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Report No: PAD1412

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT

IN THE AMOUNT OF SDR 8.3 MILLION
(US$11.6 MILLION EQUIVALENT)

AND

A PROPOSED ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 16.5 MILLION
(US$23.2 MILLION EQUIVALENT)

TO

BURKINA FASO

FOR A

SAHEL WOMEN'S EMPOWERMENT AND DEMOGRAPHIC DIVIDEND PROJECT

April 1, 2015

Health, Nutrition, and Population Global Practice (GHNDR)
Africa Regional Integration Department (AFCRI)
Africa region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective; February 28, 2015)

Currency Unit	=	MRO, XAF, XOF
US$1	=	586 XOF
US$1	=	0.7105351 SDR

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
AFD	*Agence Française de Développement* (French Development Agency)
ANC	Antenatal care
AWP	Annual Work Plans
BCC	Behavioral Change Communication
BMGF	Bill and Melinda Gates Foundation
CAS	Country Assistance Strategy
CBO	Community-Based Organizations
CCT	Conditional Cash Transfers
CERPOD	*Centre d'Etudes et Recherches sur Population et Développement* (Center for Studies and Research on Population and Development)
CILSS	*Comité Inter-Etats de Lutte contre la Sècheresse dans le Sahel (*Interstate Committee for fighting drought in Sahel)
CPS	Country Partnership Strategy
CRVS	Civil registration and Vital Statistics
CSO	Civil Society Organizations
CTD	Common Technical Document
DA	Designated Account
DFM	*Direction des Finances et du Matériel* (Finance and Equipment Department)
DHS	Demographic and Health Survey
DNP	*Direction Nationale de la Population* (Mali) (National Population Department)
ECOWAS	Economic Community Of West African States
FM	Financial Management

GDP	Gross Domestic Product
GII	Gender Inequality Index
GMP	Good Manufacturing Practices
GNI	Gross National Income
GPCL	Good Practices for National Pharmaceutical control Laboratories
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HIV-AIDS	Human immunodeficiency virus infection / acquired immunodeficiency syndrome
HNP	Health Nutrition and Population
HRH	Human Resources for Health
ICT	Information and Communication Technologies
IDA	International Development Association
IEG	Independent Evaluation Group
INFAS	*Institut National de Formation des Agents de Santé* (National Institute for Training Health Workers)
INFSS	*Institut National de Formation en Sciences de la Santé (*National Institute for Training in Health Sciences)
INS	*Institut National de la Statistique* (Niger) (National Statistics Institute)
INSD	*Institut National de la Statistique et de la Démographie (Burkina Faso)* (National Institute for Stastistics and Demographics)
INSEED	*Institut National de la Statistique et des Etudes Economiques et Démographiques* (Chad) (National Institute for Statistics and Studies on Economics and Demographics)
IPF	Investment Project Financing
IT	Information Technology
KFW	*Kreditanstalt für Wiederaufbau* (Reconstruction Credit Institute)
LIC	Low Income Countries
M&E	Monitoring and Evaluation
mCPR	Modern method Contraception Prevalence Rate
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoP	Ministry of Population
MWMP	Medical Waste Management Plan
NGO	Non-Governmental Organization
NSC	National Steering Committee
ONP	*Office National de Population* (Cote d'Ivoire) (Office of National Population)
ONS	*Office National de la Statistique* (Mauritanie) (Office of National Statistics)

ORAF	Operational Risk Assessment Framework
PAD	Project Appraisal Document
PADS	*Programme d'Appui au Développement Sanitaire* (support program for health development)
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Primary Health Care
PIU	Project Implementation Unit
PPP	Public Private Partnership
PRSC	Poverty Reduction Strategy Credit
QC	Quality Control
RBF	Results-Based Financing
RH	Reproductive Health
RMNCHN	Reproductive, Maternal, Neonatal and Child Health and Nutrition
RSC	Regional Steering Committee
RTS	Regional Technical Secretariat
SBCC	Social and behavior change communication
SSA	Sub Saharan Africa
SWEDD	Sahel Women Empowerment and Demographic Dividend project
TA	Technical Assistance
TF	Trust Fund
TFR	Total Fertility Rate
UCT	Unconditional Cash Transfer
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population
UNICEF	United Nations International Children Emergency 's Fund
USAID	United States Agency for International Development
WAEMU	West Africa Economic and Monetary Union
WAHO	West African Health Organization
WCARO	West Africa UNFPA office
WHO	World Health Organization

Vice President:	Makhtar Diop
Country Director:	Colin Bruce
Senior Global Practice Director:	Timothy Grant Evans
Country Manager:	Mercy Miyang Tembon
Practice Manager:	Trina S. Haque
Task Team Leader:	Christophe Lemière

BURKINA FASO

SAHEL WOMEN'S EMPOWERMENT AND DEMOGRAPHIC DIVIDEND PROJECT - ADDITIONAL FINANCING

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ADDITIONAL FINANCING DATA SHEET

SWEDD AF for Burkina Faso (P154549)

AFRICA

GHNDR

Basic Information – Parent			
Parent Project ID:	P150080	Original EA Category:	C - Not Required
Current Closing Date:	31-Dec-2019		

Basic Information – Additional Financing (AF)			
Project ID:	P154549	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	
Country Director:	Colin Bruce	Expected Effectiveness Date:	30-Jun-2015
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Dec-2019
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD1412
Team Leader(s):	Christophe Lemiere		

Borrower				
Organization Name	Contact	Title	Telephone	Email
GOVERNMENT OF BURKINA FASO	Ministry of Economics and Finance			

Project Financing Data–Parent (Sahel Women's Empowerment and Demographics Project-P150080)							
Key Dates							
Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P150080	IDA-55690	Not Effective	18-Dec-2014	23-Mar-2015		31-Dec-2018	31-Dec-2018
P150080	IDA-55700	Not Effective	18-Dec-2014			31-Dec-2018	31-Dec-2018
P150080	IDA-55710	Not Effective	18-Dec-2014			30-Jun-2019	30-Jun-2019

P150080	IDA-D0180	Not Effective	18-Dec-2014			30-Jun-2019	30-Jun-2019
P150080	IDA-D0190	Not Effective	18-Dec-2014	11-Mar-2015		31-Dec-2018	31-Dec-2018
P150080	IDA-D0200	Not Effective	18-Dec-2014			31-Dec-2018	31-Dec-2018
P150080	IDA-D0240	Not Effective	18-Dec-2014			31-Dec-2018	31-Dec-2018

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P150080	IDA-55690	Not Effective	XDR	36.20	36.20	0.00	0.00	36.20	
P150080	IDA-55700	Not Effective	XDR	27.10	27.10	0.00	0.00	27.10	
P150080	IDA-55710	Not Effective	XDR	13.60	13.60	0.00	0.00	13.60	
P150080	IDA-D0180	Not Effective	XDR	6.80	6.80	0.00	0.00	6.80	
P150080	IDA-D0190	Not Effective	XDR	10.20	10.20	0.00	0.00	10.20	
P150080	IDA-D0200	Not Effective	XDR	18.10	18.10	0.00	0.00	18.10	
P150080	IDA-D0240	Not Effective	XDR	3.40	3.40	0.00	0.00	3.40	

Project Financing Data –Additional Financing SWEDD AF for Burkina Faso (P154549)

[ ] Loan [ ] Grant [X] IDA Grant
[X] Credit [ ] Guarantee [ ] Other

Total Project Cost:	34.80	Total Bank Financing:	34.80
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	34.80
Total	34.80

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	Yes

Explanation

The Regional Vice President granted an exception to OP10.00 paragraph 29 and AF guidelines on Additional Financing (i.e. requiring at least 12 months of Project's well-performing implementation) in order to allow for the processing of an additional financing to add Burkina Faso to the Sahel Women Empowerment and Demographic Dividend (SWEDD) regional project. The policy allows the RVP to decide to proceed with well-performing projects that have less than 12 months of implementation, which is the case of the SWEDD regional project which was approved in December 2014.

Has the waiver(s) been endorsed or approved by Bank Management?	Yes

Explanation

See above.

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Christophe Lemiere	Team Leader (ADM Responsible)	Senior Health Specialist		GHNDR
Boubacar Diallo	Procurement Specialist	Consultant		GGODR
Ngor Sene	Financial Management Specialist	Financial Management Specialist		GGODR
Fatou Fall	Safeguards Specialist	Senior Social Development Specialist		GSURR
Hocine Chalal	Safeguards Specialist	Lead Environmental Specialist		GENDR
Mamata Tiendrebeogo	Team Member	Senior Procurement Specialist		GGODR

Extended Team

Name	Title	Location

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

Institutional Data

Parent (Sahel Women's Empowerment and Demographics Project-P150080)

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	60		
Education	Secondary education	20		
Public Administration, Law, and Justice	Central government administration	10		
Public Administration, Law, and Justice	Sub-national government administration	10		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Social dev/gender/inclusion	Gender	40
Human development	Population and reproductive health	40
Human development	Education for all	10
Human development	Health system performance	10
Total		100

Additional Financing SWEDD AF for Burkina Faso (P154549)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Education

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[ ] 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	%
Social dev/gender/inclusion	Gender	40
Human development	Population and reproductive health	40

Human development	Education for all	10
Human development	Health system performance	10
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)
Consultants Required? Consultants will be required.

I. Introduction

1. **This Project Paper seeks the approval of the Executive Directors to provide a financing in the amount of US$34.8 million to Burkina Faso for the Sahel Women's Empowerment and Demographic Dividend Project- Additional Financing** (SWEDD-AF) (P150080). This financing (AF) (P154549) is in response to the Government of Burkina Faso's request to be part of the regional Project to improve women's reproductive health and girls' education in the Sahel, so as to reap economic gains from the demographic dividend.

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

3. **The demographic dividend is characterized by a period in a country's demographic transition** when the proportion of working age population is higher compared to the number of dependents. This period can correspond to an extra economic boost through increased savings and private investments. Triggering such a demographic dividend requires two ingredients: (i) a decreased dependency ratio which is made possible only when fertility is declining more rapidly than mortality, and (ii) adequate policies to foster human capital, employment and investments to ensure that the additional working-age population can get jobs. In the Sahel, while the demographic transition has started with remarkable declines in child mortality in the past decade, the key trigger of rapidly declining fertility has yet to be achieved. Consequently, the age structure of the population has not changed and remains marked by high child dependency ratios.

4. **The proposed AF would expand the impact and development effectiveness of the SWEDD** by adding another Sahelian country to the current five countries supported by the Project. To speed up the fertility transition, the SWEDD project seeks to combine three strategies: (i) Increasing demand for reproductive health (RH) services, mainly through women and girls' empowerment (ii) Improving supply of RH services, with more efficient procurement and better distribution of products and improved quality and availability of qualified health workers, and (iii) Strengthen capacity and accountability of policymakers on population issues. The program initially targets six of the countries with the highest fertility rates in the sub-region: Chad, Côte d'Ivoire, Niger, Mali, Mauritania and Burkina Faso. Given that most of the population in many of these six countries is living in cross-border areas, focusing on these areas will generate spill-over effects between countries and extend beyond the borders of the target countries.

5. **There is strong commitment by multiple partners**, including regional bodies such as the Economic Community of West African States (ECOWAS), the West African Health Organization (WAHO), and the United Nations Fund for Population (UNFPA) Regional Office for West and Central Africa, Regional offices of the WHO, the Reproductive Health

Supplies Coalition (RHCS), as well as partners such as the Government of France, USAID, Bill and Melinda Gates Foundation (BMGF). With UNFPA, all of these partners have recently formed the Ouagadougou Partnership, which has been instrumental in raising the profile of Sahel countries' problems to achieve a demographic dividend.

6. **Project implementation at the regional level will be coordinated by the UNFPA regional office**, which will host the regional secretariat of the project. The project has been prepared by the countries with joint support from UNFPA and the Bank. The BMGF financially supported the preparation. Under the regional coordination, Governments of the six participating countries will implement country-level tasks. WAHO will also provide support to countries, and specifically WAHO will be in charge of supporting countries regarding issues such as regional harmonization and quality control of medicines, regulation and health workers curricula.

II. Background and Rationale for Additional Financing for the SWEDD in the amount of US$34.8 million[1]:

7. **In November 2013, President Issoufou of Niger put a spotlight on the link between drivers of fragility in the Sahel, population dynamics, and gender inequality.** The issues are multifold. Despite encouraging trends in mortality, fertility remains high in the Sahel. High fertility is reflected in the low prevalence of modern contraceptive methods. One of the main obstacles for increasing contraception is related to supply-side issues. Especially in rural areas, stock-outs of contraceptives are frequent[2]. Demand-side issues are also playing a major role in explaining the low modern contraception rates in the Sahel. Indeed, women's desire to space or limit births has been slow to increase in the Sahel region[3]. Early marriage and childbearing are common and contribute to overall high fertility rates[4]. The Sahel region has low levels of education (especially for girls)[5], a cornerstone of building human capital and a key driver of demand for contraception. The World Bank (President Jim Yong Kim) and the UN (Secretary-General Ban Ki-moon) responded with a pledge to actively support Sahelian countries to accelerate the demographic dividend by addressing health, nutrition, and human capital concerns.

[1] The financing is additional to the regional project already in place, however, it is new financing for Burkina Faso.
[2] May 2014, from RH supplies.
[3] Wanted fertility refers to what the total fertility would be if all unwanted births were avoided. Data on women's wanted fertility from DHS Statcompiler, most recent survey. 5.2 Burkina Faso; 6.1 Chad; 4.1 Côte d'Ivoire; 4.8 Mali; 4.1 Mauritania; 6.8 Niger; 3.2 Senegal.
[4] Sources: Demographic and Health Surveys, World Development Indicators
[5] Source: UNICEF (UNESCO, including the Education for All 2000 Assessment)

Table 1: Select Health, Nutrition and Population Indicators

	Total fertility rate (TFR)	Unmet needs for contraception[b]	Maternal mortality ratio	Under-5 mortality rate	Malnutrition prevalence: stunting	Child dependency ratio
	(# children/ woman)	(% of women of reproductive age)	(modeled, per 100,000 live births)	(per 1,000 live births)	(% of children under 5)	(pop'n < age 15 as % of working-age population)
Burkina Faso	5.8	24.5	300	108	35	89
Chad	7.1	28.3	1084	150	16	104
Côte d'Ivoire	5.0	27.0	614	108	30	88
Mali	6.9	27.6	540	133	39	94
Mauritania	4.8	32.0	510	87	23	72
Niger	7.6	16.1	590	120	55	105
SSA avg	5.1		500	98		80
LIC avg	4.0		410	82	37	69

[a] *Data source:* World Development Indicators, most recent available 2006-2013.
[b] Social Affairs • Population Division, www.unpopulation.org, 2013 Update for the MDG Database: Unmet Need for Family Planning. POP/DB/CP/B/MDG2013.

8. **The SWEDD project was prepared by six countries,** Burkina Faso, Chad, Cote d'Ivoire, Mali, Mauritania and the Niger with joint support from UNFPA and the Bank. It is organized around three main components. Component 1- *Improve regional demand for reproductive, maternal, neonatal and child health and nutrition (RMNCHN) services and increase empowerment for women and adolescents*: seeks to generate demand for RMNCHN commodities and services, by promoting social and behavioral change and empowering women and adolescents. Component 2- *Strengthen regional capacity for availability of RMNCHN commodities and qualified health workers*: seeks to strengthen regional capacity to improve supply of RMNCHN commodities and qualified personnel. Component 3- *Foster commitment and capacity for policy making and project implementation*: seeks to strengthen project high level advocacy and policy dialogue, strengthen capacity for policy making and project implementation. The Primary beneficiaries of the SWEDD will be women and adolescent girls in the project countries in the Sahel. Other beneficiaries will be children, men, health workers, government officials, members of civil society, community and religious leaders. The projects main goal and beneficiaries reflect the commitment of the Bank's Global Practice on Health, Nutrition and Population to universal health coverage, health financing, service delivery and ensuring healthy societies, as well as the World Bank twin goals of eliminating extreme poverty and boosting shared prosperity. The project approval formalizes the UN-WB commitment and partnership to address the Demographic Dividend in the Sahel.

