

AFRICAN DEVELOPMENT BANK GROUP



SUDAN

IMPROVING HEALTH ACCESS AND SYSTEMS STRENGTHENING PROJECT

RDGE/AHHD DEPARTMENTS

January 2018

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ACRONYMS AND ABBREVIATIONS

AfDB	African Development Bank Group
ADF	African Development Fund
BCISD	Building Capacity for Inclusive Service Delivery
CB	Country Brief
COSD	Bank's Sudan Country Office
CHW	Community Health Worker
CMW	Community Midwife
CSP	Country Strategy Paper
CPIA	Country Policy Institutional Rating
DBDM	Development and Business Delivery Model
DP	Development Partners
DPG	Development Partners Group
EmOC	Emergency Obstetric Care
FGM	Female Genital Mutilation
GoS	Government of the Republic of the Sudan
HMIS	Health Management Information Systems
IPR	Implementation Progress Report
I-PRSP	Interim Poverty Reduction Strategy
ITU	International Telecommunications Union
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MAM	Moderate to Acute Malnutrition
MDG	Millennium Development Goals
MoFEP	Ministry of Finance and Economic Planning
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MoWSS	Ministry of Welfare and Social Security
NCD	Non-Communicable Diseases
NDC	Nationally Determined Contribution
NNSP	National Nutrition Strategic Plan
OFAC	Office of Foreign Assets Control
PBA	Performance Based Allocation
PCN	Project Concept Note
PIU	Project Implementation Unit
PPP	Potentially Problematic Projects
PPs	Problematic Projects
PRSP	Poverty Reduction Strategy Paper
RMC	Regional Member Country
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goals
TSF	Transition Support Facility
TWG	Thematic Working Group
UA	Unit of Account
UNDP	United Nations Development Program
WHO	World Health Organization

Currency Equivalents

October 2017

UA	1	=	SDG 9.4455
UA	1	=	USD 1.4133
UA	1	=	EUR 1.1971

FISCAL YEAR:

January 1– December 31

Weights and Measures

1 metric ton	=	2204 pounds (lbs)
1 kilogram (kg)	=	2.200 pounds (lbs)
1 meter (m)	=	3.28 feet (ft)
1 millimeter (mm)	=	0.03937 inch (“)
1 kilometer (km)	=	0.62 mile
1 hectare (ha)	=	2.471 acres

LOAN INFORMATION

Client’s information

RECIPIENT : The Republic of the Sudan

EXECUTING AGENCY : Ministry of Health (MoH)

Financing plan

Source	Amount (million UA)	Instrument
TSF Pillar I (ADF 14)	20.05	Grant
GoS	2.23	Counterpart
TOTAL COST	22.28	

Timeframe - Main Milestones (expected)

Concept Note Approval	September 2017
Project Approval	December 2017
Effectiveness	January 2018
Completion	December 2022
Last Disbursement	June 2023
Last Repayment	N/A

