poverty Country Status Report (World Bank, 2014), and most recent household surveys (Demographic Health Surveys and Multiple Indicator Cluster Surveys, 2012).

A. Health financing in Niger : limited resource mobilization for health

2. In 2007-2012 Niger was affected by significant political instability, recurrent droughts, and conflict in neighboring countries. The 2009 political crisis led to a coup d'Etat led by military leaders who overthrew President Tandja and formed a transition government. After a series of local, legislative and presidential elections, a democratically elected regime under President Issoufou took office in 2011. The political crisis and coup d'Etat resulted in a temporary disruption of Niger's relation with key development partners and reduced flows of development assistance, which had impacts on government spending and the economy in 2009 and 2010. Two severe droughts also affected the country in 2010 and 2012, leading to severe food crises (World Bank, PER 2013). At present, Niger has an unprecedented opportunity to make significant advances in development and poverty reduction given current political stability and economic rebound.

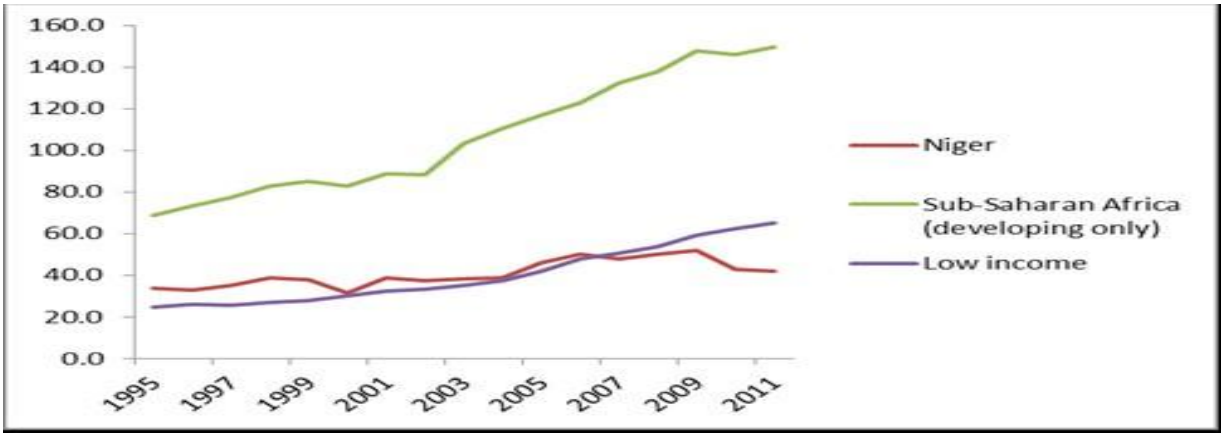
3. After growing 11.1 percent in 2012, propelled by the start of oil production and a good harvest, real GDP growth was 4.1 percent in 2013, largely due to the adverse climatic conditions on agricultural production and the regional security situation, despite a significant increase in oil production. Inflation was contained to 2.3 percent in 2013 as food prices fell thanks to the government's food security program supported by development partners, and improved food markets (IMF, 2014). The primary sector production which accounts for almost 40 percent of GDP fell by 1.4 percent because of the early end of the rains over the majority of the agricultural belt. The secondary sector which represents 21.9 percent of GDP also experienced lower growth, due to a fall in mining, uranium and gold production due to temporary closure of production sites. The tertiary sector, which represents 39 percent of GDP, continued its upward trajectory in 2013, rising by 5 percent. This performance is attributable to the dynamism of transportation and telecommunications, trade and other services arising from increases in traded volumes of harvest products and the start of operations in the Zinder refinery (Africa Economic Outlook, 2013).

4. The medium-term outlook remains favorable. Growth rebounded to 6.4 percent in 2014 and is expected to be sustained over the medium term as two large natural resource projects — crude oil export and uranium production — are scheduled to begin in 2017 and 2019, respectively. Risks to the outlook stem from both internal and external sources. The main near-term risk is a further deterioration in the regional security situation, which could severely impact investment inflows, private sector activity, and the budget. The country also remains vulnerable to climate shocks, commodity price volatility and limited predictability in donor support (IMF, 2014). With an estimated population growth of 3.9 percent in recent years, average real economic growth of at least 3.9 percent is necessary just to prevent a decline in per-capita incomes. Rapid population growth also compounds Niger's challenge of expanding the provision of basic social services.