9. **The negotiation of the SWEDD project for six countries, including Burkina Faso, was approved by the Regional Operations Committee (ROC) meeting on October 6th, 2014.** Burkina Faso shares with its Sahelian neighbors similar vulnerabilities and challenges to harnessing a demographic dividend. For example, the Total Fertility Rate (5.8) is far higher than other countries in the world[6]. Like its neighbors, Burkina Faso also

[6] Source: World Development Indicators, most recent available 2006-2013.

scores poorly in the UNDP's Gender Inequality Index as 131st out of 148 countries (0.609), below the regional index value of 0.577 for Sub-Saharan Africa. Consequently, the Country Partnership Strategy (2013-2016) for Burkina Faso makes gender a cross-cutting priority for all Bank operations. The SWEDD project was prepared in close coordination with country-level projects and national policies

10. **Due to unforeseen political events, the inclusion of Burkina Faso in the SWEDD project had to be delayed.** Shortly after the ROC meeting and prior to the Board presentation, political unrest made it impossible to proceed with negotiations as the Bank paused preparation of all new operations, awaiting the establishment of a transitory government. As a result, the Board approved on December 18th, 2014 IDA credit and grants for five countries (Chad, Cote d'Ivoire, Mali, Mauritania and the Niger) in the amount of US$170.2 million. With a transitional government in place, working with international partners to initiate urgent reforms and ensure that the October 2015 elections allow for peaceful, democratic change, the Bank's operations in Burkina Faso are back to business as usual. The Regional Vice President granted an exception to OP10.00 paragraph 29 and AF guidelines on Additional Financing (i.e. requiring at least 12 months of Project's well-performing implementation) in order to allow for the processing of an additional financing to add Burkina Faso to the SWEDD regional project. The proposed AF would increase the overall IDA funding envelope for the SWEDD to US$205 million.

11. **Out of the IDA US$34.8 million allocated to Burkina Faso, an amount of US$23.2 million is provided under the IDA 17 regional window. Indeed, the proposed project meets the four following criteria for utilizing the regional IDA envelope:**
    a. **To involve three or more countries:** The project involves six countries: Burkina Faso, Chad, Côte d'Ivoire, Niger, Mali and Mauritania.
    b. **To have benefits, either economic or social, that spill over country boundaries:** The project will support the creation or strengthening of different types of regional benefits. They are described in Annex 4.
    c. **To confirm strong interest from regional bodies and the region's countries in the project**. ECOWAS seeks to use this project to better fulfill the WAHO mandate as the main coordinating and harmonizing body in the sub-region in the health sector. The CILSS (*Comité Inter-Etats de Lutte contre la Sécheresse dans le Sahel* or Sahelian Inter State Committee for fighting drought) is also involved in the project through its population department (i.e. CERPOD). It will help the countries strengthen their mandate and capacity to coordinate analytical work on demographics in the sub-region. In addition, all the six targeted countries have strongly expressed their interest in participating in the regional operation given the relevance of the regional approach and the proposed activities.
    d. **To provide a platform for a high level of policy harmonization between countries** through support to WAHO in order to (i) harmonize registration and quality control of RMNCHN drugs and supplies, (ii) implement a sub-regional and high quality curriculum for training midwives, and (iii) set up a sub-regional mechanism for accrediting all midwifery training institutions.

III. Proposed Changes

Summary of Proposed Changes	
The purpose of the proposed Additional Financing is to add Burkina Faso to the participating countries. There are no changes to other features of the project.	
Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [ ] No [X]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

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

Change in Results Framework

Explanation:

As Burkina Faso was always intended to be reintegrated into the SWEDD project, only minor changes to the project-level results framework approved by the Board on December 18th, 2014 would need to be

made. A first group of indicators is at regional-level (e.g. number of regional evaluations). Consequently, associated target values would not change whether there are five or six countries included in the project. A second group of indicators, (mostly those related to component 1 on gender) has estimates for target values. The parent project PAD clearly mentioned (on p.29) that these estimates would be updated during a restructuring, once the countries have completed a process of a regional call for proposals, which will define which sub-projects to be implemented. Therefore, only the last group of indicators needs target values to be revised upward as a result of the integration of Burkina Faso. Changes are described in annex 1.

Compliance

Covenants - Additional Financing (SWEDD AF for Burkina Faso - P154549)

Source of Funds	**Finance Agreement Reference**	**Description of Covenants**	**Date Due**	**Recurrent**	**Frequency**	**Action**
IDA	Adoption of the Project Operational Manual	On or before one month after the Effectiveness Date, the Recipient shall adopt the Project Operational Manual in form and substance satisfactory to the Association.	31-Jul-2015	☐		New
IDA	Set up of Project Implementation Unit and of National Steering Committee	On or before one month after the Effectiveness date, create and establish the Project Implementation Unit and the National Steering Committee in form and substance satisfactory to the Association	31-Jul-2015	☐		New
IDA	Sign agreement with UNFPA	Signing the TA agreement with UNFPA, not later than two months after effectiveness	31-Aug-2015	☐		New

Conditions		
Source Of Fund	**Name**	**Type**
Description of Condition		

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

Finance

Loan Closing Date - Additional Financing (SWEDD AF for Burkina Faso - P154549)

Source of Funds	**Proposed Additional Financing Closing Date**
IDA Grant	31-Dec-2019

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

Disbursement estimates have been revised to take into account the inclusion of a sixth country (i.e. Burkina Faso)

Expected Disbursements (in USD Million)(including all Sources of Financing)

Fiscal Year	2015	2016	2017	2018	2019	2020				
Annual	20.00	40.00	60.00	60.00	20.00	5.00				
Cumulative	20.00	60.00	120.00	180.00	200.00	205.00				

Allocations - Additional Financing (SWEDD AF for Burkina Faso - P154549)

Source of Fund	**Currency**	**Category of Expenditure**	**Allocation**	**Disbursement %(Type Total)**
			Proposed	**Proposed**
IDA	XDR	(i) Goods, Non-Consulting Services,	24.8	0.00

		Consultants' Services, Operating Costs, Workshops and Training for the Project		

Components

Change to Components and Cost

Explanation:

There are no changes with the components.
But, with the addition of Burkina Faso, costs are increased (see below).

Current Component Name	Proposed Component Name	Current Cost (US$M)	Proposed Cost (US$M)	Action
Component 1: Improve Regional Demand for Reproductive, Maternal, Neonatal, Child Health and Nutrition (RMNCHN) Services and Increase Empowerment for Women and Adolescents	Addition of Burkina Faso	76.77	16.58	Revised
Component 2: Strengthen Regional Capacity for Availability of RMNCHN Commodities and Qualified Health Workers	Addition of Burkina Faso	60.97	12.52	Revised
Component 3: Foster Commitment and Capacity for Policy Making and Project Implementation	Addition of Burkina Faso	34.46	5.70	Revised
	Total:	172.20	34.80	

IV. Appraisal Summary

Appraisal Summary
Economic and Financial Analysis

Explanation:

There is no change to the economic analysis that was conducted for the parent project, given that Burkina Faso was part of the project through ROC approval.

A change in fertility dynamics is necessary for the economic transformation of the Sahel region. Bi-directional relationships exist between demographics, health, human capital, and income. Lower fertility rates are associated with better maternal and child health outcomes. Fewer births and longer intervals between births expose women to fewer pregnancy risks and chances of maternal death and result in better health outcomes for children. Lower fertility also means that families can invest more in each child, allowing for better health and education outcomes of children. In terms of the demographics and human capital link, healthier children miss fewer days of school, have greater cognitive flexibility and development, and ultimately perform better in school. In the reverse direction, better educated families (especially mothers) tend to have fewer and healthier children due to a better ability to decipher health messages and utilize appropriate services. As to the demographics and income link, healthier people are more productive and can work for a longer duration of time. There is also evidence that as health improves in a population, the longer expectation of life encourages savings for retirement and healthier labor supplies encourage foreign investments. Furthermore, there is a demographic impact on national level income as well. In the reverse direction, income has a positive effect on health: higher income households have better nutrition, greater access to clean water and sanitation, more access to quality health care and better psycho-social resources. Finally, as to the human capital and income link, education has a significant impact on income: each additional year of schooling results in a 10 percent wage increase on average and subsequent doubling of salaries. And in the reverse direction, income has a positive effect on human capital: higher income families are able to invest more in each child's education and training.

Evidence suggests that family planning can and should play a much larger role in the Sahel region's development. The returns on investment are enormous: providing family planning services to women needing it, and offering them high quality comprehensive reproductive and maternal health services has important health, social and economic benefits. Positive impact of family planning programs (leading to demographic change) on economic growth and development is their contribution to higher education of children, greater use of preventive health services and also an increased employment of women. In francophone West Africa, investing in family planning to meet the unmet needs expressed by women to space or limit births would avert 7,400 maternal deaths and 500,000 child deaths in the next 10 years. Cumulative savings of the costs of maternal and child health care will be US$182 million for the next 10 years and US$1.9 billion by 2040. Moreover, a regional analysis indicates that every US$1 invested in family planning saves US$3 in other development sectors that contribute to achieving the MDGs (education, vaccinations, water and sanitation, maternal health, and malaria treatment). However, evidence from the region also shows that uptake of family planning services is much higher when these services are bundled with other Health,

Nutrition and Population services. This not only allows for greater economies of scale and service delivery, but also empowers mothers and young women to access these services without the stigma and social disapproval of accessing family planning services.

The economic benefits of investing in the healthy development of adolescents and other women of reproductive age, and the economic costs of not doing so are already widely recognized: competent adolescents and other women who enter the work force can raise the economic productivity of a country. Economists stress the importance of using this "demographic dividend" for national development. On the other hand, not investing in the health and development of adolescents and other women of reproductive health contributes to the vicious cycle of ill-health and socioeconomic deprivation. For example, girls from poorer communities are more likely than those from higher income communities to get pregnant during their adolescence. This in turn leads to loss of educational and employment opportunities, keeping them in poverty.

The rationale for public sector engagement for the SWEDD Project is based on the role of the governments to promote economic and social goals and their spillover effects. Investments funded through the Project are to generate demand for and provide social services (access to quality social services for the most vulnerable: health services, education access, empowerment activities for girls and women). Moreover, these interventions have positive externalities and important spillovers which justify the key role of Governments. Additionally, the public sector is also targeted by specific interventions to strengthen capacities of the different governments for policy making related to women's empowerment and demographic issues. Finally, the complexity (multi-sectorial aspects) and sensitivity of the population issue in the Sahel countries requires a regional intervention and the coordination of the Governments of the six countries to address it.

Technical Analysis

Explanation:

There is no change to the technical proposal that was made for the parent project, given that Burkina Faso was part of the project through ROC approval.

The proposal is based on global evidence on high-impact interventions that improve demand for RMNCHN services and increase women's and girls' empowerment. A combination of interventions focused on Social and behavior change communication (SBCC) and women's and adolescent girls' empowerment are proposed, all of which have been shown to impact both health and non-health outcomes as evidenced by impact evaluations and rigorous program evaluations.

A range of global examples of SBCC programs in diverse regions of the world have shown positive results. 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 significantly 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. 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 evidence base also indicates that empowerment interventions targeting adolescent girls and their communities can be effective in improving outcomes both within and beyond the health sector. Some of the interventions that have proven to be most effective for improving the above outcomes among adolescent girls include the following three broad categories: life skills interventions, economic and livelihoods interventions, and incentives to improve schooling outcomes.

There is growing evidence that empowerment interventions via life skills and mentoring can improve health outcomes, for example from the *Maharashtra Life Skills Program* in India (Pande et al, 2006). In addition to stand-alone programs, life skills are increasingly being integrated as key components within broader adolescent girl interventions. For example Ethiopia's *Berhane Hewan* combines life skills with an in-kind incentive (livestock) to families who commit to keeping their daughters in school, and an evaluation shows that girls aged 10–14 were one-tenth as likely to be married at end-line, and three times more likely to be in school (Erulkar et al, 2009).

Several economic and livelihood interventions have shown very large economic impacts, for example from rigorous evaluation of job, business and life skills training in Liberia's Empowerment of Adolescent Girls and Young Women (EPAG) project (Adoho et al, 2013). A life skills plus livelihoods intervention in Uganda has shown dramatic health outcomes for girls (Bandiera et al, 2012). Experience from these programs as well as from youth training programs in Latin America suggests that life skills are a key complement to increase the effectiveness of livelihood and vocational skills (Katz, 2008).

Social Analysis

Explanation:

There is no change to the social assessment that was conducted for the parent project. 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.

Environmental Analysis

Explanation:

The Environment Assessment (EA) Category is C (Not Required). There is no change to the social assessment that was conducted for the parent project.

The project will mostly fund consulting, communication costs, training services, as well as some equipment. No civil works is contemplated or envisaged. As part of the technical assistance, appropriate support is given to beneficiary institutions regarding sound management of medical waste and obsolete drugs. The AF will not finance the procurement of drugs. Consequently the project is classified as category C and no environmental and social safeguards instrument is required. The detailed assessment, together with the proposed arrangements for disbursements, accounting, auditing, monitoring and procurement, are provided in Annex 3.

Applying the climate and disaster risks screening tool indicates that the primary climate and geophysical hazards that may impact project impact are shorter and more erratic rainy seasons in the future leading to increased opportunity for drought and instability in target populations' livelihood stability. In the case of any potential effects of increased drought, the project will contribute to the improvement in the availability and quality of health services for the targeted population, including nutritional services.

Risk

Explanation:

Political and governance risk is substantial. A deterioration of the security situation and terrorist activities in countries such as Mali, and neighboring countries such as Nigeria could heighten insecurity and result in an influx of refugees. This situation could severely disrupt the supply of the health services and potentially the interventions of the NGO in the communities. This would also have a deleterious effect on the overall coordination mechanisms set up under the project. The Bank will monitor closely the country political and security environment, and advise on adequate responses to address the specific risk situations. Countries will seek to contain these risks through close security cooperation with regional and international partners, increased spending on security, and the design and implementation of a plan for development and security in the Sahelo-Saharan zone of the country. Its implementation will require significant amounts of resources, including donor support. The risk is largely exogenous to the project.

Macroeconomic risk is high. Burkina Faso is indeed vulnerable to unanticipated production and/or price shocks in its most important export sectors, cotton and gold. In addition, an increase in oil imports or a rise in oil prices may put pressure on the balance of payments. In the context of the upcoming elections, the country may face increased fiscal pressures arising from demands by public sector unions and/or arrears generated by unauthorized budgetary spending in previous years. The WB will address these issues in close cooperation with IMF team through its focus on PFM reform. The DPO series is designed to mitigate fiscal risks by supporting measures designed to expand production in the cotton sector and enhance the revenue impact of the mining industry. It also supports broad improvements in competiveness and diversification by reducing transportation and trade costs and by facilitating widespread credit access. Effective implementation of these reforms will significantly attenuate Burkina's macroeconomic vulnerabilities.

Regarding the sectors involved in the project, the key ministries (Health, Population, Education, Youth, Midwifery training hub, etc.) who will implement the project may lack adequate ownership and commitment to a shared regional strategy, and there may be lack of clarity on their specific roles and responsibilities. The regional implementation arrangement through the Regional Steering Committee, WAHO and UNFPA as well as the Bank close engagement will ensure that there is a common vision, and understanding of such a vision amongst all target country agencies. The project will also closely involve ECOWAS to help build this commitment and an effective coordination mechanism. In addition, the project will support a communications campaign to continuously reinforce the vision and objective of the project in target countries and implementing bodies. Moreover, to ensure that organizations in question do not overlap in responsibilities, there will be a very clearly defined set of operational guidelines in the Operations Manual, accompanied by learning events to ensure sufficient clarity.

Technical design of the project is a substantial risk. The design is complex given its regional and multi-sectoral nature, with two coordinating and implementing agencies (WAHO and UNFPA) as well as six stakeholder countries. The project design with its multiple sub-components also adds to the general complexity in a relatively weak capacity environment. The project team will work with all clients to ensure that the design and the partnership and implementation arrangements of the project will be as simple as possible. It will rely on the expertise of UNFPA to ensure that the project is implemented in a smooth and timely fashion and that the central role that WAHO will play as the regional implementing agency will be closely supported by UNFPA and linked with key line ministries. Furthermore, Bank experience in health, education and social protection, and regular contacts with sectoral leaders at multiple levels, coupled with Bank experience with a variety of regional operations in the Africa Region and elsewhere, is incorporated into the design. Complexity of the project moreover will be mitigated by the role of the Regional Steering Committee providing oversight, and intensive Bank supervision during implementation.

Relatively weak implementation capacity of national level agencies including the MoH as well as the capacity of WAHO to effectively coordinate the project could hamper the timely implementation of the project and the achievement of project outcomes. This includes insufficient fiduciary management capacity in terms of procurement, financial management, monitoring and reporting. The regional Project Steering Committee will guide overall project implementation and will be assisted by UNFPA which will bring its substantial expertise in managing and implementing projects in this field and take on a leadership role as an implementing agency along with WAHO. Extensive technical assistance will also be included in the project under Component 3 to build the capacity at all levels, including financial management, procurement, M&E, etc. Furthermore, the project has obtained support from the Bill and Melinda Gates Foundation to secure a Trust Fund to ensure additional financing for TA, Capacity Building and knowledge creation and dissemination.