Project Summary

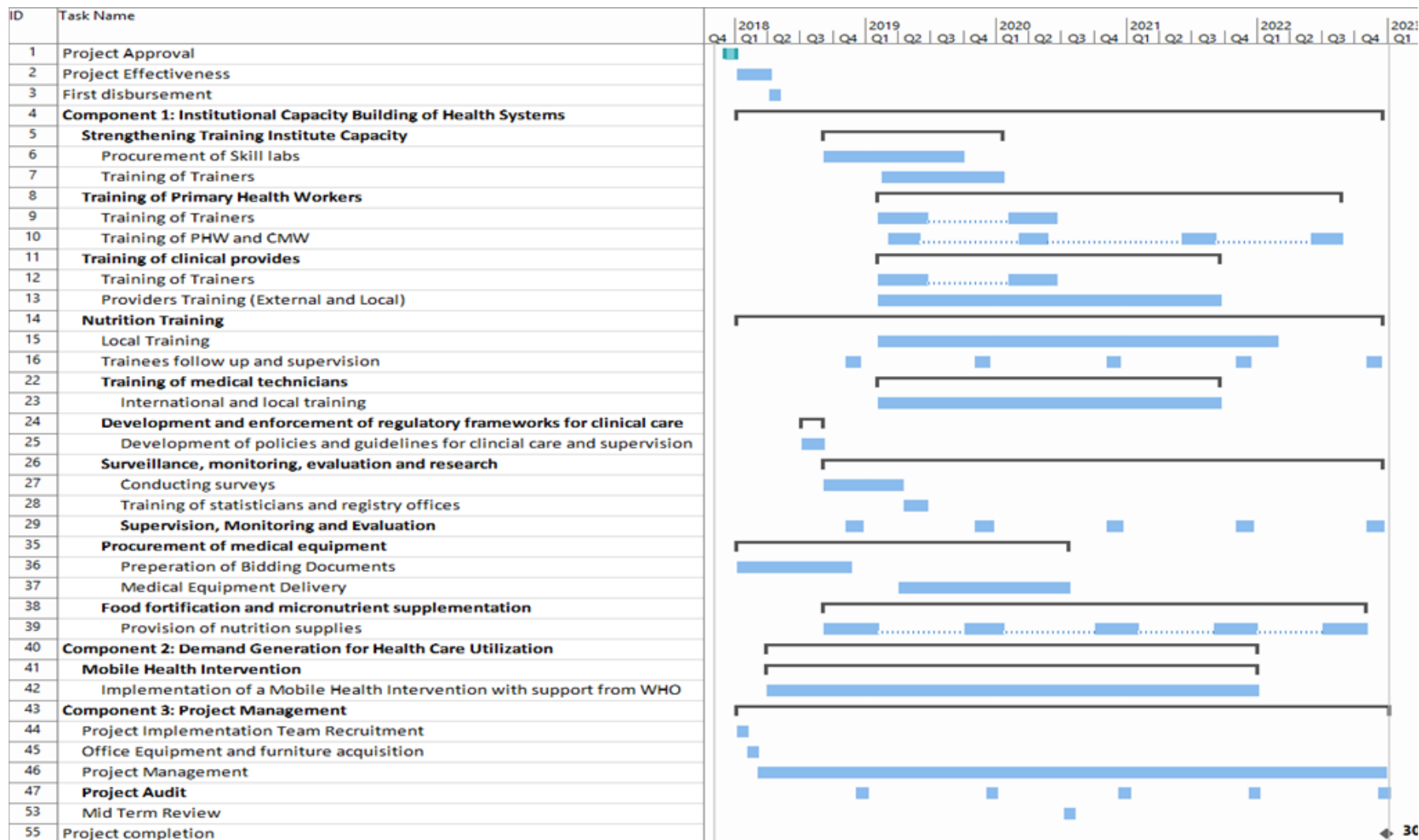
Project Overview	<p>The objective of the Improving Health Access and Systems Strengthening Project is to increase the demand for health care and improve the supply of health services to reduce the high rates of mortality and morbidity among women and children in four states of Sudan, namely El Gezira, Khartoum, Northern State and River Nile.</p> <p>The project will address key health priorities of the country including reproductive and child health, nutrition and cancer control. The three main project components are: 1) Institutional Capacity Building of Health Systems including subcomponents a) Capacity Building of Human Resources for Health and b) Support for Health Service Delivery; 2) Demand Generation for Health Care Utilization; and 3) Project Management.</p> <p>The project aims to improve health knowledge, access to health services, quality of health services and the functioning capacity of the health system. Significant gains are expected in maternal and reproductive health, nutritional status of women and children, early detection and treatment of cancer and eventually reduction of mortality and morbidity among women and children. The project goals of improving health and well-being are enunciated in the Bank’s High 5 priority of “Improving the Quality of Life of Africans.”</p> <p>The project cost is estimated at UA 20.05 million to be financed by the Transition Support Facility Pillar I. The total cost including Bank and counterpart funding is UA 22.28 million. The project will be implemented over a period of 57 months from March 1, 2018 to December 31, 2022.</p>
Needs Assessment	<p>Much progress has been made in improving health in Sudan but several challenges remain. Maternal and child mortality rates remain high despite recent declines. The high rates of fertility (4.5 children per woman) have a detrimental impact on women’s health and survival prospects. High levels of malnutrition lead to one-third of children under the age of five being underweight and 38.2 percent stunted. Malnourishment during infancy and childhood is associated with poor growth, cognitive development and an increased risk of mortality. Disease patterns are undergoing a shift, signaling an epidemiological transition, as the prevalence of communicable diseases is decreasing and that of non-communicable diseases such as cancer