5. Government revenues account for 15 percent of GDP on average in 2007-2012. Tax revenues reached 15.3 percent of GDP in 2013 up from 14.5 percent in 2012, although still below the 17 percent minimum set by the West African Economic and Monetary Union (WAEMU) convergence criteria. This improvement reflects the Government's efforts to strengthen tax mobilization, particularly by increasing the special re-export tax on rice and the vocational education tax, as well as the implementation of financial management reforms. With ongoing public investment, the GDP share of public expenditure and net loans rose from 23.3 percent in 2012 to 24.8 percent in 2013. Efforts to strengthen security on the country's borders and Niger's participation in the military intervention in Mali led to an increase in military spending at the expense of social spending. Wages also grew as a result of government administrative needs and security reinforcement. Since 2011, the stock of public debt has significantly increased from 17 percent in 2010 to 33.5 percent in 2013, signaling a risk of excessive indebtedness (Africa Economic Outlook, 2013).

6. The sources of finance for health are based mainly on household out-of-pocket spending (48 percent) in the absence of nationally pooled funds. The state mobilizes little resources for health (32 percent of total health expenditure), while external aid accounts for about 20 percent of the sources of finance for health in 2009. Total health spending represented 5.2 percent of GDP, and on a per capita basis, about US$17-18 per capita (in current US$). This situates the country far below to the regional average, which spend approximately US$150 for health. Niger is estimated to spend nearly half of what low-income countries spend on average for health. Due to a disproportionate financial burden assumed by households, financial protection remains limited, despite the removal of user fees for children under five (curative care) and pregnant women (ANC) in 2006.

Figure 6: Trends in Health Expenditure per capita in Niger and Peer Countries (2000-2011), in Constant 2005 International Dollar



Source: World Development Indicators, 2014.

7. The health share of the budget decreased from 9.2 percent in 2001 to 5.4 percent in 2013. Health spending is not linked to the economic growth and the total government spending. In contrast with the rest of the region, government health spending is not primarily driven by wages and salaries (accounting for 28 percent of government health spending); transfers and subsidies rather represent nearly half of the government health expenditure. Capital expenditure declined from 2007 to 2012, representing only 8.4 percent of government health spending in 2011. Overall, budget execution is still largely centralized (at 81 percent of total government health spending) despite progress made toward partial decentralization of the health budget. Budget execution is low overall at 67 percent of the budgeted envelope, low rates being largely driven by investments (23 percent execution rate).

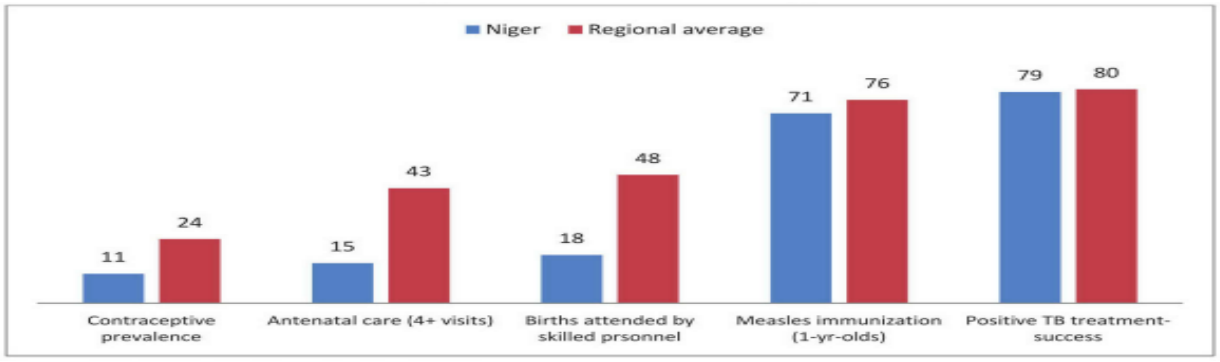
B. Economic rationale for investing in the health sector in Niger

8. **Investment in health pays off.** Improving health outcomes and access to health services is critical to building all citizens' capabilities and enabling them to compete for jobs and opportunities generated through inclusive and sustainable development. Providing health services equitably to all citizens to prevent the ill-effects of diseases and injuries, and to do so without exposing them to burdensome and often catastrophic medical expenses, has been demonstrated to yield significant socioeconomic as well as health benefits at the individual and population levels. Returns to investing in health have been increasingly documented over the past two decades, recognizing economic benefits, through increase in personal and national incomes, and the value of better health in and of itself national incomes, and the value of better health in and of itself (Deaton 2003; Bloom and Canning 2008, Savedoff et al 2012, The Lancet Commission on Investing in Health 2013). Several studies have measured the effects of good health on income and growth, showing that healthier people are more able to work and have a productive life in the long run. Bloom and Canning (2000, 2008) defined the health-income relationship using four main categories/"mediators": productivity, investments in physical capital and education, and demographic dividend. Health improvements have accounted for about 11 percent of economic growth in low-income and middle-income countries between 2000 and 2011 (The Lancet Commission on Investing in Health 2013).