There is also a substantial fiduciary risk. Although the project will be implemented by a seasoned PIU, there are still concerns, especially regarding procurement, such as (i) the limited experience in Bank procedures of staff from “Direction des Marches Publics – DMP” within the Ministry of Health and (ii) the difficulties to apply the Bank increased procurement thresholds at

national level. Several mitigations measures have been proposed, especially regarding thresholds to be used and capacity building efforts. These measures are described in annex 3.

Finally some stakeholders may not be fully committed. The project's inclusion of multiple agencies and with its focus on multiple beneficiaries (Ministry of Health, Ministry of Population, Ministry of Education, Ministry of Youth, ECOWAS, UNFPA, WAHO, multiple hubs, etc.) could impose high transaction costs and result in significant coordination challenges. This could also possibly dilute ownership of the project, thereby reducing its development impact. The risk of weakened focus and possible reduced ownership will be minimized through regular intensive interactions between line ministries, assisted by the Regional Steering Committee and the regional coordinating and implementing agencies. During preparation, efforts have been made to ensure that implementation arrangements are as clear and straight-forward as possible, with details on exact coordination channels outlined in the Project Implementation Manual of the project. The World Bank team will also closely monitor the coordination and will work with all partners to make adjustments during implementation, if necessary. The leadership of WAHO and UNFPA as regional implementing agencies, with support from ECOWAS will also bring more cohesion, urgency, and accountability to project implementation.

Implementation

A. Implementation arrangements

12. **In Burkina Faso, project implementation will be supervised by a national steering committee (NSC),** to be composed of representatives of the following entities:
    a. Ministry of Economics and Finance (MEF) (Direction générale de l'économie et de la planification or DGEP);
    b. Ministry of Health (MoH) (Direction Générale de la Santé or DGS)
    c. Ministry of National Education and Alphabetization (MNEA)
    d. Ministry of Social Action and National Solidarity (MSANS) (Direction Générale de la promotion de la famille et des services sociaux or DGPFSS)
    e. Ministry of Women Promotion and Gender (MWPG) (Direction générale de la promotion de l'entrepreneuriat féminin or DGPEF)
    f. Ministry of Secondary and Higher Education
    g. UNFPA
    h. Civil Society Organizations (CSOs).

13. **The NSC will be chaired by the Secretary General of the Ministry of Health.** The NSC will meet at least twice a year. Its responsibilities are to (i) review progress in the implementation of the project and (ii) to consider and approve the annual action plan for national activities and the annual activity report.

14. **The secretariat of the NSC will be the responsibility of the PADS Management Unit (UG or Unite de Gestion) .** The project will be implemented by the "Programme d'Appui au Développement Sanitaire" (PADS) of the Ministry of Health, which has the necessary

staff for the mission. Additional staff will be recruited as needed including an M&E specialist. Each of the line ministries (MS, MASSN, MESS, MENA, MPFG and MEF) should designate a focal point, with whom the PADS will work for implementation.

B. Financial management

15. **A Financial Management (FM) assessment of the SWEDD project was conducted in September 2014, by the Bank's FM team**, in accordance with the new Financial Assessment Principles. During its assessment, the Bank's FM team consulted the various texts establishing the national institutions in charge of implementing the Project and reviewed the fiduciary arrangements of proposed implementing entities which have experience in managing IDA financing (Health Sector Support & Multisectoral AIDS Project - P093987 and Reproductive Health Project - P119917). A review of the FM capacity of the entities involved in the implementation of the SWEDD project identified inherent and control risks, for which the team developed corresponding mitigation measures. The residual control risk is Moderate. The proposed FM arrangements for this Project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP 10.00. The implementing entities are compliant with the Bank's FM requirements and there are no overdue audit reports and interim financial reports from these entities.

C. Procurement

16. **Procurement assessments for the entities in charge of implementing SWEDD in Burkina Faso have been completed**. The overall risk for procurement (prior to mitigation measures) is considered moderate. For a total amount of US$26 million, equivalent to 13% of the total financing of the SWEDD project, UNFPA will sign a TA agreement with each of the countries[7]. UNFPA has been selected on the basis of its unique track record in designing and implementing population-related interventions in the Region. The detailed assessment is provided in Annex 4.

D. Citizen Engagement

17. **The proposed Additional Financing (as well as the Parent project P150080) will significantly strengthen engagement**, through its components 1.2 (women and girls empowerment) and 3.1 (accountability). Component 1.2 will focus on interventions for empowering beneficiaries through girls' education, economic empowerment and life-skills training. Similarly, component 3.1 will strengthen capacities of Community-Based Organizations to monitor Government commitments in demographic dividend.

V. World Bank Grievance redress

18. **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

[7] For an amount equivalent to 13% of the financing

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

BURKINA FASO

SAHEL WOMEN'S EMPOWERMENT AND DEMOGRAPHIC DIVIDEND PROJECT
Results Framework

19. **As Burkina Faso was always intended to be reintegrated into the SWEDD project, only minor changes to the project-level results framework approved by the Board on December 18th, 2014 would need to be made.** A first group of indicators is at regional-level (e.g. number of regional evaluations). Consequently, associated target values would not change whether there are five or six countries included in the project. A second group of indicators, (mostly those related to component 1 on gender) has estimates for target values. The parent project PAD clearly mentioned (on p.29) that these estimates would be updated during a restructuring, once the countries have completed a process of a regional call for proposals, which will define which sub-projects to be implemented. Therefore, only the last group of indicators needs target values to be revised upward as a result of the integration of Burkina Faso.

Project Name:	SWEDD AF for Burkina Faso (P154549)			Project Stage:	Additional Financing	Status:	FINAL
Team Leader(s):	Christophe Lemiere	Requesting Unit:	AFCRI	Created by:	Christophe Lemiere on 17-Mar-2015		
Product Line:	IBRD/IDA	Responsible Unit:	GHNDR	Modified by:	Christophe Lemiere on 21-Mar-2015		
Country:	Africa	Approval FY:	2015				
Region:	AFRICA	Lending Instrument:	Investment Project Financing				
Parent Project ID:	P150080	Parent Project Name:	Sahel Women's Empowerment and Demographics Project (P150080)				

Project Development Objectives

Original Project Development Objective - Parent:

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

Proposed Project Development Objective - Additional Financing (AF):

Results

Core sector indicators are considered: Yes

Results reporting level: Project Level

Project Development Objective Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
No Change		☐	Percentage	Value	5.50	5.50	2.20
				Date	22-Oct-2014		22-Oct-2018

	Percentage of drop-out in secondary schools among participating adolescent girls			Comment			
No Change	Percentage of participating adolescent girls and women (10-19) with improved knowledge on RMNCHN	☐	Percentage	Value	28.50	28.50	58.50
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of young women (16-19) participating in life-skills or livelihood interventions	☐	Number	Value	0.00	0.00	210000.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	A regional framework contract for purchasing RMNCHN commodities is in place	☐	Number	Value	0.00	0.00	1.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
Revised	Number of students enrolled in the regional hubs (for retraining as a midwifery faculty)	☐	Number	Value	0.00	0.00	299.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			Addition of Burkina Faso
Revised	Number of countries with a Demographic Dividend observatory which is functional and part of the regional observatory network	☐	Percentage	Value	0.00	0.00	6.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			Addition of Burkina Faso
No Change	Number of completed regional evaluations (related to girls' empowerment and demographic impact)	☐	Number	Value	0.00	0.00	5.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of regional-level knowledge sharing events	☐	Number	Value	0.00	0.00	8.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
No Change	Percent of test audience who recall seeing or hearing a specific message related to the campaign	☐	Percentage	Value	0.00	0.00	70.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Percent of test audience who has RMNCHN knowledge	☐	Percentage	Value	25.50	25.50	55.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of girls who benefited from schooling interventions (transportation services, accommodation, food, school supplies, additional courses, UCT or CCT)	☐	Number	Value	0.00	0.00	87900.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of adolescents, women and men who have been reached by SBCC interventions	☐	Number	Value	0.00	0.00	4400000.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of country experiences (component 1.2) that have been peer reviewed by other countries	☐	Number	Value	0.00	0.00	10.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of countries that have adopted a drug regulation consistent with WAHO/WAEMU directives	☐	Number	Value	0.00	0.00	4.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of drug regulation staff that have been trained	☐	Number	Value	0.00	0.00	86.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			

No Change	Number of labs that have achieved GPCL compliance	☐	Number	Value	0.00	0.00	1.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
Revised	Number of countries with a functional logistics management information system (LMIS)	☐	Number	Value	0.00	0.00	6.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			Addition of Burkina Faso
No Change	Number of prequalified contraceptive products registered in the 5 countries	☐	Number	Value	0.00		20.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of individuals who have received training in new midwifery/RMNCH competencies (through new short and longer term training programs)	☐	Number	Value	0.00		9550.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of regional high-level meetings held for monitoring policies, financial commitment and results linked to demographic dividend	☐	Number	Value	0.00	0.00	8.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			
No Change	Number of persons trained on demographic / population analysis at regional level	☐	Number	Value	0.00	0.00	293.00
				Date	22-Oct-2014		22-Oct-2018
				Comment			

20. **Baseline and targets for indicators related to component 1.2 of the Project (women's and girls' empowerment) will need to be updated at the beginning of the Project (through a restructuring).** Indeed, this sub-component will support setting up a regional evaluation mechanism to approve, finance and evaluate adolescent girls' programming in the six countries. At the

beginning of the Project, a call for proposals will be launched and the six countries will prepare and propose young women's and girls' empowerment subprojects in selected areas. Then, these subprojects will be evaluated and approved by the regional steering committee before implementation. With such a design it is therefore not possible before the subprojects (and the targeted areas) are selected to provide accurate baseline and target values data for interventions under component 1.2.

Breakdown of the Result Framework for Burkina Faso

		Target Values			
Project Development Objective Indicators	**Baseline**	**2015**	**2016**	**2017**	**2018**
1. Percentage of drop-out in post primary among participating adolescent girls (up to 19 years)	5.5	5.5	4.7	3.4	2.2
2. Percentage of participating adolescent girls with improved knowledge on RMNCHN	28.5	32.2	38.8	47.5	58.5
3. Number of young women participating in life-skills or livelihood interventions	0	0	12000	20000	45000
4. A regional framework contract for purchasing RMNCHN commodities is in place	(REGIONAL LEVEL indicator)				
5. Number of students enrolled in the regional hubs (for retraining of training as a midwifery faculty)	0	10	20	30	40
6. Number of countries with a Demographic Dividend observatory which is functional and part of the regional observatory network	0	0	0	0	1
7. Number of completed regional evaluations (i.e. end-line data) (related to girls' empowerment and demographic impact)	0	0	0	1	1
8. Number of regional-level knowledge sharing events	(REGIONAL LEVEL indicator)				
Intermediate Outcome Indicators	**Baseline**	**2015**	**2016**	**2017**	**2018**
Percent of target audience who recall seeing or hearing a specific message related to the campaign	0	65	68	70	70
Percent of target audience who has RMNCHN knowledge	25.5	28	33	42	55
Number of girls who benefited from schooling interventions (transportation services, accommodation, food, school supplies, additional courses, UCT or CCT)	0	0	2500	4500	6000
Number of adolescents, women and men who have been reached by SBCC interventions	0	98,000	391,000	684,000	860,000
Number of country experiences (component 1.2) that have been peer reviewed by other countries	(REGIONAL LEVEL indicator)				
Number of additional countries (Burkina Faso) that have adopted a drug regulation consistent with WAHO/WAEMU directives	0	0	1	1	1
Number of drug regulation staff that have been trained	0	0	20	40	60
Number of labs that have achieved GPCL compliance	(REGIONAL LEVEL indicator)				
Number of countries with a functional logistics management information system (LMIS)	0	0	1	1	1
Number of prequalified contraceptive products registered in the 6 countries	0	0	10	15	20
Number of individuals who have received training in new midwifery/RMNCH competencies (through new short and longer term training programs)	0	0	0	0	2500
Number of regional high-level meetings held for monitoring policies, financial commitment and results linked to demographic dividend	(REGIONAL LEVEL indicator)				
Number of persons trained on demographic / population analysis at regional level	0	20	80	120	143

ANNEX 2 – DETAILED DESCRIPTION OF PROJECT ACTIVITIES

Overview of budget allocation by activity for Burkina Faso

1. Component 1

1.1. Launch a regionally-coordinated communication campaign

Project activities	USDm	Detailed activities	Type of expenditure
1.1. Launch a regionally-coordinated campaign	0.20		communication

1.2. Set up a regional fund for designing, financing and evaluating country programs in women and girls empowerment

This sub-component 1.2 will fund sub-projects on the following topics:

Project activities	USDm	Detailed activities	Type of expenditure
Interventions for girls education	5.40	Cash transfers for girls	cash transfers
		Supplies for girls	goods
		Transportation for girls	
		Accommodation for girls	equipment, operating costs
		Support for families	
		Prizes for girls	
		Gender-focused training/sensitization for teachers	
Sensitization for girls and adolescents	4.60	Support to youth centers	
		Set up of a phone line for youth	
		Sensitization for men ("*école des maris*")	communication, equipment, operating costs
		School-based sensitization	
Interventions for economic empowerment of women	5.80	Training for women cooperatives and financial support for women	training
		Training for out-of-school girls	
		Rehabilitation of women training centers	
Sub-total	**15.80**		

2. Component 2

2.1. Foster regional harmonization of registration and quality control of Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCHN) Commodities

This sub-component 2.1 will include the following activities:

Project activities	USDm	Detailed activities	Type of expenditure
1) Harmonize and strengthen regulatory systems for RMNCHN products	1.20	Capacity strengthening for the pharmaceutical directorate	training, equipment
2) Improve quality controls through support to a network of quality control labs	0.30	Capacity strengthening for the national quality control lab	
Sub-total	1.50		

2.2. Strengthen country efforts for enhancing the performance of their RMNCHN supply chain

Several activities will be funded through this sub-component:

Project activities	USDm	Types of expenditures
Strengthening of local drug transportation system	1.00	
Capacity building for districts	1.50	
Mobile technology for drug inventory monitoring	0.50	
Sub-total	**3.00**	

2.3 Establish a regional tracking system for stock levels of contraceptives
.

This activity will be carried out by UNFPA.

2.4. Support rural midwifery training institutions in target countries to increase the quantity and quality of midwives and other personnel involved in RMNCHN health

This sub-component will support 3 activities:

Project activities		USDm	Types of expenditures
1) Building capacity of one (or two) large mid-level sub-regional training institution	Scholarship for sending faculty students	1.00	scholarships
2) Strengthening quality assurance and regulation of	Carried out by WAHO		

midwifery education at regional level			
3) Strengthening capacity of rural midwifery training institutions	Capacity strengthening for midwifery/nursing schools	1.00	equipment
	Capacity strengthening for internships sites	2.00	equipment
	Capacity strengthening for clinical supervisors	1.00	training, operating costs
Sub-total		**5.00**	

3. Component 3

3.1. Strengthen Advocacy and Political Commitment on RMNCHN at regional and national levels

The two activities here are carried out by UNFPA:
1) Create a regional monitoring and accountability mechanism on demographic dividend
2) Help the creation of or strengthen existing regional networks with parliamentarians, religious and traditional leaders, and civil society organizations

3.2. Strengthen Capacity for policy making, monitoring and evaluation related to demographic dividend issues

This sub-component will support the following activities:

Project activities	USDm	Types of expenditures
Surveys for the regional observatory	1.00	data collection
Capacity strengthening for the national observatory	0.90	training, equipment
Regional training for demographers and statisticians	0.80	training
Sub-total	**2.70**	

3.3. Strengthen project implementation capacity

Project activities		USDm	Types of expenditures
3.3. Strengthen project implementation capacity	Support to project implementation	2.00	consultants, IT and office equipment, vehicles, workshops, operating costs

The government will provide additional funding to cover implementation costs.

The total amount allocated to each subcomponent adds up to a total of US$30.2 million. An additional US$4.6 million of the financing will be allocated to UNFPA for technical support and coordination, totaling US$34.8 million for Burkina Faso.

<u>Description by component</u>

Component 1: Generate demand for RMNCHN services by promoting SBCC and empowering women and girls

This component will help improve the lives of women and adolescent girls in the Sahel region by supporting regional initiatives to deliver a number of critical interventions that seek to 1) increase the demand for and use of quality RMNCHN services consistent with a voluntary, rights-based approach; 2) improve sexual and reproductive health knowledge and practices; 3) delay marriage and pregnancy; and 4) enhance girls' autonomy, social networks, and participation to enable informed decision-making.