is increasing. Non-communicable diseases account for 34 percent of all deaths, with cardiovascular disease and cancer contributing the largest number of deaths. Malignant breast cancer was the most commonly diagnosed cancer accounting for 29.4 percent of all cancer registrations with a higher incidence of cancer among women. Weak health system capacity, low levels of health care utilization, deficiencies in the quality of care and high rates of health workforce attrition contribute to poor health and survival outcomes.</p>
Bank’s Added Value	<p>Improving health and nutritional outcomes of the population is fundamental to the success of development goals such as the SDGs. Investments in health services are necessary for empowering the workforce and increasing productivity for economic growth. The project will provide critical support to the Ministry of Health for expanding the scope, coverage and effectiveness of health services for reproductive and child health, nutrition and cancer control. Project financing will be directed at addressing current gaps in the health system by upgrading skills of health providers, building the capacity of diagnostic and treatment services at health facilities and strengthening community outreach of essential health services. Innovations such as mobile health intervention will be used to disseminate health knowledge to women and improve access to health services.</p>
Knowledge Management	<p>The project will generate knowledge and evidence from studies that will be carried out during the course of implementation. Several research studies are planned, for example, using mixed methods to train community midwives in cancer screening, measuring the impact of the mobile health intervention on knowledge, attitudes and behaviors, measuring trends in health and nutrition indicators in project areas, quality of health systems, and overall impact of the project on outputs and outcomes. The project will strengthen M&E and HMIS systems to improve the quality of data availability. Reports generated by the studies will be disseminated among key stakeholders for knowledge sharing. Scientific papers will be published in national and international journals for wider dissemination. In line with Bank’s Knowledge Management Strategy 2015-2020, the knowledge obtained will be captured, documented and shared within the Bank and with other DPs and RMCs.</p>