9. Living conditions in Niger have improved in recent years, but there is room for progress particularly to reduce interregional disparities. The most recent national household and agriculture survey (ECVMA 2013) indicates that the poverty rate went from 59.5 percent in 2008 to 48.2 percent in 2013, but remains high in relation to the 31.5 percent goal set for 2015, especially in remote areas (Eastern and Northern areas). The human development indicator (HDI) improved slightly (0.304 in 2013 over 0.297 in 2012) but it remains weak, putting the country in last place (187th) in the 2013 United Nations Development Program (UNDP) human development report. This ranking conceals progress in health conditions, achieved via the implementation of the health development plan (HDP 2011-15), but also reflects inadequate access to basic social services in general.

10. The 2012 demographic and health survey revealed that infant mortality has fallen significantly, with a rate of 127 per 1,000 although the MDG target is 106 per 1,000 by 2015. Also, chronic malnutrition in children from 0-59 months remains extremely high, at 42.5 percent nationally. Maternal mortality also fell to 535 per 100,000, but remains significantly above the MDG target set for 2015 (175 per 100,000). The incidence of HIV/AIDS has also fallen since 2006 (0.4 percent compared with 0.7 percent), making the achievement of the 2015 target possible. Meeting the basic needs of the population has been made more difficult by increasing demographic pressure with an overall fertility rate of 7.6 children nationally, compared with 7.1 children in 2006. Healthcare service coverage remains limited in Niger, and particularly inequitable. Antenatal coverage (3+ visits) is estimated at 15 percent (against 43 percent in the region), while skilled birth attendance at 18 percent (against 48 percent in the region). Only 5 percent of the poorest 20 percent benefit from skilled birth attendance, versus 71 percent of the urban and 59 percent of the wealthiest.

Figure 7: Coverage of Essential Health Services compared to needs, (% of total), 2012



Source: WHO, 2012.

11. The overall goal of the present project (PDO) is to increase the utilization of reproductive health and nutrition services. The project will support supply-side interventions to boost use of RHN services in remote and underserved areas, as well as demand-generating activities, among spouses, young girls and married women. The project will target 5 regions (Dosso, Maradi, Tahoua, Tillaberi and Zinder). The project will target approximately 12.9 million People, including 2.8 million women in child bearing age, 2.6 million children under-five and 522,647 expected newborns. The project will use a Disbursement Linked Indicators approach which links project payments to key results and indicators established for measuring those results. The

achievement of DLIs is the basis for disbursements. Each DLI is individually priced at the capped amount of the maximum payment available.

12. Investing in mother and child health services is critical to improve access to quality services for direct beneficiaries. The economic justification relies on the disproportionate burden of maternal and neonatal deaths in Niger and the fact that affordable and cost-effective interventions to prevent these avoidable deaths are well-established. Evidence for low-income countries suggests that improved coverage with a package of interventions directed to mother and child is extremely cost-effective (US$82-US$142 per DALY averted).[74] The interventions proposed under this project are all considered global "best buys" in this respect.

Table 16: Cost-effective Interventions for Mother and Child Health

Health interventions	Percent of Global Disease Burden Averted	Cost per DALY averted (global)	Estimated annual cost per capita (global)	Included in project
Integrated management of childhood illness	14.0	40.00	1.60	Yes
Expanded Program for Immunization	6.0	14.5	0.50	Yes
Prenatal and delivery care	4.0	40.00	3.80	Yes
Family planning	3.0	25.00	0.90	Yes

Source: Adapted from Cleason et al, 2000.

13. The choice of the project components, notably through a DLI approach, relies on strong economic rationale. The DLI approach has already demonstrated its effectiveness and efficiency in addressing health system bottlenecks in the region. The DLI approach operates through decentralizing health financing to front-line providers. The mechanism responds to the concern that a large source of system inefficiency originated from the extremely limited share of financial flows to operational costs (less than 18 percent) (Public Expenditure Review, 2013). Closing the gap between financial resources and effective service delivery is an obvious direct benefit for users. The performance payment approach also relies on the assumption that an extrinsic motivation, without crowding out the intrinsic values, will encourage health personnel and the sector to adopt an entrepreneurial approach aimed at increasing the use and quality of services provided. Past experiences have proven to be strongly cost-effective for increasing use of services.

C. Cost-Benefit analysis of the project

14. **A Cost-Benefit Analysis (CBA) was conducted to measure the project's economic performance** and to ultimately assess its net returns against alternatives (e.g., status quo). The analysis focused on the DLI project component consisting of 64 percent (or US$66.6 million) of the total project budget. The method consisted of: (i) identifying the DLI project's inputs and outputs; (ii) monetizing benefits of project; (iii) discounting benefits and costs; and (iv)

[74] Disease Control Priorities, Second Edition, 2006.

computing the net returns. Costs and benefits have been discounted with a real social discount rate over 5 years, estimated at 5 percent in real terms in this setting. It defines the rate at which future values in the economic analysis are discounted to the present and therefore reflects the social view on how net future project benefits should be valued against present ones. Computing of economic performance consisted of assessing the economic net present value (NPV) (i.e. the difference between the discounted total benefits and costs) and the economic rate of return (RR) (i.e., the rate that produced a zero value for the NPV). Projects with an RR lower than the social discount rate (5 percent) or a negative NPV are generally not considered economically sound.