1.1. Launch a regional campaign and support national social and behavior change communication (SBCC) campaigns on RMNCHN services

<u>The Global Evidence Base</u>

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 RMNCHN commodities (e.g. oral rehydration salts, water purification tablets, insecticide-treated bednets, 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* program in Senegal focuses on community education and mobilization, and engages communities to pledge public declarations against harmful practices such as early marriage.[i] *Tostan* claims a large number of converted communities through documented pledges, results on actual declines in child marriage are less conclusive.[ii]. There is also a potential for testing a regional effort in Islamic advocacy, as showed by promising experiences from Mauritania.

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.

Project Financing to Support and Add onto the Global Evidence Base on SBCC

To improve the impact of national SBCC programs, project funds will be used to launch a regionally coordinated communication campaign. Communications strategies targeting policy makers, religious and community leaders, media practitioners, as well as communities and other stakeholders will be developed and activities implemented in partnerships with civil society

organizations, including women's organizations, faith based organizations, celebrities and media outlets. The media campaigns will incorporate gender informed messages into existing campaigns, including through social media, radio, television, newspapers, community media, online communication and other relevant outlets. Such a campaign would also include messages from high-level champions, which would raise awareness among policymakers of issues surrounding access to RMNCHN services. The main languages understood in the region will be used, in addition to French. The content would be locally generated so as to be most relevant and culturally appropriate. In particular, the campaign will involve religious leaders to refine its messages and the key audiences as well (women, girls and young people) to ensure community participation.

The regional campaign will be coordinated by the UNFPA regional office and will be rolled out in the 6 countries. A communication agency will be subcontracted to lead the campaign.

For this component 1.1, the activities and the allocation of project budget are the following (in USD Million):

	Burkina	**Chad**	**Côte d'Ivoire**	**Mali**	**Mauri-tania**	**Niger**	**UNFPA**
Launch a regional and support national social and behavior change communication campaigns	0.2	0.68	0.30	2.50	0.75	3.25	2.00

1.2. Set up a regional evaluation mechanism for designing, financing and evaluating country programs in women's and girls' empowerment.

Girls and women in all the selected countries are facing gender inequality issues that constrain their agency, influence their fertility preferences, and reduce demand for contraception. Addressing these gender gaps early on is critical, as low levels of empowerment and unproductive employment are especially detrimental for adolescent girls and have long-lasting effects on later stages in life and the next generation. It is important that interventions begin at early ages to have the greatest impact since (i) adolescent outcomes can have long-term effects throughout the life cycle; (ii) it is important to reach young women before they have children to break the inter-generational transmission of poverty and its associated outcomes; and (iii) behavior change may be easier to achieve among younger people.

Projects developed under this component will seek to address the key drivers of early marriage and childbearing in the Sahel region through approaches that have been proven successful. Namely, the key drivers that will be addressed under this project component include:

(i) **Knowledge deficits around RMNCHN health and services**. Insufficient knowledge about reproduction, the existence of contraceptive methods and services (including how contraceptives work, side effects, costs, how to access, etc.) can reduce the perceived risk of becoming pregnant and the desire to avoid it.

(ii) **Financial constraints and gender norms in marriage markets.** Scarce family resources can reduce the relative cost of early marriage and childbearing. Early marriage most often

occurs in poor, rural communities; girls living in poor households are almost twice as likely to marry before age 18 than girls in higher income households. Unable to provide for their schooling and care, poor families may see a daughter as an economic burden to be shed through marriage. Families also often perceive marriage as a way to provide for their daughter's future, although in actuality girls who marry young are more likely to be poor and remain poor.[iii] Economic gains through the marriage of a daughter may also motivate poor families. In South Asia and sub-Saharan Africa, marrying girls is paired with exchanging wealth between the bride's and groom's families—in the form of a dowry or a bride price.[iv]

(iii) **Limited aspirations and opportunities for the future.** If perceived or actual future opportunities are limited, the costs of marriage and childbearing may be lower. The opportunity cost of childbearing is higher for more educated and employable women. Young women with fewer opportunities may adjust thus their aspirations and expectations towards short-term targets.

(iv) **Women's (particularly young women's) low bargaining power to negotiate and implement decisions about sex, fertility decisions and use of contraception.** Women with increased decision-making power within the household can better negotiate their own preferences for fewer children.

Empowering women and adolescent girls to effectively achieve their desired fertility is key for achieving other health and development goals, in particular achieving the demographic dividend through their participation in the labor market. Women are often disempowered as consumers in the health market and in their interactions with health service providers. Women are also disempowered within the household, manifesting in low bargaining power to negotiate and make informed decisions about sex, fertility decisions and use of contraception. Furthermore, low bargaining power results in constraints in mobility and resources (thus impacting access to health information and services).

A first issue is that most people **do not have adequate access to information** about available contraceptive methods and associated advantages and disadvantages, including information on the side-effects of each method. Youth are particularly disadvantaged in this regard, and youth-friendly service provision, while necessary, is insufficiently available in most Sahelian settings. Also, **low bargaining power is itself partially explained by the low economic power of women**. Across 34 countries, about one-third of married or cohabiting women report that they cannot refuse sex – the figure exceeds 70 percent in several Sahel countries, including Senegal, Mali, and Niger. On average, across 15 countries for which data are available, 11 percent of women report that their first sex was forced.[8] Furthermore, the share of women (particularly young women) who face opposition from husbands or family members over the use of contraception remains significant in many countries.

And poor educational outcomes disempower adolescent girls and women – this is evidenced by **low school enrollment of girls,** especially at secondary school level. Social norms are motivating parents to marry their daughters very early. But, beyond these social norms, it appears that girls' access to secondary schools is hindered by logistical and cost issues. Secondary school is generally not free, and even small tuition fees, and the cost of textbooks and uniforms can be

[8] Analysis of DHS, most recent surveys.

prohibitive. Secondary schools are usually further from home than primary schools, and transportation may not be may not be available and when available, too expensive. Adequate accommodation and food for girls may also not be available. Crucially, school quality and learning outcomes are often poor, thus making schooling much less attractive an option. Further, for many girls and their families, the opportunity cost or lost income for the period that girls spend in school when they could be working is too high. These factors reinforce the decisions made by parents not to send their daughters to school and to marry them early. Early marriage and childbearing are both a cause and a consequence school leaving.

The mechanisms of change underlying projects within this component include: (i) empowering girls and women with knowledge and skills to effectively achieve their desired fertility; (ii) widening the set of educational and economic opportunities available to girls and young women such that there are increased incentives and demand to delay marriage and pregnancy; and (iii) creating a supportive community environment in which girls and women can pursue opportunities and exercise choice concerning their family formation decisions.

The following section outlines successful program approaches that address all or a sub-set of the aforementioned barriers, and that have achieved impact through one or more of these mechanisms of change.

<u>The Global Evidence Base</u>

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:

- Health: age of marriage; pregnancy; risky sexual behaviors; use of condoms and other contraceptives; sexual and reproductive health knowledge and attitudes
- 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.)

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

(i) Strengthened provision of reproductive health education and life skills;
(ii) Economic empowerment interventions; and
(iii) Enhanced access to secondary education for girls

There is growing evidence that life skills interventions[9] 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, FGM, and education.

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

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, FGM, 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.

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% and incomes by 80%. 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.

Finally, schooling interventions have been shown to result in lower rates of adolescent marriage, HIV, and school dropouts. 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. 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 enrolment 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.

Communities must be engaged to achieve significant social change, particularly around the issue of early marriage. Adolescents seldom have sole decision-making power over their health and development outcomes. Mobilizing and educating parents and community members is typically implemented within broader programs targeted to adolescent girls. Interventions include

one-on-one meetings with parents or community meetings and education sessions, committees and forums to guide services for girls, communication campaigns, and public announcements and pledges by community gatekeepers. For example, the rigorously evaluated *Maharashtra Life Skills Program* in India engaged parents and adults in committees and forums to guide the life skills and SRH curricula. A key finding from the evaluation was that communities must be involved to change social norms that discourage youth's access to SRH information and services. In less than three years, girls' age at marriage increased by one year (from 16 to 17), unmarried girls experienced greater self-confidence and an increased ability to negotiate with parents, married women's knowledge and use of health services increased, and decision-makers in young married women's lives showed greater support for young women's reproductive health needs. [v]

A systematic review of adolescent girl programs evaluated to-date (Hallman et al, 2012) finds that programs that were shown to improve health status, behaviors, and mediators general share the following characteristics:

- were single-sex, girl-only interventions
- included girls younger than 14 years of age
- were offered to rural populations
- had a follow-up period of more than 12 months
- used a multi-level intervention approach
- provided a safe space in the community for girls to regularly meet in groups
- offered financial education or savings training
- had a rights training element
- employed age- or grade-specific targeting and content

However, there is limited evidence from Sahel region, and this project presents a tremendous opportunity to build, innovate, test, and scale.

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[i] 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.
[ii] 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.
[iii] Pande R, K Kurz, S Walia, K MacQuarrie, and S. Jain. 2006. "Improving the Reproductive Health of Married and Unmarried Youth in India: Evidence and Effectiveness and Costs from Community-Based Interventions." Washington DC: ICRW.

Project Financing to Support and Add onto the Global Evidence Base on Adolescent Girls' Programming

Based on the evidence, the project will support Governments to empower women and girls through a number of strategies that meet a diverse set of needs by reaching different age groups and risk profiles:

(i) Strengthened provision of reproductive health education and life skills;
(ii) Economic empowerment; and
(iii) Enhanced access to secondary education for girls

Practically, a call for proposals will be issued at the regional level. Through this call for proposals, each Government will have to propose one or several layered sub-projects addressing the above-mentioned issues. Each proposal will have to be prepared in collaboration with UNFPA teams. A meeting of the regional steering committee will rate the various proposals and will propose two decisions on each proposal: (i) full acceptance or (ii) revision.

Each proposal will have to comply with the following criteria:

- the proposal targets cross-border areas (where inter-country migration movements are frequent);
- the proposed interventions are based on evidence, including an assessment of the key bottlenecks at local level;
- the proposed interventions fit within the categories of interventions described above, and leverage the potential complementarities between them;
- the proposed interventions are consistent with existing interventions (i.e. no overlapping with other Government or donor funded programs);
- the proposed interventions can be replicated in the other Sahel countries;
- the proposal embeds a rigorous evaluation (preferably experimental or quasi-experimental) that measures a common regional set of outcomes that impact adolescent girls' and women's empowerment; and
- the proposed implementing arrangements involve Community-Based Organizations (CBOs)[10], Civil Society Organizations (CSOs) and/or local councils and take advantage of existing projects' institutional arrangements (for instance, where cash transfers for girls are proposed, they will have to use existing registries and systems).

Participating countries have already planned their funding allocation for their sub-projects. They are described below (numbers remain indicative).

[10] Including community-based management committees for schools (i.e. COGES in Mali and Burkina).

1. Strengthened reproductive health education and life skills

	Burkina	Chad	Côte d'Ivoire	Mali	Mauritania	Niger
Planned allocation (in USD million)	**4.60**	**3.59**	**4.69**	**5.00**	**0.89**	**6.50**
Creation of and/or support to safe space for girls (or adolescents)	✓	✓		✓	✓	✓
Sensitization on early marriage / childbearing	✓	✓	✓			✓
Community-based sensitization for boys and husbands (e.g. "husbands' school")	✓			✓	✓	✓
School-based sensitization on reproductive health		✓				✓
Sensitization on household and lifesaving skills			✓			

2. Economic empowerment

	Burkina	Chad	Côte d'Ivoire	Mali	Mauritania	Niger
Planned allocation (in USD million)	**5.80**	**1.56**	**3.40**	**4.50**	**1.16**	**6.50**
Basic training for out-of-school girls and women	✓	✓	✓	✓	✓	✓
Funding for women/mother cooperatives	✓	✓	✓	✓	✓	✓
Support to income generating activities for women	✓	✓	✓	✓	✓	✓

3. Girls education

	Burkina	Chad	Côte d'Ivoire	Mali	Mauritania	Niger
Planned allocation (in USD million)	**5.40**	**6.00**	**4.70**	**1.74**	**4.98**	**4.50**
School transportation for girls					✓	
Accommodation and food for girls	✓	✓			✓	✓
Cash transfer / scholarships	✓	✓			✓	✓
Prizes for best students	✓		✓	✓		
School supplies	✓	✓		✓	✓	
Support for vulnerable schooled girls	✓	✓	✓	✓	✓	
Training on gender for teachers			✓		✓	✓

While sub-projects will be implemented by countries, UNFPA will be in charge of (i) supporting countries for designing their sub-projects and (ii) evaluating the sub-projects.

Overall, for component 1.2, the budget breakdown is the following:

Project activities	Burkina	Chad	Côte d'Ivoire	Mali	Mauri-tania	Niger	UNFPA
1.2. Set up a regional fund for designing, financing and evaluating country programs in women and girls empowerment	15.79	11.65	12.99	11.24	7.03	18.00	5.50

Component 2: Strengthen Regional Capacity for Availability of RMNCHN Commodities and health workers

2.1. Foster regional harmonization of registration and quality control of Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCHN) Commodities. Specifically, the component would finance three activities.

The component will set up the pre-requisites for a regionally-pooled procurement mechanism for RMNCHN commodities. To that effect, the component will foster regional harmonization of registration and quality control of RMNCHN Commodities. It would finance the following activities.

First, it will support the regional harmonization and strengthening of regulatory systems for medicines. Harmonizing medicines registration in the sub-region is an essential step for (i) shaping markets in the region, in particular for prequalified generic products and (ii) reducing costs of medicines registration. To that end, ECOWAS/WAHO has produced "Common Technical Document" (CTD) for medicines registration. The project will support the adoption and implementation of these CTDs in the participating countries. Harmonized quality and information systems are also required to facilitate collaboration between the regulatory authorities. Regional task-forces coordinated by WAHO will address these issues. Building upon the success of the harmonization process in the East African Community, twinning programs and joint technical assessments will be established as an effective mechanism to strengthen the capacity of national medicines regulatory authorities, so that they can adequately perform their registration duties.

Secondly, the component will strengthen the capacity of post-market surveillance systems and a regional network of quality control labs, with the objective of selecting from this network one laboratory that will be brought to international standards (pre-qualified by WHO and/or ISO-certified) and will become the regional reference laboratory for quality control tests. Currently, basic quality control tests for drugs (including RMNCHN commodities) are first carried out by national quality control labs, but, when a second (or "referral") test is requested by a drug manufacturer, it is carried out outside the Sahel region. Such referral tests can indeed be conducted only by labs that have been deemed by WHO as compliant with Good Practices for National Pharmaceutical Control Laboratories (GPCL) and relevant parts of WHO Good Manufacturing Practices (GMP). In Africa, there are currently only 6 of such labs. None of them is in the Sahel or in West or Central Africa.[11]. The investments supported by the component would allow for improvements in post-market surveillance systems and for the labs of the selected countries to reach minimum acceptable standards. These regional laboratories will thus specialize to provide services (e.g. quality control; support with drug resistance surveys; higher-level testing, including second line drug susceptibility testing and molecular diagnostics) to other laboratories in neighboring countries, thus reducing the need to ship specimens to laboratories on other continents. Overall, by the end of the project, this regional approach would significantly reduce the need (and associated costs) to request drug quality control tests outside the Sahel region.

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[11] Two in South Africa, two in Kenya, one in Tanzania and one in Algeria. See http://apps.who.int/prequal/lists/PQ_QCLabsList.pdf for the latest list of these labs.

These activities will be implemented by the countries, under WAHO leadership, which is already coordinating such efforts in the ECOWAS region, and with technical support from WHO, UNFPA and/or other technical agencies (e.g., US Pharmacopeia).

Thirdly, the component will also help setting up a regional mechanism for better tracking and monitoring stock levels of contraceptives. Through this IT supported network interested parties can monitor stock levels at various levels, in particular at central warehouses and high volume facilities in target areas. This will result in improved matching of demand and supply from existing sources and improve visibility across the different supply chains, thus facilitating the creation of a regional procurement system.

2.2. Establish a regional mechanism to support country efforts for enhancing distribution of RMNCHN commodities. There is strong evidence that stockouts of RMNCHN commodities at the end user level may not be the result of a lack of commodities at national level but rather the result of a weak distribution (especially for the "last-mile" distribution). This "last-mile" issue is especially frequent for reproductive health products[12]. It is also quite prevalent in rural and cross-border areas, which are usually far from the national or regional drug warehouse. Therefore, the component will support technically and financially requests from countries to improve the distribution part of their RMNCH commodities supply chain.

From a technical perspective, a hub of experts will be established in the regional office of UNFPA. They could be UNPFA employees, secondees from the commercial sector or NGOs as well as consultants. These experts will provide and/or facilitate the technical assistance requested by the countries and build capacity at the national level through joint assessments.
This hub will also provide capacity building for national supply chain managers and facilitate regional knowledge sharing.