15. Only direct costs and benefits of the DLI project were accounted for. Direct costs consisted of total DLI project costs for purchasing services (outputs approach) and for providing support to inputs (i.e. investments in quality and provision of reproductive health commodities). Indirect costs were not included in the analysis due to difficulties to assess and monetize (e.g., opportunity costs supported by users). Direct benefits refer to total gains generated from health services delivered to beneficiaries. Indirect benefits were not accounted for (e.g., users behavior change).

Estimation of the NPV and RR:

$$ENPV = \sum_{t=0}^{n} a_t S_t = \frac{S_0}{(1+i)^0} + \frac{S_1}{(1+i)^1} + \ldots + \frac{S_n}{(1+i)^n}$$

$$0 = \sum \frac{St}{(1+ERR)^t}$$

16. The CBA relied on the main following project parameters:

Parameter description	**Total (cumulative)**	**Total (annual)**
Beneficiaries		
Component 1 (DLI supply-side interventions)		
Children under five	2.8 million	560,000
Women in childbearing age	2.6 million	520,000
Expected pregnancies	522,647	104,530
Component 2 (demand-side interventions)		
Women (15-49 years old)	4.7 million (SBCC) 5.1 million (WRA)	940,000 (SBCC) 1.02 million (WRA)
Young girls (10-19 years)	2.9 million (SBCC)	580,000 (SBCC)
Male spouses (15-49 years old)	604,000 (male)	120,800
Costs		
Costs item	**Costs estimate (cumulative)**	**Costs (annual)**
Total project budget	US$103 million	US$20.6 million
Total DLI component budget	US$66.6 million	US$13.32 million
Total DLI intervention budget (excluding project design and implementation)	US$52.9 of which: - 32.50 for payments to facilities - 2.76 for quality investments - 17.58 for reproductive health commodities.	US$10.58 of which: 6.50 (payments to facilities); 0.55 for quality; and 3.52 for commodities.

Per capita output budget (per year)	US$3.5	
Social discount rate	5%	
Budget execution rate	80%	

17. The CBA analysis shows a net value of US$6.5 million, with a rate of return of approximately 18.2 percent. Those results demonstrate the positive economic performance of the DLI approach proposed in this project and its capacity to generate large returns for the country economy and society.

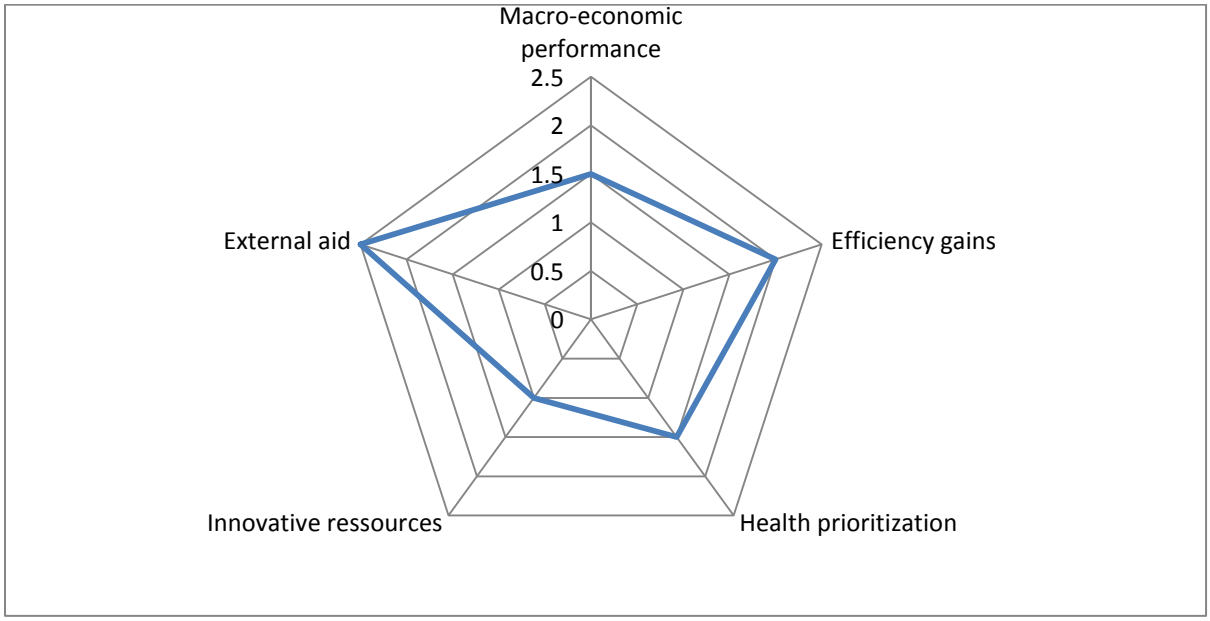
18. Sensitivity analysis allows the determination of the 'critical' variables or parameters of the model. Such variables are those whose variations, positive or negative, have the greatest impact on a project's financial and/or economic performance. The analysis is typically carried out by varying one element at a time and determining the effect of that change on RR or NPV. In the setting of the Niger operation, results show that it is unlikely that the net return of the project will be sensibly modified, given prices of services purchased will unlikely be modified over the course of the project. A diminishing social discount rate is also expected not to affect results.

D. Sustainability issues

19. The selection of the project components, especially the DLI and the health systems strengthening approach, creates the conditions for a sustainable investment in the sector. By boosting the system's reliance on existing health facilities and delivery mechanisms, the project will be directly contributing towards the sustainability of the sector. By spending US$3.5 per capita, per year (including overhead costs), the cost is likely to be affordable and sustainable in the long term for the country. Despite the fiscal fragility of the health sector, there is noticeable space to further connect health investments with income growth.

20. In the medium run, there is sizeable room for increasing the fiscal space for health, mainly through: (i) effective mobilization of government revenues; (ii) a re-prioritization toward health; and (iii) gains in technical and allocative efficiency of health spending; and (iv) external aid. The situation provides therefore realistic options for sustaining the present project expected results over time in Niger, including through domestic resources.

Table 17: Analysis of the Potential Sources of Fiscal space for Health (medium term), Niger



Source: World Bank estimations.

E. Other issues

21. **Appropriateness of Public Sector Provision or Financing**. One of the outcomes of country political instability is the degradation of public services for education and health. The poor status of human development in the country is a result of pervasive market failures. Investing in health systems and other public sector management systems will enable the government to play a stewardship role in resource distribution to contribute to correcting salient market failures.

22. **World Bank Value Added**. International organizations are essential in conceiving development norms and establishing regulatory frameworks for policy implementation. The World Bank is well placed to provide the necessary financial and technical assistance and to support government ownership of these reforms. The comparative advantages of the World Bank in advancing the health reform agenda include: its impartiality, capacity to engage diverse groups in open dialogue, normative functions, and extensive networks of expertise. The World Bank has a unique network of experts able to provide tailored country advice. As a leading goal for the Organization, RHN is at the core of the Bank's technical capacities. Finally, given the Performance Based Financing (PBF) portfolio of the World Bank, it positions itself as the leading organization to support design and implementation of the DLI approach in Niger.

Annex 11: Memorandum of Understanding of the Pooled Fund Supporting the HDP

NIGER: POPULATION AND HEALTH SUPPORT PROJECT (P147638)

MEMORANDUM OF UNDERSTANDING BETWEEN:

1) The Government of Niger (the "**Government**") represented by the Minister of Health (MOH), and
2) The Donors (the "Donors")

(Hereinafter, collectively, the **"Signatories").**

1. GENERAL

- The Health Development Plan adopted by the Government, described in Annex **2** (the **"Program"**), aims to help reduce maternal and infanto-juvenile mortality by improving the efficiency and quality of the health system, starting on the basis of the present potentials.
- The Government has signed with all of its financial and technical partners (the "**FTP**") a document entitled **"Partnership Framework"** which expresses the willingness of all the Signatories to support the implementation of the **Health Development Plan** with harmonized procedures for implementing and monitoring their contributions.
- Each Donor has signed or is about to sign with the Republic of Niger a bilateral agreement (each a **"Bilateral Agreement"**) pursuant to which it is granting a credit, a loan or a grant intended to contribute to the financing of the Program, of all or part of the activities included in the Program.
- The objective of this Memorandum of Understanding (the **"Memorandum"**) is to improve the communication and coordination among the Donors, and with the Government, in order to facilitate implementation of the Bilateral Agreements and the implementation of the Program.
- The Memorandum sets forth the Signatories' understanding as regards the procedures for allocation, disbursement of financings, financial management, procurement, monitoring and evaluation of the Program.
- In the event of any conflict between the provisions of the Memorandum and those of the Bilateral Agreements, the provisions of the Bilateral Agreements shall prevail.
- The Memorandum does not constitute an international treaty, nor a contract that is binding upon its Signatories, but is an indicative document which sets out certain procedures connected with making available the Program's financing.
- The procedures and mechanisms described in the Memorandum are supplemented by the procedures and guidelines to be applied for the implementation of the Program in the administrative, financial management, procurement, monitoring and evaluation of the Program included, *inter alia*, in the following documents: the Health Development Plan Implementation Manual, the Manual of Administrative, Financial and Accounting Procedures, and the Monitoring and Evaluation Guidelines (collectively referred to as the "**Manuals**"), whose provisions are considered satisfactory by the Donors. The provisions of the Manuals can be modified and updated during the Joint Reviews (as hereinafter defined) of the Program, in order to meet implementation needs, or at any time subject to written approval of the Donors in accordance with the procedures set forth in the Manuals.