The technical experts will assist countries and ensure they submit proposals for their national supply chain strengthening component that:

- target cross-border areas where inter-country migration movements are frequent (see map at the end of this annex);
- are based on a thorough assessment of "last-mile" distribution issues and is linked to an approved national strategy on drug distribution;
- are replicable in neighboring countries;
- embed a rigorous evaluation and peer review (i.e. countries are involved in evaluation of other countries proposals); and
- are innovative, meaning that it implies (i) use of IT technologies (including e-health or mobile health), (ii) involvement of the private sector, (iii) vendor- or district- managed inventory models, or (iv) involvement of communities (including community health workers).

[12] The main reason is that reproductive health commodities are usually provided for free to women (in the Government sector). Consequently, health facilities do not get any profit from providing these commodities and thus are prone not to provide (and stock) them.

The component will also address the need for better visibility across national supply chain systems by the establishment of an IT-supported tracking system of stocks (this could include dashboards with national stock levels of contraceptives).

Overall, for Component 2.1 and 2.2, the activities and the allocation of project budget are the following (in USD Million):

Project activities		**Burkina**	**Mali**	**Niger**	**Côte d'Ivoire**	**Chad**	**Mauri-Tania**	**UNFPA**	**WAHO**
2.1. Foster regional harmonization of registration and quality control of Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCHN) Commodities	1) Harmonize and strengthen regulatory systems for RMNCHN products	1.20	1.58	1.00	0.50	0.90	0.07	1.25	1.00
	2) Improve quality controls through support to post-market surveillance and a network of quality control labs	0.30	2.20	2.40	0.40				0.23
2.2. Establish a regional mechanisms that will support country efforts for enhancing the performance of their RMNCHN supply chain systems		3.00	4.79	6.00	3.00	1.20	0.51	3.75	
TOTAL		**4.50**	**8.57**	**9.40**	**3.90**	**2.10**	**0.58**	**5.00**	**1.23**

2.3. Strengthening regional capacity to increase availability and quality of health workers with midwifery[13] skills in rural parts of the Sahel.

RMNCHN services in the Sahel region are provided by different types of health workers, including community health workers, midwives, nurses and physicians. Although midwives, more than any other cadre, are educated to deliver critical primary health care services ranging from family planning, sexual health education and counselling to antenatal, postpartum and newborn care[14], all cadres have a role to play in providing call called midwifery services. Whilst most midwives in the Sahel are trained for the standard period of 3+ years, global evidence such as the Midwifery Lancet series (June 2014) suggests that some basic SRMNH competencies can also be carried out by alternative, non-traditional cadres, for example nurses, auxiliaries or community lay workers who have been provided with a core set of midwifery skills. What is important is that such cadres are adequately trained to deliver clearly defined services, that they are adequately remunerated and subsequently supervised and mentored, and that they are closely integrated into the formal service delivery sector.

[13] The component seeks to enhance midwifery skills, among midwives, nurses and other qualified personnel. It is thus not limited to midwives only.

[14] WHO, 2009: The role of primary health-care providers in sexual and reproductive health: Results from an inter-country survey. Geneva.

A key problem is that most health workers with midwifery skills end up in urban areas after their training, inadequately motivated or ill-prepared to deliver services in rural areas and challenging work environments. Part of the problem lies in the current training model for health workers: health worker students, including midwifery students, mainly come from urban areas[15]; training is primarily carried out in urban settings; curricula and training strategies focus on theory over practice, inadequately preparing health workers for the realities or needs of rural service; and graduates are usually recruited nationally without being informed about the location of their future job. As such, few graduates are willing to take up posts in rural areas, as they are tied to urban based family and partners, they benefit from career development and additional income generation opportunities, are used to better living and working conditions, and trained to deliver services in well-equipped and managed health facilities. Those that do take up rural posts often stay for short periods only, as they find themselves struggling to provide services in challenging environments where equipment and commodities are in short supply, fellow health workers are often absent, and where management and accountability systems are often weak.

Global evidence suggests that so called "rural pipeline" strategies can significantly increase the availability, accessibility, acceptability and quality of health workers with SRMNH competencies in rural areas. So called "rural pipeline" strategies can improve rural job uptake and retention of health workers, as well as improve competence and motivation, by decentralizing education to rural areas, focusing on the selection of students from rural areas (as opposed to urban), emphasizing practical and applied learning in rural environments (over theoretical learning), delivering new courses for the development of alternative cadres with specific rural expertise (for example rural health extension workers), and providing on-site mentoring and support following rural placements. Additional information on the rural pipeline concept to increase the chances of rural uptake after graduation is provided in the box below.

Box: Overview and principle of Rural Pipeline Strategies

Various studies have proved that the so called "rural pipeline strategies" for healthcare providers can help address the above issues of training, deployment and retention in rural areas by various means, such as:

a) primarily selecting interested students from rural areas through career promotion (e.g scholarships; incentives regarding job prospects; value added in communities) and community engagement;
b) ensuring the students are adequately trained, mentored and supported to serve rural healthcare needs;
c) setting up of properly equipped rural healthcare units that can also serve as internship sites for students and
d) system of incentives for serving in rural areas, for example with mechanisms to ensure trainees return and serve in the disadvantages areas with a benefit package for a minimum of years before they consider moving to other places

[15] Mainly because the admission tests to these schools are national and therefore more easily passed by urban applicants.

Applying the 'rural pipeline' concept to the midwifery workforce would help fill the critical resource gap in rural areas where the needs for maternal, newborn and child survival are greatest by ensuring that midwifery students are selected from and deployed to rural areas after undergoing competency based trainings in all the requisite skills.

For the "rural pipeline" concept to be effective, there is additional need for adequate health system policies and regulations; appropriately structured educational programmes designed to address specific needs of rural areas; incentive structure (scholarships, jobs); a supportive environment, better living and working conditions. At times, some kind of "bonding schemes" may be necessary to ensure that the rural students, who are trained using scholarships, indeed return back to practice in rural areas for a specified duration.

Various 'rural pipeline strategies' have been successfully applied in several countries such as Afghanistan, Bangladesh, Indonesia, Malawi, Zambia, Mozambique as well as Burkina Faso, Mali, Benin, etc. in the West Africa region. It is important that the issues of deployment, retention and regulation be simultaneously addressed to ensure programme success. In Afghanistan, for instance, the community midwifery programme proved hugely successful because students were selected from rural areas with community engagement, trained and then sent back to practice in rural areas to practice with assured jobs. In Bangladesh, the government has assured and created a budget line for 3,000 jobs for trained midwives. In Burkina Faso positions for human resources for health have been opened per region at sub national levels to facilitate the posting of newly recruited midwives in decentralized areas. In Zambia, South Sudan, Mozambique and Brazil a bonding system was established and students who received scholarships to become midwives had to sign a bond to serve in rural areas before they could seek redeployment to other areas of the countries. In Benin, recent opening of civil servants positions in specific areas of the country are intended to improve equitable distribution and retention of health workers.

A key constraint in the implementation of rural pipeline strategies and the production of a RMNCHN workforce lies in overall capacity constraints of education institutions. Regional assessments of the pre-service education of midwives across the Sahel identified key technical, organizational and physical capacity constraints related to midwifery education in the region (WHO, WAHO, UNFPA 2014), hampering progress on improving the availability and quality of health workers with RMNCHN skills in the region. Midwifery institutions located in more rural areas are particularly weak. The following summarizes some of the key findings from the assessments:

Box A2.1: Summary of Midwifery Training Capacity Weaknesses in Sahel

Technical capacity is a major issue: Adequately trained faculty and clinical instructors are short in supply and will be needed to implement any envisioned rural orientated and tailored training strategies. Recent assessments of midwifery institutions across the Sahel have pointed to major technical capacity limitations, in terms of the number and quality of both faculty and clinical instructors (at practicum sites), particularly in more remote training institutions in the Sahel. Furthermore, recent WAHO requirements in the region require midwife faculty to hold a master's level degree (up from secondary qualifications required previously) resulting in a massive shortage

of required qualified midwifery faculty. Currently no institution in the Sahel is offering the required master level training, with such program development costly and capacity intensive.

Organizational capacity is another issue: Organizational capacity of midwifery training institutions needs is weak and needs to be strengthened to develop, implement, manage and monitor training strategies including those that maximize retention, competence and motivation of health workers in rural areas (rural pipeline policies). Admission strategies currently tend to favor students from urban backgrounds, training is largely theoretical (rather than applied), and few strategies or incentive schemes are developed to motivate staff, clinical instructors, supervisors or rural mentors. Few training institutions moreover have explored opportunities to deliver theoretical training models through e-learning technology (freeing up time of scarce faculty to focus on applied training), or developing non-traditional training programs alongside traditional midwifery programs, such as shorter term certificates on RMNCHN for alternative new or existing cadres (with training durations of 1month-1 year).

Physical capacity constraints are a further challenge. Across the Sahel region, health training institutions or satellite sites, particularly in rural areas, often lack adequate teaching equipment and supplies to carry out required training. Particularly problematic is the lack of well-equipped rural practicum sites linked to training institutions, both in terms of equipment and supplies and clinical supervision capacity. This is a key reason why training strategies have not been able to emphasize practical and applied over theoretical training.

Moreover, at a regional level accreditation of midwifery education continues to be weak and not harmonized. Regional accreditation and regulatory efforts (by WAHO) remain under-developed and inadequately linked to national accreditation bodies. WAHO is planning to develop a new regional accreditation and regulatory body with strong links to national level accreditation agencies; however existing levels of capacity to carry out this function are limited. Accreditation and regulation in addition to regional level harmonization, adaptation of curricula and training strategies is needed particularly for midwifery faculty training, and rural midwifery schools and programs (both traditional or alternative)

In light of these challenges, there is currently strong regional commitment to strengthen midwifery competencies in the Sahel. Recognizing the importance of midwifery skills in the region, Governments and partners alike have raised the issue of midwifery development to the forefront of the development agenda in recent years. Regional commitment culminated in a multi stakeholder workshop in Cotonou in 2013[16], which published a regional declaration calling for urgent action to: scaling up the number of qualified midwifery faculty and clinical supervisors in the region; strengthening competency based training models in midwifery training institutions; invest in (rural) internship sites so that they are in accordance with regional norms and standards; use of e-learning in education in pre-and in-service training of midwives, and move towards a regional accreditation mechanism for midwifery schools and faculty (WAHO norms).

[16] The workshop in Cotonou 2013 brought together stakeholders from across the Sahel countries (HRH directors, Midwifery Associations, Muskoka reps, WAHO, UNFPA, WHO etc) to take stock of the midwifery situation in the region and agree on critical areas of investment.

Interventions on midwifery skills education in the region are best carried out in a coordinated and harmonized manner. Health workers move across the region in the Sahel, meaning that one type of training in one country can affect the service delivery quality in another. Furthermore, scaling up midwifery education is costly, and few institutions currently possess the required physical and technical training capacity required to provide masters level training to nurses/midwives faculty. Other functions (e.g. curriculum harmonization, accreditation, e-learning modules etc) will be developed in a more cost-effective and streamlined way if done at regional level. Moreover, regional institutions already exist to support these tasks (WAHO, FASFACO, AMREF, and Midwifery Association for Francophone Africa). A further rationale for regional level intervention is linked to the political economy and special interests surrounding midwifery education. Midwives usually hold a weak political position in each Sahel country, and national midwifery associations often block innovation. Bringing the issue of midwifery training, and particularly rural pipeline strategies to the regional level, will strengthen the bargaining position of midwives and should lead to the implementation of bolder, more effective and innovative policies.

Accordingly, this sub-component will strengthen regional capacity to increase availability and quality of health workers with midwifery[17] skills in rural parts of the Sahel. Drawing on the Cotonou Declaration, and increasing the emphasis on a rural pipeline approach, proposed priority actions supported under this component in the 6 target countries can be categorized into three main areas:

1. **Strengthening the capacity of WAHO to carry out harmonized strategy development, accreditation and regulatory functions related to midwifery training.** This includes strengthening capacity to :
    - Develop and disseminate a regional strategy and curricula for harmonized training approaches for rural midwifery (i.e. harmonized approaches to training of community lay workers, auxiliaries, nurses and midwives in midwifery competencies).
    - Develop new tools and carry out accreditation of midwifery training and midwifery faculty training, including training sites such as internship sites
    - Develop and carry out regulatory activities on midwifery
    - Amend midwifery faculty training strategy and oversee midwifery faculty training implementation.

2. **Strengthening two regional hubs, so that they can train the trainers/faculty of all the 6 countries on new midwifery faculty training curricula:**
    - strengthening the physical, organizational, and technical capacity of the two regional training hubs (and satellite training centers and internship sites in rural areas) to deliver a WAHO accredited midwifery faculty training program for the region (equipment and supplies, management, training of trainers etc…)
    - Finance scholarships for individuals from the 6 target countries to train as midwifery faculty in the regional training hubs (as well as relevant allowances).

[17] The component seeks to enhance midwifery skills, among midwives, nurses and other qualified personnel. It is thus not limited to midwives only.

3. **Strengthen the capacity of rural midwifery training institution to graduate quality workers for the rural labor market in the 6 target countries:**
    - o strengthening the physical, technical and organizational capacity of rural and cross-border schools to deliver relevant rural training programs, including
        - Strengthening equipment and supplies of rural schools, including of rural internship sites
        - Supporting implementation of rural pipeline policies (including support for students from rural areas) and strengthening management capacity to monitor and administer such policies
        - Strengthening the capacity of clinical supervisors/mentors at internship sites to supervise practical learning experience

Capacity building and support towards each of these activities will be provided by UNFPA who will work closely with the implementing agencies, leverage and draw on existing technical knowledge, work closely with partners including the World Health Organization (whose mandate to strengthen HRH in the region is substantial), and lead policy discussions on complementary reforms needed to accompany these training interventions. They include interventions related to rural deployment, and management and supervision of HRH once health workers with midwifery skills are posted. The support provided on midwifery fits into a larger strategy in the region, that is supported by other partners also, which focuses on addressing these critical non training related interventions which are required to ensure actual employment in rural areas, and retention following the training.

Overall, for Component 2.3, the activities and the allocation of project budget are listed in the table below (in USD Million). Details pertaining to each of these interventions are discussed in greater detail in the paragraphs below:

Project activities	Burkina	Chad	Côte d'Ivoire	Mali	Mauri-tania	Niger	UNFPA	WAHO
a) Strengthening the capacity of WAHO to carry out harmonized strategy development, accreditation and regulatory functions related to midwifery training.							1.50	1.27
b) Strengthening two regional hubs, so that they can train the trainers/faculty of all the 6 countries on new midwifery faculty training curricula:	1.00	1.00	1.50	3.70	0.45	0.40	2.00	
c) Strengthen the capacity of rural midwifery training institution to graduate quality workers for the rural labor market in the 6 target countries:	4.00	4.50	3.00	2.59	1.00	5.00	3.50	1.50
Total for 2.4	**5.00**	**5.50**	**4.50**	**6.29**	**1.45**	**5.40**	**7.00**	**2.77**

a) Strengthening the capacity of WAHO to carry out harmonized strategy development, accreditation and regulatory functions related to midwifery training.

The project will support strengthening the capacity of WAHO (the health arm of ECOWAS) to carry out its regional mandate or quality assurance and harmonization related to the education of health workers with relevant RMNCHN skills. The ultimate goal is to increase the quality of training and thus health workers with rural relevant RMNCHN skills, by strengthening WAHO capacity to develop and oversee and coordinate adoption of training strategies, standards regulation and accreditation of learning environments. In order to strengthen the quality of health worker education across the region, implement desired rural training strategies, and ensure adoption of common norms and training standards, sufficient capacity will be needed at the level of WAHO to carry out coordination, regulatory and accreditation activities of midwifery related training sites and programs across the Sahel region. UNFPA and WHO will play a critical normative role in working jointly with WAHO to carry out the required activities and to build relevant capacity within WAHO to do so.

Financing will be provided towards the following specific activities:

Activities	**USD (million) WAHO**	**USD (million) UNFPA**
Develop and harmonize and disseminate harmonized training approaches, strategies and guidelines for rural midwifery training (including for community lay workers, auxiliary cadres, nurses and midwives)	0.07	0.20
Develop new tools and carry out accreditation of midwifery training and midwifery faculty training, including training sites such as internship sites (the role of WAHO is to work closely with governments to set up and carry out national and regional accreditation on midwifery).	0.20	0.10
Develop and disseminate norms, standards and regulation of midwifery in the Sahel (jointly with the regional midwifery association)		0.10
Oversee and coordinate the midwifery faculty development program of the two hubs (i.e. amendment of faculty curricula and strategy for rural training approaches – i.e. increasing period of practical experience in rural areas). WAHO will work closely with CAMES on this.	1.00	0.10
Supporting design and implementation of rural midwifery strategies in the region (including training for HR directors, workshops and studies)		1.00
TOTAL	**1.27**	**1.50**

b) Strengthen the capacity of two training institutions to emerge as regional hubs for rural midwifery faculty training

The project will help two large mid-level training institutions strengthen their capacity to emerge as regional centers of excellence responsible for delivering a new (WAHO-accredited) rural midwifery faculty and clinical instructor training program for the region. The goal is to increase the number of midwifery faculty and clinical instructors in the region who are sufficiently trained to deliver a quality, rural orientated training program in rural midwifery schools (during and beyond the project timeframe). The project will support strengthening the technical, organizational, physical and financial capacity of the selected regional hub to develop and deliver the envisioned WAHO accredited rural faculty and clinical instructor training programs.