- The procedures and arrangements described in this Memorandum are supplemented by the provisions of the following annexes:

  1.9.1 Annex …: List of Donors
  1.9.2 Annex …: Description of the Program
  1.9.3 Annex …: Institutional Arrangements for the Implementation of the Program
  1.9.4 Annex …: Indication of the Contributions
  1.9.5 Annex …: Performance indicators

2. PROCEDURES FOR CONSULTATION AND COORDINATION OF THE SIGNATORIES

- The Government designates the General Secretariat (**"General Secretariat"**) of MOH as the unit responsible for the strategic coordination of the Program.
- The General Secretariat will ensure the links with all the technical ministries such as the Ministry of Economy and Finance and the Ministry responsible for the Civil Service, and the coordination of all the directorates of the MOH. The General Secretariat will also ensure consultation with all FTP and the regular organization of the meetings for consultation, coordination and Joint Review of the sector.
- The Government designates the Planning and Studies Directorate of the MOH (*Direction des Etudes et de la Planification*) (the "**DEP**") for operational coordination of the implementation of the Program. The DEP will ensure the management of the entire Program, either contributing or facilitating mobilization of any technical support necessary for the implementation of the Program by the technical directorates.
- The DEP will be responsible for, among other things, coordination between the various entities participating in the implementation of the Program, in particular those from the different technical ministries and technical directorates, at the central and the regional or the district levels (collectively, the **"Implementing Entities"**). The institutional arrangements adopted for the financing of the Program are set forth in Annex **3**.
- The responsibilities of the various parties involved in the implementation of the Program are described in detail in the Manuals.
- Within 75 days of the end of each civil semester, the General Secretariat will organize, following the procedures described in the Manuals, a meeting for consultation (**"Joint Review"**) that the FTP, the Implementing Entities (as hereinafter described), other Government's representatives and other parties involved in the implementation of the Program, will be invited to attend.
- The purpose of the Joint Review is to enable the participants to receive regular information in a harmonized format, based on terms of reference and timetables further described in the Manuals and to review in a coordinated and concerted manner: i) the progress of the Program's implementation and the utilization of the funds allocated to its financing through the Financial Monitoring Report ("**FMR**") (as defined in 6.2.3 below); and ii) the activities planned for the next year or semester and the financing required for their implementation.
- Each Joint Review meeting will be chaired by the General Secretary and minutes of the meeting approved by the participants will be produced by the DEP.

3. ANNUAL ACTION PLAN

- Each year the MOH prepares a plan of activities for the period from January 1 through December 31, for the implementation of the Program and the related budget (the **"draft Annual Action Plan")**. The draft Annual Action Plan is submitted to the FTP for review during the Joint Review held during the second semester of the year. Once the draft Annual Action Plan included in the MOH budget (the "**Annual Action Plan**"), it is submitted to the FTP for approval.
- The draft Annual Action Plan takes into account the annual work plans of the Implementing Entities at the central, regional and district levels. The General Secretariat provides the draft Annual Action Plan to each participant in the Joint Review for review thirty (30) days before the Joint Review meeting. The final version of the draft Annual Action Plan which is included in the MOH draft budget for submission to the Parliament in accordance with the national procedures for the approval of the annual State budget will take into account the recommendations formulated during the Joint Review meetings. The related budget will be based on the financing needs of the Annual Action Plan, taking into consideration the projected available amounts from the MOH budget and the FTP's contributions which might be allocated thereto.
- The approval of the MOH's budget as part of the Law on Finance makes the Annual Action Plan final, subject to, as the case may be, the provisions of any revision of the Law of Finance.
- If the Donors approve the final Annual Action Plan and its budget, each of them will confirm: (i) the amount of the contribution that it wishes to allocate to the financing of the Annual Action Plan; (ii) as the case may be, the amount allocated to specific activities in the Annual Action Plan, and (iii) the procedures for disbursement of its contribution.
- Once confirmed, the cumulative amount of the contributions of the FTP and the Government will be included in the Medium-Term Expenditures Framework (MTEF).
- If necessary, subject to compliance with budgetary procedures applicable in Niger, modifications of the Annual Action Plan and the budget approved by the Donors can be made in the course of the year to which they relate, during a Joint Review meeting, or at any time with the written consent of the Donors participating in the financing of such activities, in accordance with the procedures described in the Manuals.