The institutions to host the so called *Regional Faculty Skills Development Hubs* (RFSDH) are the INFSS in Bamako and the INFAS in Abidjan. They were selected based on the criteria that they were large mid-level cadre training institutions, with regional ambitions, existing capacity, and proven commitment and desire to carry out the envisioned faculty and clinical instructor training program for the region. The interventions related to the regional hub that will be supported under this project will be developed and implemented in close collaboration with WAHO, UNFPA, Regional and National Midwifery Associations, and WHO. Close collaboration will also be sought from CAMES. A brief overview of the training institution that will be supported to fulfill this regional faculty training role is provided in box A2.1 below.

Box A2.1: Overview of the Training Institution which will emerge into the regional hub

1. INFSS Mali
The INFSS is located in Bamako, but has branches in Mopti, Kayes, Segou and Sikasso.
It provides pre-service education to nurses and midwives, as well various health technicians.
It also offers Master-level training in several areas, including reproductive Health.

2. The **INFAS (Institut National de Formation des Agents de Santé)** is located in Abidjan, Côte d'Ivoire. Beyond the two main facilities in Abidjan, the INFAS also operates 3 additional sites: Bouake (Center), Korhogo (North) and Aboisso (South). It plans to open four new branches: Daloa, Abengouou, San Pedro and Man. The INFAS provides two different types of training.
1. First, it offers pre-service education to nurses, midwives and Health Technicians ("*Techniciens Supérieurs de Santé").* For these three degrees, the training duration is 3 years. All candidates must have a secondary degree. There are currently 2,548 students enrolled for obtaining these degrees.
2. Secondly, the INFAS is offering 2-year specialization for nurses, midwives and health technicians. 530 students are enrolled for these specialization degrees. The INFAS has 121 full-time faculty and about 250 part-time faculty. None of them are educated at masters level.

The *Regional Faculty Skills Development Hubs (RFSDHs)* will deliver both short and longer term training programs (tailored certificates and masters level degrees) for existing and new midwifery faculty and clinical instructors across the region, and equip them with the relevant skills and qualifications needed to deliver rural orientated training programs. Midwifery Faculty training will follow an adapted form of the WAHO faculty training curricula (2 year training of bachelor level nurses and midwives), and focus on applied learning in rural environments and surroundings, in a decentralized environment, equipping midwifery faculty with the relevant skills to deliver a rural orientated training program back in their home institutions. Whilst the first year faculty training will be carried out in the regional hub, the second year training will be carried out in a rural environment and facility in the home country (supervised by staff from the school). Each faculty trained and provided with a scholarship will be required to return to, or be hired into, the rural midwifery training institutions they originated from. Clinical Instructors, which are linked to the local rural training institutions, working at internship sites in rural areas across the region on the other hand will be provided with training in-country. These are shorter yet intense on site applied training sessions carried out in-country by the regional hub experts or others.

The two regional hubs will be provided with financing for the following activities:

	CÔTE d'IVOIRE (INFAS)	**MALI (INFSS)**
1. Funding for a mix of qualified PhDs and qualified nurses and midwives to deliver the faculty training program at the hub in year 1. This can be retired nurses/midwives, and relevant professors in each country.	0.50	1.70
2. Scaling-up of the physical capacity of the hubs (including minor upgrading and repairs and procurement of required equipment and supplies for training purposes) so as to accommodate the faculty students	1.00	2.00
TOTAL	1.50	3.70

The four other countries will fund scholarships (through the project) to send their students to the regional centers of excellence. They will also be provided funding to finance very experienced senior nurses and midwives to carry out supervision of the faculty training program (in year 2) which takes place in the country of origin of the faculty student. In addition, the in-country training of clinical supervisors/mentors (as organized by the regional hubs) of the regular midwifery training program will also be financed by the countries. All activities will be carried out in close collaboration with WAHO, UNFPA and WHO.

	Burkina	**Chad**	**Mauritania**	**Niger**	**UNFPA**
Scholarships for sending students to the regional training hubs (for year 1)	- Number: 10 per year (total: 40) - Cost: $1m	- Number: 44 - Cost: $1m	- Number: 10 per year - Cost: $0.45m	- Number: 10 per year - Cost: $0.40m	
Financing national level training and supervision for year 2 of faculty training program (carried out in the sending country in a relevant rural environment)					0.50m
In-country **training** of Clinical Supervisors (certificate) for the practical component of regular (non-faculty) midwifery training curricula.					0.50m
TOTAL					1.00m

c) Strengthen the capacity of rural midwifery training institution to graduate quality workers for the rural labor market in the 6 target countries:

The project will support midwifery training institutions in the 6 target countries in the Sahel (in particularly those from rural and cross-border areas) strengthen their organizational (i.e. management) and physical (i.e. infrastructure and equipment) capacity so that they can step up efforts to develop and implement a rural pipeline approach to training quality health workers with RMNCHN (or midwifery) skills. These interventions complement the strengthening of technical (i.e. teaching) capacity built through the faculty training intervention discussed above. The overall goal is to increase the number and quality of health workers with profiles and training to deliver midwifery services in challenging rural and cross-border environments (during and beyond the timeframe).

Table: Midwifery Institutions supported in each target country

	Institutions to be targeted
BURKINA	National School of Public Health and its regional subsidiaries, and 4 private schools
CHAD	Schools of Abeche, Sahr, Moundou and N'Dkjamena
CÔTE D'IVOIRE	- INFASS
MALI	- INFSS - schools of Kayes, Segou, Mopti and Sikasso
MAURITANIA	- schools of Rosso, Nema, Selibabi
NIGER	- the two government schools: Nimaey and Zinder - five private schools: Agadez, Diffa, USB of Maradi, ISPS of Tillabéri, and IPCSP of Tahoua

Health workers produced will largely be "traditional" midwives, but some countries, depending on demand, may complement "traditional" midwifery training with new innovative training approaches of alternative cadres, for example one year trained health extension workers, or approaches to provide short term RMNCHN certificate skills training to existing lower level cadres (such as health assistants, community lay workers, auxiliaries or nurses). Global experience (including the recent Lancet series on midwifery (2014)) has shown that alternative cadres and so called "task shifting" approaches can make a significant and positive contribution to rural service delivery (Ethiopia being a good example), complementing and supporting the existing traditional workforce, and filling gaps as needed.

Rural pipeline training strategies (strengthening education institutional in rural areas, ensuring intake of students who come from rural areas, exposing students to rural practicum sites, strengthening practical over theoretical training etc) and related capacity building activities that will be supported under the project will go hand in hand with policy discussions at the level of the Ministry, to ensure that subsequent recruitment of health workers produced is aligned with training location and strategy (i.e. so that a midwife trained in rural area x, for example, is also subsequently recruited in rural area x), and that health workers recruited are adequately mentored and supported once deployed. The interventions will be developed and implemented in close collaboration with WAHO, UNFPA, Regional and national Midwifery Associations, WHO and the designated regional hub.

Specifically, financing will be provided towards the following:

Financing will support strengthening the organizational, physical and financial capacity of midwifery training institution in the 6 countries to develop and implement a rural pipeline strategy to training health workers with midwifery (RMNCH) competences.

Objectives	Cost items to be funded	Burkina	Chad	Côte d'Ivoire	Mali	Mauri-tania	Niger	UNFPA	WAHO
SCHOOLS									
Assessing and monitoring capacities of schools	- consultants - workshops							0.50	0.50
Strengthening physical and	- equipment - supplies	1.00	0.80	1.50	1.00	0.50	??		

organizational capacity of rural schools	- training on data management and rural pipeline implementation plans							0.40	
Supporting students from rural areas	- full scholarships for rural students - refresher courses for rural candidates and to provide them with pre-admission training to bring them up to speed.							1.50	
CLINICAL TRAINING SITES and CLINICAL SUPERVISORS									
Supporting clinical supervisors (aside from training them, which is addressed above)	- transport and accommodation if needed, - incentive schemes for clinical supervision or mentoring	1.00	2.35	0.90	0.59			1.00	
Strengthening the capacity of clinical training sites	- equipment - supplies	2.00	1.35	0.60	1.00	0.50			
OTHER									
Adapting and delivering the theoretical part of the curricula as an e-learning module	- training - IT							0.10	1.00
TOTAL		**4.00**	**4.50**	**3.00**	**2.59**	**1.00**	**5.00**	**3.50**	**1.50**

Component 3: Foster Political Commitment, and Capacity for Policy Making and Project Implementation

3.1. Strengthen Advocacy and Political Commitment on Demographic Dividend at regional and national levels. This would be achieved through two main activities:

The project will first support the **creation of a regional monitoring and accountability mechanism on demographic dividend**. Practically, the project will strengthen collection of data related to the demographic dividend. These data will allow a better monitoring (i) policies for achieving the demographic dividend (description of policies, status of endorsement and implementation), (ii) fiscal commitments for demographic dividend (budget amounts that are committed and executed), and (iii) results. Each country will collect these data, while the regional secretariat (UNFPA, in coordination with CERPOD[18]) will have to aggregate them and prepare an annual report on progress made regarding demographic dividend. This report will be presented to the regional steering committee. This activity will therefore include expenditures for (i) data collection tasks (national and regional levels), (ii) Data analyses and development tools for

[18] See box below

advocacy and policy dialogue and (iii) advocacy tasks. These should result in the creation of a demographic dividend focused monitoring mechanism at regional level and an increased political evidence based engagement at country level

The CERPOD: Centre d'Etudes et Recherches sur Population & Développement

The « *Comité Permanent Inter-états de Lutte contre la Sécheresse dans le Sahel* » (CILSS) is a sub-regional organization with a membership of 13 countries from West and Central Africa : Burkina Faso, Bénin, Cape Verde, Côte d'Ivoire, Gambia, Guinea, Guinea Bissau, Mali, Mauritania, Niger, Sénégal, Togo and Chad. The CILSS and its member-states have endorsed the Programme of Action of the 1994 International Conference on Population and Development held in Cairo.

To support the implementation of the ICPD programme of action, the CILSS and its member states have drafted and adopted in 1997 the Programme of Action of Ouagadougou (PAO). Within the CILSS, a department of the Institut du Sahel (INSAH) is in charge of supporting member-states for population policies. This department is the CERPOD (*Centre d'Etudes et Recherches sur Population & Développement* or Center for Studies and Research on Population and Development).

The CERPOD is currently the only Sahelian organization with an explicit mandate for supporting regional coordination on population issues. Through UNFPA, the project will support the CERPOD to fulfill its mandate. More precisely, the project will support the CERPOD in its role of coordinator of the regional network of DD observatories, which will imply support (i) to set-up and maintain a database of population data and (ii) to train policymakers and experts in analyzing these data.

The component will also **help the creation of or strengthen existing regional networks with parliamentarians, religious and traditional leaders, and civil society organizations**.

Existing regional networks are – for instance – the ***"Forum des Parlementaires Africains sur la Population et le Développement"*** **(African Parliamentary Forum on Population and Development which has regional component). These regional networks identified and assessed for their consistency will be supported through training and funding of meetings, and demographic dividend monitoring activities.** Data on budget allocations and results related to demographic dividend issues will be collected regionally and will be discussed within these regional networks. The component will support the collection of data and the operating costs of these networks.

The expected result is to have demographic dividend policies promoted in the region with full participation and support of parliamentarian networks, youth organizations, civil society organizations and faith based organizations at regional level. In countries, demographic dividend policies should be developed with full participation and support of the parliamentarians and various Civil Society Organizations and could be promoted at community level.

To increase impact, training activities will go beyond individuals to help support networks in each country. In addition, sensitization and social mobilization activities will be carried out by parliamentarians during the inter session periods in the different countries on population issues.

Regional and national training and orientations will target a diversity of actors in each country, including actors involved in national statistics systems as well as those implicated in population issues and leaders of society (parliamentarians, religious leaders, journalists, youth and women's organizations, NGOs).

The budget for this activity 3.1 will be the following:

	UNFPA
1) Create a regional monitoring and accountability mechanism on DD	- collection and reporting of regional data (with CERPOD): 1.04 million
2) Help the creation of (or strengthen existing) regional networks with parliamentarians, religious and traditional leaders, and civil society organizations	- training and workshops for regional networks: 0.96 million
TOTAL	**2 million**

3.2. ***Strengthen Capacity for policy making, monitoring and evaluation related to demographic dividend issues.*** The component will strengthen the countries' policymaking and analytical capacity on demographic dividend issues. In practice, the project will fund a regional network of "*demographic dividend (DD) observatories*". Each country will host a DD observatory, while regional coordination of these observatories will be carried out through UNFPA (and CERPOD). These observatories will (i) collect data related to population issues, (ii) analyze these data and (iii) prepare annual reports/briefs for policymakers. To carry out these tasks, the project will fund (i) data collection, (ii) capacity building (training and equipment) and (iii) dissemination events.

The national DD observatories will be located in the following departments:

- **BURKINA**: INSD (Institut National de la Statistique et de la Démographie)
- **CHAD** : INSEED (Institut National de la Statistique et des Etudes Economiques et Démographiques)
- **CÔTE D'IVOIRE** : ONP (Office National de la Population)
- **MALI** : DNP (Direction Nationale de la Population)
- **MAURITANIE** : ONS (Office National de la Statistique)
- **NIGER** : INS (Institut National de la Statistique)

As part of the capacity building for the regional network of observatories, financial as well as technical support will be provided to a sub-regional demographic dividend oriented training program for population studies and demography both through scholarships and through the creation of a graduate degree in demography and demographic dividend oriented economics in one or two countries' universities of the region, depending on the existing situation to build on. Through this activity, the selected training institutions and/or universities in the Sahel region will be equipped with enough capacity to develop appropriate DD training programs including research and study at regional scale.

To establish the DD observatories in countries, the joint regional coordination (UNFPA et CERPOD) will: (i) Develop a concept and methodological document on observatories, (ii) Conceptualize the DD indicators to monitor by the observatories, (iii) Validate the conceptual and methodological document and the set of the DD indicators by national observatories and (iv) Support the creation and establishment of the regional observatory and national observatories.

These observatories will have to (i) collect data related to population issues, (ii) analyze these data and (iii) prepare annual reports/briefs for policymakers. To carry out these tasks, the project will fund (i) data collection, processing and analysis, (ii) training including in knowledge management methodologies, (iii) dissemination of results and (iv) advocacy material development.

The regional observatory will increase the availability of quality population data as well as data on policies for achieving the demographic dividend (description of policies, status of endorsement and implementation) in the region. At country level, national observatories will serve as information depository for population and development data (demographic, sociocultural, etc.), data on policies for achieving the demographic dividend (description of policies, status of endorsement and implementation) and will feed the regional observatory in charge of aggregating and coordinate the processing of the DD information in the Sahel region.

Given the peculiar situation of the region a real-time early-warning system will be created to provide data on key indicators in the Sahel region. These data will build greater understanding, monitor progress, and further catalyze an informed movement for women's empowerment driven by regional policy dialogue and political action. Not to create duplication in terms of data collection and for reason of efficiency, the observatories should be used for the data collection and processing while the early warning system will have its own analysis and functioning methods and approaches in order to do the scanning of the regional and national environment and provide the appropriate alert whenever needed. When a real-time early-warning system is in place this will ensure environment scanning in the region and a real time monitoring of the DD policies and mechanisms in place.

The component will also fund quality assurance activities to CRVS, DD oriented researches, studies and surveys (including DHSs, MICS), additional analysis of censuses, etc. to complement national projects surveys related to demographic dividend wherever a national project cannot support the costs. This support through the regional frameworks in place to promote demographic data collections, CRVS, and studies will enhance the knowledge base on DD in the region and strengthen the quality of the developed policies.