4. FINANCING OF THE ANNUAL ACTION PLANS

- The Annual Action Plans will be financed from the Government's budget and funds available for that purpose under the Bilateral Agreements and financing agreements entered into with other FTP.
- The contributions referred to in Annex 4 are solely an indication of the volume of funds envisaged for the financing of the Program.
- The Donors' contributions will be paid into the account opened by the Government for the disbursement of the Donors' contributions and only applicable to the financing of the Program (the **"Pool Account"**), in accordance with the procedures set forth in the Bilateral Agreements and the Manuals.
- The contributions of the Donors will be disbursed by the Government's duly authorized representative (the **"Directorate of Financial Affairs"**), according to the applicable legal

and regulatory provisions, the operating procedures of the Pool Account on which they have been deposited, and the provisions of the Bilateral Agreements. The Government designates the Secretary General and the Financial Affairs Director in the MOH to jointly make the disbursements from the Pool Account. This designation remains valid until written notification to the Donors of the designation of one or several new duly authorized representatives for that purpose by the Government, in accordance with applicable legal and regulatory provisions and with the provisions of the Bilateral Agreements.

- With the exception of the activities implemented at the central level, the Directorate of Financial Affairs of the MOH ("**DAF**") will ensure that the funds intended for financing activities implemented at the regional or district level are allocated or transferred for the performance of said activities, in accordance with the procedures described in the Manuals.
- In the event that funds made available to the Government by the Donors are not used for the financing the Program and remain available upon completion of the Program, or after the closing date set forth in the Bilateral Agreements, they will be returned to the Donors pro rata to their respective contributions and in accordance with the provisions of the Bilateral Agreements. If the MOH only carries out part of the Program, the Donors will adjust all or part of the unpaid amount of their contribution, in accordance with the provisions of the Bilateral Agreements.

5. PROCEDURES FOR THE IMPLEMENTATION OF THE PROGRAM

A. Implementation of the Program

- The MOH declares that it undertakes: (i) to achieve the objectives of the Program, and to act with the required diligence and efficiency to facilitate its proper implementation, and (ii) to make available to the Implementing Entities the funds, premises, services and other resources necessary for the implementation of the Program.
- The MOH will take the necessary steps to ensure that the Program's accounts, books and procedures are kept in accordance with the Manuals.
- The Government will grant all necessary permits and authorizations, including work permits for the consultants and the import licenses and other authorization required for the implementation of the Program.
- The Government will inform the Donors without delay of any circumstances (including theft and diversion of funds) that compromise or could compromise the implementation of the Program, and will take all necessary steps to ensure that persons guilty of diversion of Program funds are prosecuted with the full force of the law in Niger.

B. Financial Management

- The General Secretariat will ensure that the Implementing Entities establish and maintain a financial management system in accordance with the terms of reference included in the Manuals.
- The DAF will keep, or will ensure that the Implementing Entities keep, the documents and evidences relating to the implementation of the Program and its financing, in accordance with the terms of reference and procedures detailed in the Manuals. These documentations and evidences will be made available to the Signatories for Joint Reviews and other monitoring and evaluation missions of the Program and the Implementing Entities, and to the auditors for the annual financial audit of the Program.

- Each year the MOH will prepare the Program's annual accounts, and will obtain the annual financial statements of each of the Implementing Entities prepared in accordance with accounting procedures acceptable to the Donors and applied in a consistent manner, which reflect the operations, funds and expenditures relating to the Program.
- The Government will take the necessary steps to ensure that the resources allocated to the financing of the Program are reflected in the Government's projections, budgets and accounts.

C. Procurement

- The DAF will ensure that: (a) all contracts for works, goods and services (with the exception of consultancy services) for the implementation of the Program, financed by the Donors, are procured in accordance with the provisions of Section I of the "Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers "dated January 2011 (revised July 2014) and those set out in the Manuals; and (b) All consultants' services shall be procured in accordance with Sections I and IV of the "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 (revised July 2014) and those set out in the Manuals (collectively the "**Procurement Guidelines**").

D. Monitoring and Evaluation

- The General Secretariat will ensure that each Implementing Entity establishes and maintains a system for monitoring and evaluating its activities for the implementation of the Program, in accordance with the terms of reference included in the Manuals and with the performance indicators listed in Annex **5** subject to further modifications at Joint Review meetings or at any time with the approval of the Donors (the "**Performance Indicators**").

6. MONITORING THE IMPLEMENTATION OF THE PROGRAM AND THE USE OF THE FUNDS INTENDED FOR ITS FINANCING

A. Implementation, monitoring and evaluation of the Program

- Each year, the MOH will prepare semi-annual and annual Program implementation reports (the **"Program Implementation Reports"**) on the basis of the terms of reference and format set forth in the Manuals. These reports will also include the results of the monitoring and evaluation activities conducted during the year covered by the annual report and the description of the progress made with respect to the Program's Performance Indicators.
- Each year, the General Secretariat will send the Program Implementation Reports to each of the FTP no later than thirty (30) days before the Joint Review meeting following, as the case may be, the end of the civil semester, or the end of the calendar year to which the Program Implementation Report relates.

B. Financial Management

- Each year, the General Secretariat will procure that an audit of the Program's accounts and of the Implementing Entities' financial statements be performed, using audit procedures considered acceptable by the Donors, by an independent auditor selected on the basis of a competitive bidding conducted in accordance with the Procurement Guidelines. A copy of the auditor's report (the **"Financial Audit Report"**) will be transmitted to the Donors no

later than two hundred and twenty five (225) days after the closing of the calendar year to which it relates. The copy of the Program's accounts and of the financial statements of the Implementing Entities certified by the auditor will be attached to the Financial Audit Report.

- At the end of each semester, the DAF will prepare a financial monitoring report (FMR) on the Program (a **"Financial Monitoring Report"**) covering the past semester, on the basis of the terms of reference and format included in the Manuals, indicating: (i) the sources of financing for the Program, the use of the funds allocated to the financing the Program, with explanation of variations between the projections and actual amounts of funds used; (ii) the progress in the Program implementation for the period covered by the FMR and on a cumulative basis, and (iii) details of procurement for Program implementation as of the end of the period covered by the FMR. The FMR will be sent by the General Secretariat to the Donors within 45 days of the end of the civil semester to which it relates.

C. Procurement Audit

- Upon request from the Donors, the General Secretariat will have the procurement of goods, works and services audited by an independent audit firm with expertise in this field acceptable to the Donors, retained on the basis of competitive bidding conducted in accordance with the Procurement Guidelines. The procurement audit will be carried out in accordance with the terms of reference included in the Manuals. The auditor's report (the **"Procurement Audit Report"**) will be provided to the Donors at the same time as the Financial Audit Report.

D. Missions

- Each Donor will be invited by the MOH to participate in the joint evaluation missions of the Implementing Entities (at the district, regional or central level). This evaluation will cover among other things their capacity, practices and procedures in financial management, procurement, monitoring, evaluation, and the progress of their activities.
- The monitoring and evaluation activities will be included in the Annual Action Plan. Each monitoring or evaluation mission will produce a mission report (each one referred to as a **"Mission Report"**), which will be distributed by the General Secretariat to the FTP within 30 days of the completion of the mission.

7. SETTLEMENT OF DISPUTES

- The Signatories will try to settle any dispute regarding the provisions of the Memorandum amicably, by consultation among the Signatories.
- Should it become impossible to apply all or part of the provisions of the Memorandum, the Signatories will meet to assess the situation and try to agree on different provisions for the future.
- Any dispute between one or more Donors and the Government shall be settled in accordance with the provisions of their respective Bilateral Agreements.

8. WITHDRAWAL

- Each Donor can withdraw from the Memorandum or terminate its support to the Program by notifying the other Signatories of its intention, in writing, if possible and subject to the provisions of the Bilateral Agreements, at least (3) months before such withdrawal becomes effective. Any notification of withdrawal will be put on the agenda of the next Joint Review meeting so that the consequences of the decision for the Program can be assessed.

9. ADMISSION OF NEW DONORS

- Any third party contributing to the financing of the Program can become a Signatory to this Memorandum, subject to approval by the other Signatories, after having signed the Memorandum or submitted in writing its approval of the provisions of the Memorandum.

10. MODIFICATION

- Any modification of the provisions of the Memorandum shall be subject to the prior written agreement of each Signatory.

11. EFFECTIVENESS AND TERM

- The provisions of the Memorandum shall apply to the Signatories as of the date of signature of the Memorandum by the Government and at least one Donor.
- The procedures set forth in the Memorandum shall apply throughout the entire term of the Program, unless otherwise agreed in writing by the Signatories.

12. NOTIFICATIONS

- All notifications or communications in application of the Memorandum shall be given in writing and shall be deemed to have been validly given, made or addressed to the intended recipients on the date of their delivery to said recipients in person or by international courier or facsimile at the addresses listed in Annex ...
- Any Signatory can change the address to which notifications and communications are to be sent, by written notification to the other Signatories in accordance with the provisions of this paragraph.
- All communications to the Signatories shall be in the French language.

13. SIGNATORIES

- In witness whereof the Signatories, acting through their representatives duly authorized for this purpose, have signed the present Memorandum in their respective names:

For the Government: **May 19, 2006.**
For the Association: **May 19, 2006.**
For French Development Agency: **May 19, 2006.**
For UNICEF: **Mars 2011.**
For Spain International Cooperation Agency – AECID: **March 2010**.
For GAVI – Mundial Alliance for Vaccines and Immunization: **March 2011.**

For UNFPA: **August 14, 2014.**