The budget (in US$m) for this activity will be the following:

	Bur-kina	**Chad**	**Côte d'Ivoire**	**Mali**	**Mauri-tania**	**Niger**	**UNFPA**
Surveys related to DD:	1.00	1.00	1.00	2.50	1.65	4.00	
Capacity building for DD observatories	1.70	0.40	0.61	1.50	0.50	1.50	1.00
Regional training on demographics		1.10	1.10	1.20	0.70	2.00	1.00
Sub-total	**2.70**	**2.50**	**3.41**	**5.20**	**2.85**	**7.50**	**2.00**

3.3. Strengthen project implementation capacity. The component will strengthen project management capacities for the implementing agencies, at national and regional (UNFPA and WAHO) levels.

	Bur- kina	Chad	Mali	Niger	Côte d'Ivoire	Mauri- tania	UNFPA
Staff, workshops and operating costs for the PIU: 1m	2.00	0.80	1.00	3.00	1.00	1.00	2.50

ANNEX 3 –

BURKINA - Financial Management, Disbursements and Procurement

Financial management

In accordance with the Financial Management Manual for World Bank-Financed Investment Operations that became effective on March 1, 2010, the financial management systems of the Sahel Women's Empowerment and Demographics Project has been assessed to determine whether it is acceptable to the Bank. To this end, the financial management aspects of the World Bank-financed Reproductive Health Project in Burkina Faso (RH), on which the proposed project will be entrusted, have been reviewed. The proposed project will follow an approach similar to the arrangements in place for the RH Project implemented by the Programme d'Appui au Développement Sanitaire (PADS), the Support Program for Health Development, that will be strengthened. The financial management performance of PADS was rated moderately satisfactory following the recent supervision mission. PADS has no overdue audit reports.

The overall FM risk is considered **Moderate**. The proposed financial management arrangements including the mitigation measures for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.00.

The review revealed that the following actions will need to be completed (i) the updating of the PADS's existing manual of procedures to capture the specificities of the new project, ensure adequate ownership by the new stakeholders, and strengthen the anti-corruption aspects; (ii) the recruitment of one additional Accountant dedicated to the new project; (iii) the configuration of the existing version accounting software to reflect the new project specificities; (iv) the extension of the work-program of the PADS's internal audit Unit to the new project; and (v) the recruitment of an independent external auditor in compliance with acceptable Terms of Reference.

Financial Management and Disbursement Arrangements

Country PFM situation

In terms of Public Finance Management (PFM), Burkina Faso has a strong track record and the World Bank has noted that economic and financial governance issues have been strongly addressed through reforms of public finances. The Public Financial Management Reform Program (*Stratégie de Renforcement des Finances Publiques*) adopted in 2007 has benefited from the financial support of most development partners. Its effective implementation over three years has facilitated the practice of untied budget support from multiple development partners through a Memorandum of Understanding. In view of this reform, the World Bank has granted its eleventh budget support operation to Burkina Faso. In addition, diagnostics in terms of transparency, reliability and efficiency in the management of public finances, conducted regularly since 2007 with the evaluation of Public Expenditure and Financial Accountability (PEFA) show that progress has been made by the government. Thus, the credibility of the budget has increased and the adequacy of the budgetary provisions has been

confirmed through coverage and transparency, policy-based budgeting, budget predictability and control of execution indicators.

Since 2009, progress has also been noted in the area of revenue mobilization through the implementation of the recovery unit approach (*Approche Unité de Recouvrement*), which helped raise the tax burden of 11.9 percent in 2008 to about 16.0 percent in 2012, which means that Burkina Faso is only one percentage short of the West African Economic and Monetary Union (WAEMU) minimum tax mobilization target of 17 percent. The same situation exists with the payroll management for public servants based on a biometric census of 2012 and the scope of the external audit is increasingly promoted by the Government through the strengthening of the Inspectorate General of Finances *(Inspection Générale des Finances*) operational capacity. The government commitment in favor of public finance reforms continued in 2011 by promoting an institutional change through the merger of the former Ministry of Finance and Budget with the Ministry of Economy and Development. To lead its mission effectively, the MEF has developed the Economy and Finance Sector Policy (*Politique Sectorielle de l'Economie et des Finances, POSEF*) which takes into account the *Stratégie de Renforcement des Finances Publique*s and the Economy and Development Management Strengthening Program (*Programme de Renforcement de la Gestion de l'Economie et le Développement*). The POSEF was adopted by the Council of Ministers on June 8, 2011 and is the contribution of the "Economy and Finance" sector to achieve accelerated growth and sustainable development in Burkina Faso. In addition, since 2005 the MEF has started to develop the Integrated Circuit for Donor-financed Projects (*Circuit Intégré des Financements Extérieurs, CIFE*). All the above cited measures are intended to ensure strong application of the WAEMU directives.

The CIFE, launched on April 7, 2011, following the final approval by the Council of Ministers held on March 2, 2011, is built on a computerized system and aims at applying the country PFM system at the projects level by involving key players of country system in project monitoring (Directorate General for Cooperation, Directorate of Budget, Directorate of Finance Control, and Directorate of Public Treasury, etc.). CIFE has six modules; two are already being utilized since 2008 (projects seeking funding, and preparation and monitoring of financing agreements). The four others which are in line with the national system for public finances include monitoring and budgetary control, mobilization, reimbursement and accounting for external funding, procurement, management and monitoring/evaluation. The application of CIFE interfaces with integrated national information systems such as *Circuit Intégré de la Recette, Système d'Information Intégré des Marchés Publics, Circuit Informatisé de la Dépense and Système de Gestion et d'Analyse de la Dette*. For now, CIFE is only operational at the central level but it is currently being decentralized to the project level. The proposed project will be channeled through CIFE as per the recommendations of the Bank analytical on Burkina Faso's PFM system. Upon satisfactory reconciliation of the financial data and decentralization of CIFE at project level, decision will be made to fully rely on CIFE. To this end, policy dialogue will be pursued with the aim to render CIFE fully operational at project level.

Implementing entity

The AF activities will be entrusted to the PADS Project implementation unit and rely on the Reproductive Health Project’s fiduciary arrangements that will be strengthened. For starting

the implantation of the Project (before effectiveness), the PADS may use retroactive financing up to SDR 1 million.

Risk Assessment and Mitigation Measures

The Bank's principal concern is to ensure that project funds are used economically and efficiently for the intended purpose. Assessment of the risks that the project funds will not be so used is an important part of the financial management assessment work. The risk features are determined over two elements: (i) the risk associated to the project as a whole (inherent risk), and (ii) the risk linked to a weak control environment of the project implementation (control risk). The content of these risks is described below.

Risk	Risk rating	Risk Mitigating Measures Incorporated into Project Design	Risk after mitigation measures
INHERENT RISK	**M**		**M**
Country level Poor governance and slow pace of implementation of PFM reforms that might hamper the overall PFM environment.	M	PFM reform programs have made significant progress in addressing the key challenges the country is facing.	M
Entity level No risk identified.	M	PADS is familiar with IDA FM procedures and is well staffed.	M
Project level None except additional workload.	M	Recruit one more Accountant recruited on competitive basis.	M
CONROL RISK	**M**		**M**
Budgeting No risk identified.	M	Budgeting procedures are well established and applied.	M
Accounting Risk of increasing of the FM team workload leading to some delays in the submission of the required reporting.	M	The current FM staffing arrangement is adequate but may be strengthened with one additional Accountant recruited on competitive basis.	M
Internal Controls and Internal Audit Weak compliance with FM procedures manual and of circumventing internal control systems	S	(i) Regular internal audit missions (technical and financial audit) will be conducted during the project	S

		implementation with a focus on fraud and corruption risk; and (ii) Update the work-program of the current Internal Audit Unit to reflect the new project specificities.	
Funds Flow - Risk of misused of funds and use funds to pay non eligible purposes or combined with other projects funds managed by PADS - Risk of misused and inefficient use of funds. - Weak capacity in the disbursement procedures of the World Bank which could affect the disbursement rate.	M	- Organize frequent controls in each involved actor in order to help to prevent and mitigate the risk of diversion of funds. - Payment requests will be approved by the Coordinator and the financial management specialist prior to disbursement of funds. - Require of the FM team to ensure monthly submission of the withdrawal application. - Perform external audit.	M
Financial Reporting (i) Delay in the submission of IFRs due to the increase in the PCU activities; (ii) format and content of the IFR may not be appropriate	M	(i) A computerized accounting system in place and adequate staffing arrangements are in place under the Reproductive Health Project (RH). (ii) The current content and format of the RH's IFR are acceptable to IDA. The IFR of the new project will use the same format and content.	M
External Auditing External audit arrangements are not defined and lack of capacity of public institutions of control to assure the external audit of the project	M	Recruitment of independent external auditor based on agreed TOR developed in line with International Accounting Standards (including fraud and corruption).	M
Governance and Accountability Risk of fraud & corruption	H	(i) The TOR of both internal audit unit and external auditor will comprise a specific chapter on corruption auditing (ii) the PIM will include anti-corruption	H

		measures with a specific safety mechanism that enables individual persons and NGOs to denounce abuses or irregularities ; (iii) Robust FM arrangements designed to mitigate the fiduciary risks; (iv) Measures to improve transparency such as providing information on the project status to the public, and to encourage participation of civil society and other stakeholder will be built into the project design.	
Overall FM risk	**M**		**M**

The overall risk rating at preparation is **Moderate**.

Financial Management Action Plan to reinforce the control environment

Issue	Remedial action recommended	Responsible entity	Completion
Staffing	Recruit one additional accountant dedicated to the new project.	PADS	Within three months after effectiveness
Information system accounting software	Upgrade the existing accounting software version to reflect the new project specificities	PADS	Within three months after effectiveness
Administrative, Accounting and Financial Manual of procedures	Update the current RH's manual of procedures (i) to include the specificities of the new project; (ii) ensure adequate ownership by the new players; and (iii) strengthen the anti-corruption aspects.	PADS	Within one month after effectiveness
Internal auditing	Update the work-program of the current Internal Audit Unit to reflect the new project specificities.	PADS	Within three months after effectiveness
External financial auditing	Recruitment of the external auditor acceptable to IDA	PADS	Within three months after effectiveness

Fraud and Corruption: The existence of several entities in charge of different types of controls (verifiers, independent controller, PADS internal audit unit, and the external audit arrangements) are concrete mitigation measures aiming at addressing the risk of fraud and corruption. Lastly a mechanism of sanctions of fraudulent cases will be developed and made publicly available.

Staffing and Training: PADS is staffed with a Finance Manager and four accountants all well experienced in the implementation of Bank-financed projects. One additional accountant will be recruited to reinforce the FM team in the perspective of the workload which the new project will generate. The team will have the overall FM responsibility over, budgeting, accounting, reporting, disbursement, internal control and auditing.

Budgeting: The budgeting arrangements designed for the ongoing Reproductive Health Project (RH) implemented by PADS will be applied for this project.

Accounting Policies and Procedures: The RH's manual of procedures currently used by PADS details the accounting policies and procedures which are in line with OHADA (*Organisation pour l'Harmonisation en Afrique du Droit des Affaires*) accounting principles. This manual of procedures will be revised to include the new project's specifics. The current RH's accounting software with multi-project, multi-site, and multi-donor will be updated to reflect the new project specificities. As per CIFE procedures, the project accounting transactions will be reflected into the national financial statements. This will improve reliability of the national financial statements.

Internal Control and Internal Auditing: Subject to revision of the manual of procedures, the existing internal control arrangements will be applied. The PADS's internal audit arrangement is acceptable and will be applied to the new project. The work-program of this internal audit unit will be revised within three months after effectiveness to take into consideration the project specificities. Ex ante control and control over delivery (*contrôle du service fait*) of procurement contracts above the national thresholds will be performed by the Directorate of Financial Control. The PADS internal audit unit will continue to perform its internal audit mission jointly with the Inspectorate of Ministry of Health and make use of the risk map developed in this Ministry.

Financial Reporting and Monitoring: The Project will use the same format of IFRs as Reproductive Health Project which will be automatically generated from the project's accounting software. The IFR includes (i) the statements of sources and used funds, and utilization of funds per category, (ii) the updated of the procurement plan, (iii) the physical progress, (iv) expenditure types and implementing agent, showing comparisons with budgets; (iv) Designated Account activity statements and explanation notes to the IFR; (v) and the summary of missions of internal audit as well as implementation status of the recommendations of internal or external audit and supervision missions. The IFR will be prepared by the PADS and submitted to IDA, 90 days after the end of each calendar semester. In compliance with International Accounting Standards and IDA requirements, the Project will produce annual financial statements. These include: (i) a Balance Sheet that shows Assets and Liabilities; (ii) a Statement of Sources and Uses of Funds showing all the sources of Project funds, expenditures analysed by Project component and category expenditures (iii) a Designated Account Activity Statement; (iv) an Implementation Report containing a narrative summary of the implementation progress of the Project; (v) a Summary of Withdrawals using SOE (transactions-based disbursement), listing individual withdrawal applications by reference number, date and amount; and (vi) Notes related to significant accounting policies and

accounting standards adopted by management and underlying the preparation of financial statements. The financial statements will be submitted for audit at the end of each year or other periods to be stated.

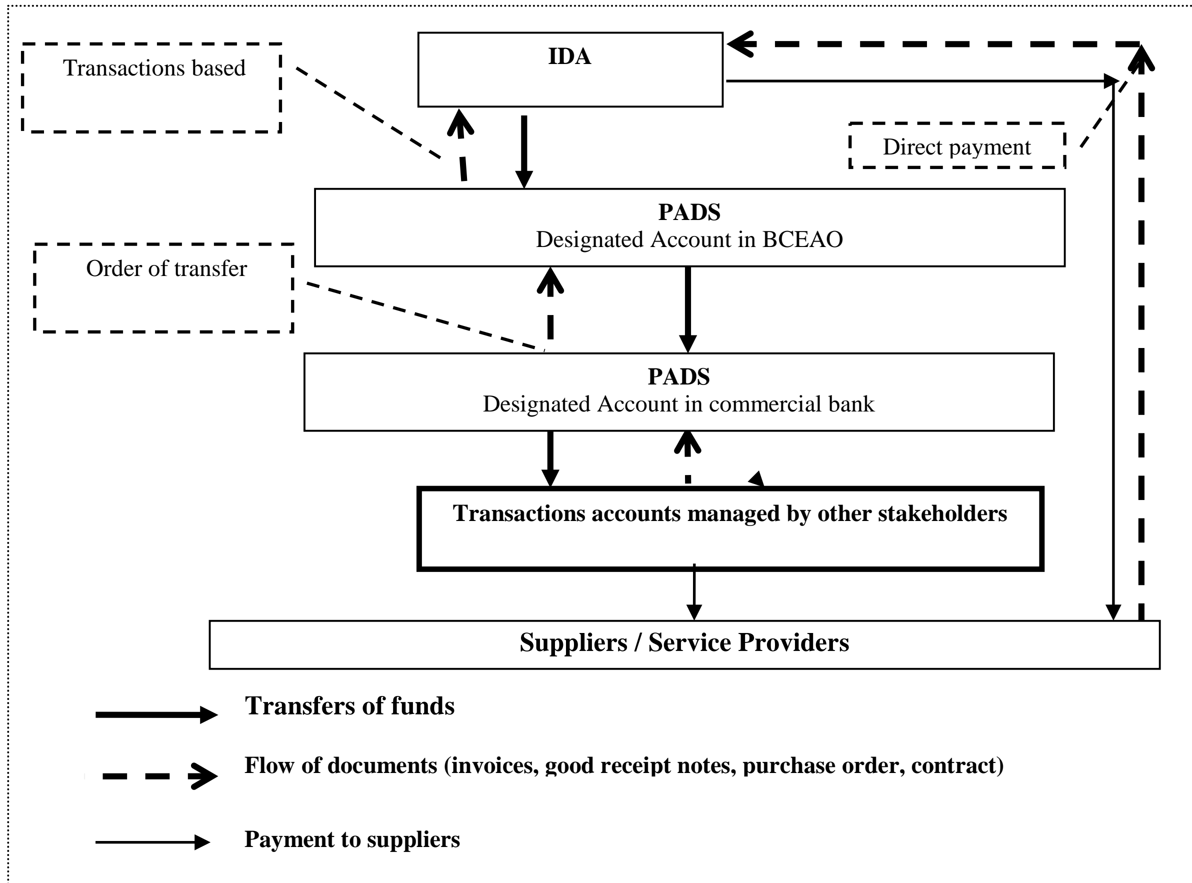
External Auditing: The project's financial statements and internal control system will be subject to external annual audit by an independent external auditor which will be recruited on ToRs acceptable to IDA. The external auditor will give an opinion on the annual financial statements in accordance with auditing standards of IFAC. In addition to audit reports, external auditor will also produce a management letter on internal control to improve the accounting controls and compliance with financial covenants under the financing agreement. The project will be required to submit, not later than six months after the end of each fiscal year, the annual audited financial statements of the previous year. In line with the new access to information policy, the project will comply with the disclosure policy of the Bank of audit reports (for instance making available to the public without delay after receipt of all reports final financial audit, including audit reports qualified) and place the information on its official website within one month after acceptance of final report by IDA.

Funds Flow and Disbursement Arrangements: A Designated Account (DA) will be opened in the Central Bank in Ouagadougou and will receive project proceeds on the basis of the project cash needs. Upon grant effectiveness of the financing agreement and request from the project, the Bank will deposit the initial advance indicated in the disbursement letter into DA. The DA will be used as a transit account and as such, funds will be transferred from the DA to PADS transactions account opened in a commercial bank acceptable to IDA. The Coordinator and the Financial Management Specialist will be joint signatories of these accounts. This DA will be managed according to the disbursement procedures described in the PIM and the Disbursement Letter (DL) for the Project. The ceiling of the account will be specified in the DL estimated to be the equivalent of four months of project cash needs and will take into account the Project's disbursement capacity. This ceiling will be set at XOF1.4 billion. This Designated Account will be used to finance all eligible project expenditures under the different components. Payments will be made in accordance with the provisions of the PIM (i.e. two authorized signatures will be required for any payment). The Designated Account will be replenished against withdrawal applications supported by Statements of Expenditures (SOE) and other documents evidencing eligible expenditures as specified in the Disbursement Letter. All supporting documents should be retained at the project and readily accessible for review by periodic IDA implementation support missions and external auditors.

Disbursement arrangements:

Disbursement method: Upon Grant/Credit effectiveness, transaction-based disbursements will be used during the first year of the project implementation. Thereafter, the option to disburse against submission of semester unaudited Interim Financial Report (also known as the Report-based disbursements) could be considered subject to the quality and timeliness of the IFRs submitted to the Bank and the overall financial management performance as assessed in due course. In the case of the use of the report-based disbursement, the DA ceiling will be equal to the cash forecast for the following semester unaudited Interim Financial Report. The option of disbursing the funds through direct payments to suppliers/contractors for eligible expenditures will also be available for payments equivalent to twenty percent (20%) or more of the DA

ceiling. Another acceptable method of withdrawing proceeds from the IDA Financing 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). The authority to sign the withdrawal applications is vested on the Ministry of Economy and Finance. The funds' flows diagram for the DA is as follows:



Disbursement of Funds to other Service Providers and Suppliers: PADS will make disbursements to service providers and suppliers of goods and services in accordance with the payment modalities, as specified in the respective contracts/conventions as well as the procedures described in the PIM. In addition to these supporting documents, the Project will consider the findings of the internal audit unit while approving the payments. PADS, with the support of its internal audit unit, will reserve the right to verify the expenditures ex-post, and refunds might be requested for non-respect of contractual clauses. Misappropriated activities could result in the suspension of financing for a given entity.

Implementation support Plan: The Bank's FM implementation support mission will be consistent with a risk-based approach, and will involve a collaborative approach with the entire Task Team. Based on the current overall residual FM risk, the project will be supervised 3-4 times a year to ensure that project FM arrangements still operate well and funds are used for the intended purposes and in an efficient way. A first implementation support mission will be performed three months after the project effectiveness. Afterwards, the missions will be

scheduled by using the risk based approach model and will include the following diligences: (i) monitoring of the financial management arrangements during the supervision process at intervals determined by the risk rating assigned to the overall FM Assessment at entry and subsequently during Implementation (ISR); (ii) integrated fiduciary review on key contracts, (iii) review the IFRs; (iv) review the audit reports and management letters from the external auditors and follow-up on material accountability issues by engaging with the task team leader, Client, and/or Auditors; the quality of the audit (internal and external) also is to be monitored closely to ensure that it covers all relevant aspects and provide enough confidence on the appropriate use of funds by recipients; and, (v) physical supervision on the ground specially; and (vi) assistance to build or maintain appropriate financial management capacity; (vii) The supervision mission will include transactions reviews of expenditures occurred.

Conclusions of the FM Assessment: The overall residual FM risk at preparation is considered **Moderate**. The proposed financial management arrangements for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.00.

Procurement

Guidelines. Procurement for 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 and revised July, 2014, "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 and revised July, 2014, and the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006 and revised in January 2011, and the provisions stipulated in the Financing Agreement. National Competitive Bidding (NCB) shall be in accordance with procedures acceptable to the Bank.

Procurement Documents. Procurement will be carried out using the Bank's Standard Bidding Documents or Standard Request for Proposal (RFP) respectively for all International Competitive Bidding (ICB) for goods and the selection of consultants. For National Competitive Bidding (NCB), the Borrower will submit a sample form of bidding documents to the Bank for prior review and, once agreed upon, will use this type of document throughout the project. The Sample Form of Evaluation Reports published by the Bank will be used.

Frequency of procurement reviews and supervision. Bank's prior and post reviews will be carried out on the basis of thresholds indicated in the following table. The Bank will conduct six-monthly supervision missions and an annual Post Procurement Review (PPR); the ratio of post review is at least one to ten contracts. The Bank could also conduct an Independent Procurement Review (IPR) at any time up to two years following the closing date of the project.

Procurement and Review Thresholds

Expenditure Category	Contract Value (Threshold)	Procurement Method	Contract Subject to Prior Review
	US$		**US$**
1. Works	≥ 10,000,000	ICB	All
	< 10,000,000	NCB	
	< 200,000	Shopping	
	No threshold	Direct contracting	≥ 100,000
2. Goods	≥ 1,000,000	ICB	All
	< 1,000,000	NCB	
	< 100,000	Shopping	
	<500,000	Shopping (Vehicles & fuel)	
	No threshold	Direct contracting	≥ 100,000
3. Consultants *Firms*	No threshold	QCBS; LCS; FBS	All contracts of 500,000 and more
	< 200,000	CQ	
Individuals	No threshold	IC (EOI) : ≥ 100,000 IC (at least 3 CVs) : < 100,000	All contract of 100,000 and more
	No threshold	Single Source (Selection Firms & Individuals)	≥ 100,000
All TORs regardless of the value of the contract are subject to prior review			

All training, terms of reference for contracts, and all amendments of contracts raising the initial contract value by more than 15 percent of the original amount, or above the prior review thresholds, will be subject to IDA prior review. All contracts not submitted for prior review, will be submitted to IDA post review in accordance with the provisions of paragraph 5 of Annex 1 of the Bank's Consultant Selection Guidelines and Bank's procurement Guidelines.

Procurement Plan. For each contract financed by the grant, the procurement plan will define the appropriate procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, the prior review requirements, and the time frame. The procurement plan will be reviewed during project appraisal and will be formally confirmed during negotiations. The procurement plan will be updated at least annually, or as required,

to reflect the actual project implementation needs and capacity improvements. All procurement activities will be carried out in accordance with approved original or updated procurement plans. All procurement plans should be published at the national level and on the Bank website according to the relevant guidelines. The Client and the Bank have agreed on a procurement plan covering the first eighteen (18) months of the Project dated March 25, 2015.

Procurement Filing. Procurement documents must be maintained in the project files and archived in a safe place until at least two years after the closing date of the project. The project Procurement Unit will be responsible for the filing of procurement documents, with support from the FMS.

Anti-Corruption. The Client will ensure that the project is carried out in accordance with the provisions of the Anti-Corruption Guidelines of the Bank: "Guidelines on Prevention and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006 and updated January 2011.

Assessment of the Agency's Capacity to Implement Procurement. Procurement activities and overall fiduciary responsibility will be carried out by PADS the current Coordination Unit of the Reproductive Health Project (RH) which is a structure depending of the Ministry of Health. This structure is very familiar with implementing of Bank-financed projects like "Projet de Developpement sanitaire - PDSN", "Projet Population et Lutte contre le Sida – PPLS" et "Projet d'Appui au Secteur de la Sante – PASS/Sida.

During the preparation phase of the SWEDD, a procurement assessment was carried out by the Bank. The assessment reviewed the organizational structure for implementing the project, the institutional arrangement and the capacity of project staff responsible for procurement. It concluded that the PADS procurement department, headed by a Procurement Specialist with a procurement assistant, is well experienced with Bank procedures. The review found these staff are qualified and sufficient to handle the procurement activities for both the SWEDD project and the ongoing Reproductive Health Project that will close on 12/31/2016.

Procurement risk at the country level

In 2013, under the initiative of the WAEMU Commission, the Bank funded a study on how to boost budget execution for a better development impact. The Boosting Budget Execution in WAEMU countries report noted that, most of the time, the contracts amounts are underestimated by bidders because of the weak capacity to correctly estimate contract and in order to be awarded the contract. The main consequences of this are (i) failing in contract execution, (ii) poor quality of deliverables and (iii) no respect of contractual deadline.

The country report of Burkina Faso recommended a series of actions in order to reduce the delays, enhance the procurement process and improve the value of money. The actions plan of this study at the regional level was approved on February 28, 2014 when the meeting of the "Comité d'Experts" (Experts Committee) of the WAEMU was held in Burkina Faso.

Procurement risk at the Project level

The main risks identified during the assessment are the following: (i) the limited experience in Bank procedures of staff from "Direction des Marches Publics – DMP" within the Ministry of Health and (ii) the difficulties to apply the Bank increased procurement thresholds at national level.

Mitigation Measures

The Mitigation Measures proposed are presented in the table below.

Action Plan for Strengthening Procurement Capacity			
Ref.	**Tasks**	**Responsibility**	**Comments / Due date**
1	Allow the Bank thresholds to apply for the project	Ministry of Economy and Finances	Not later than one month after effectiveness
2	Strengthen the capacity of DMP and the evaluation committee members in Bank procedures	PCU/Bank	Not later than three month after effectiveness
3	Update of the Implementation Manual (PIM)	PCU	Not later than one month after effectiveness

The overall Procurement Risk Assessment is considered as Substantial.

ANNEX 4 - ELIGIBILITY OF THE PROPOSED PROJECT FOR THE REGIONAL IDA ENVELOPE

The proposed project meets the four regional criteria for utilizing the regional IDA envelope:

(a) **It involves three or more countries:** The project involves six countries: Burkina Faso, Chad, Côte d'Ivoire, Niger, Mali and Mauritania. [19]

(b) **It has benefits, either economic or social, that spill over country boundaries:** The project will support the creation or strengthening of four different types of regional benefits.

1. Regional spill-over effect (through a focus on cross-border areas):
All the 6 countries are neighbors and are experiencing significant inter-country migration (including migration of health workers). The map below illustrates the intensity of these migration flows along a line from Mauritania to Chad. These migration flows have recently increased due to climate change and security issues. They create major challenges to Governments for providing basic services (including education and health). This is especially the case given that, in most of the 6 countries, a large portion of the population (and most of the urban population) is concentrated in cross-border areas. The project will therefore focus on these cross border areas, thus maximizing the spill-over effects for the 6 countries.

2. Generation and sharing of regional knowledge:
To tackle demographic dividend issues in the Sahel, there is a need to create and share regional knowledge on what works, what does not and why. The project will produce this knowledge not only through major investments in M&E but also in supporting countries to design and evaluate their own efforts.

Along the same line, the proposed investments in regional procurement and financing of RMNCHN commodities will generate a wealth of regional-level data on needs, prices and best practices for distribution of these commodities.

3. Regional-level accountability:
Political commitment on demographic dividend has sometimes been lacking or not sustained, thus preventing successful policies or programs to be implemented on a large scale. The proposed regional project will support the creation of mechanisms for increasing accountability to results on demographic dividend issues. One of these mechanisms is a regional data platform to monitor policies, expenditures and results of countries in relation to demographic dividend. Another mechanism supported by the project is a series of regional sub-committees on various topics (such as SBCC, gender, commodities, HRH and demographics). Each of these sub-committees will be chaired by a Minister who will be championing the issue.

4. Scale economies:
Most of the covered countries are rather small in population and weak in resources. Implementing project interventions only through national projects would be highly inefficient, as it would prevent

[19] A sixth country, Burkina Faso, might join at a later date with an additional financing.

the countries from tapping into the economies of scale that can be obtained only through pooling scarce national resources.

For instance, the project will support a regional procurement mechanism so as to obtain better prices for Reproductive Maternal Neonatal Child Health and Nutrition (RMCHN) products. A total discount of 20-30% on product total costs (including procurement and transaction costs) can thus be achieved.

Along the same line, the regional project will provide a mechanism for pooling resources to train high-quality midwifery faculty.

The expected size of these two benefits of the regional project is even greater given that regionally-harmonized norms already exist for contraceptives as well as for midwifery curricula. Similarly, setting up sound quality assurance programs for contraceptives and accreditation systems for training institutions can be cost-effective only when done at regional level.

(c) **Confirms strong interest from regional bodies and the region's countries in the project**. ECOWAS seeks to use this project to better fulfill the WAHO mandate as the main coordinating and harmonizing body in the sub-region in the health sector. The CILSS (*Comité Inter-Etats de Lutte contre la Sécheresse dans le Sahel*) is also involved in the project through its population department (i.e. CERPOD). It will help the countries strengthen their mandate and capacity to coordinate analytical work on demographics in the sub-region. In addition, all the six targeted countries have strongly expressed their interest in participating in the regional operation given the relevance of the regional approach and the proposed activities.

(d) **Provides a platform for a high level of policy harmonization between countries** through support to WAHO in order to (i) harmonize registration and quality control of RMNCHN drugs and supplies, (ii) implement a sub-regional and high quality curriculum for training midwives, and (iii) set up a sub-regional mechanism for accrediting all midwifery training institutions.

The table below summarizes the regional benefits of the different project components.

Project activities		Type of regional benefits	
COMPONENT 1			
1.1. Launch a regional media campaign		Activity will raise awareness on population issue in the 5 countries (and at a reduced cost, compared to national campaigns)	- regional spill-over effect - scale economies
1.2. Set up a regional mechanism for designing, financing and evaluating country programs in women and girls empowerment		Activity will generate regional knowledge on women and girls empowerment (policies that are much neglected by researchers in the Sahel). It will also focus on cross-border-areas.	- regional knowledge - regional spill-over effect (cross-border areas)
COMPONENT 2			
2.1. Foster regional harmonization of registration and quality control of	1) Harmonize and strengthen regulatory systems for RMNCHN products	Activity will allow countries to register medicines at the regional level, thus saving national resources	- scale economies

Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCHN) Commodities	2) Improve quality controls through support to a network of quality control labs	Like the above-mentioned activity, the set-up of a regional network of drug quality control labs will allow the countries (i) to have the quality control of drugs done at regional level and (ii) thus saving national resources	- scale economies
2.2. Establish a regional mechanism to support country efforts for enhancing the performance of their RMNCHN supply chain		Activity will improve availability of RMNCHN commodities in cross-border areas. It will also generate regional knowledge on how to best tackle the "last mile" distribution issue	- regional spill-over effect (cross-border areas) - regional knowledge
2.3. Support rural midwifery training institutions in target countries to increase the quantity and quality of midwives and other personnel involved in RMNCHN health	1) Building capacity of two large mid-level sub-regional training institution	Activity will improve quality for the midwifery faculty of all countries, while saving national resources	- regional spill-over effect - scale economies
	2) Strengthening quality assurance and regulation of midwifery education at regional level	Through harmonization of curricula and accreditation, activity will improve quality of health workers in all the 5 countries	- regional spill-over effect
	3) Strengthening capacity of rural midwifery training institutions	Activity will benefit mostly to cross-border areas, where the needs for more and better health workers are the highest. It will generate knowledge on the best ways to improve rural retention of health workers.	- regional spill-over effect (cross-border areas) - regional knowledge
COMPONENT 3			
3.1. Strengthen Advocacy and Political Commitment on RMNCHN at regional and national levels	1) Create a regional monitoring and accountability mechanism on demographic dividend	Activity will set up and maintain a regional tool for assessing progress made by each country on demographic dividend	- regional accountability
	2) Help the creation of or strengthen existing regional networks with parliamentarians, religious and traditional leaders, and civil society organizations		
3.2. Strengthen Capacity for policy making, monitoring and evaluation related to demographic dividend issues		Activity will fund surveys to help countries to compare their progress with each other. Activity will also fund regional training programs on demographic dividend.	- regional accountability - regional knowledge - scale economies
3.3. Strengthen project implementation capacity		Activity will allow countries to generate the above-mentioned regional benefits.	

Overview of regional and national IDA grants and credits

Participating Countries or Institutions	Total by Country (US$)	Regional IDA (US$)	National IDA (US$)
Burkina Faso	34.80	23.20	11.60
Chad	26.70	17.80	8.90
Cote d'Ivoire	30.00	20.00	10.00
Mali	40.00	26.70	13.30
Mauritania	15.00	10.00	5.00
Niger	53.50	35.70	17.80
WAHO	5.00	5.00	0.00
	205	138.4	66.6