RESULTS BASED LOGICAL FRAMEWORK

Country and project name: SUDAN: IMPROVING HEALTH ACCESS AND SYSTEMS STRENGTHENING PROJECT						
Purpose of the project : TO IMPROVE HEALTH OUTCOMES AMONG WOMEN AND CHILDREN						
RESULTS CHAIN		PERFORMANCE INDICATORS			MEANS OF VERIFICATION	RISKS/ MITIGATION MEASURES
		Indicator (including CSI)	Baseline 2014-15	Target 2022		
IMPACT	Impact Improved health and survival outcomes among women and children in four states of Sudan.	Maternal Mortality Ratio	311	280	Census SHHS	The project is expected to increase health care utilization and improve the quality of maternal and reproductive health, cancer and nutrition services leading to reductions in mortality and morbidity among women and children.
		Female Adult Mortality Rate	194.9	175.5		
		Child Mortality Rate M/F	70.1	63.1		
		Infant Mortality Rate M/F	47.6	42.8		
		Total Fertility Rate	5.2	4.5		
		Underweight for age (% children under 5) M/F	33.0	27.9		
Stunting prevalence (% Children under 5) M/F	38.2	34.3				
OUTCOMES	Outcome 1 Improved knowledge and competency among health providers	Health worker knowledge M/F	*	*	MoH Health Facility Survey	Risk: Health worker attrition Mitigation: Training and upgrading facilities to retain skilled health workers. Risk: High out-of-pocket health expenditures. Mitigation: Expand national health insurance coverage that covers women and children's health. Risk: Delay in disbursement due to residual effects of the sanctions Mitigation: Opening of special accounts with the Bank of Khartoum that has an OFAC licence. Risk: Limited geographical access of the population to health facilities. Mitigation: GoS is planning rehabilitation of facilities. Community outreach of health services and referral linkages will be strengthened. Risk: Slow pace of project implementation. Mitigation: Involvement of MoH officials as PIU staff to dedicate time commitment for project implementation. Risk: Weak ownership of the project at the community level. Mitigation: Use of community mobilization and participatory approaches in collaboration with Gender Directorate, MoWSS
		Health worker competency M/F	*	*		
		Health worker performance M/F	*	*		
	Outcome 2 Improved efficiency of the health system to deliver high quality health services	Caesarean section deliveries (% deliveries)	9.1	5.0	SHHS	
		Breast/Cervical cancer screening (% women)	1.0	15.0	MoH Health Facility	
		Emergency obstetric care availability (% facilities)	*	*	Survey	
	Outcome 3 Improved health knowledge and utilization of care in target population	Antenatal care coverage 4 visits (% pregnant women)	50.7	60.8	SHHS	
		Knowledge of disease symptoms (% mothers)	26.9	30.0	M&E Reports	
		Institutional delivery (% deliveries)	27.7	33.5		
		Contraceptive prevalence rate (% women)	12.2	14.6		
Exclusive breastfeeding (% infants<6 months) M/F	55.4	63.7				
OUTPUTS	Component 1: Institutional Capacity				HRHS M&E Reports M&E Reports Nutrition Survey M&E Reports	
	<i>Component 1a: Human Resources</i>					
	1.1 Strengthening training institutes	Number of Trainers trained M/F	0.0	80		
	1.2 Training Community Health Workers	Number of Community Health Workers trained M/F	0.0	40,000		
	1.3 Training of Clinical Providers	Number of Clinical Health Providers trained M/F	0.0	973		
	1.4 Training of Nutrition Providers	Number of Nutrition Providers trained M/F	0.0	1073		
	1.5 Training of Medical Technicians	Number of Medical Technicians trained M/F	0.0	95		
	<i>Component 1b: Service Delivery</i>					
	1.6 Medical equipment procurement	Number of hospitals upgraded with equipment	0.0	5		
	1.7 Micronutrient supply	Number of children receiving supplements M/F	0.0	412480		
Component 2: Demand Generation						
2.1 Mobile health campaign	Population coverage of mobile health campaign % M/F	0.0	50	M&E Reports		
2.2 Mobile health clinics	Population coverage of mobile health clinics % M/F	0.0	20			
2.3 Mass media campaign	Population coverage of mass media campaign % M/F	0.0	50			
KEY ACTIVITIES	COMPONENTS Component 1- Institutional Capacity Building of Health Systems Component 2- Demand Generation for Health Component 3- Project Management					INPUTS Total Project Cost: UA 22.28 million ADF (TSF Pillar 1): UA 20.05 million GoS: UA 2.23 million

* Ongoing MoH National Survey of Health Facilities will provide baseline data in January 2018. Targets will also be determined from the baseline data. Detailed indicators provided in Section 2.8.

PROJECT IMPLEMENTATION SCHEDULE



REPORT AND RECOMMENDATION OF THE MANAGEMENT TO THE BOARDS OF DIRECTORS ON A PROPOSED TSF-PILLAR I GRANT TO THE GOVERNMENT OF THE REPUBLIC OF THE SUDAN FOR THE IMPROVING HEALTH ACCESS AND SYSTEMS STRENGTHENING PROJECT IN SUDAN

Management submits the following report and recommendation on a proposed Transition Support Facility (TSF)-Pillar I grant not exceeding UA 20.05 million to finance the Improving Health Access and Systems Strengthening Project in Sudan.

I – STRATEGIC THRUST & RATIONALE

1.1 Project Linkages with Country Strategy and Objectives

1.1.1 A high level of commitment for improving the health of the population is evident at the policy level in Sudan. The Sudan Global Health Strategy 2015-2019 and the Primary Health Care Strategy emphasize achieving Universal Health Coverage as a part of the post-MDG agenda. The Family Health approach has been adopted as a platform for delivering an integrated package of health services that is accessible to the population across the life course and is equitable and affordable. Ensuring better health outcomes among women and children is considered a priority and integral to the progress of development goals. Provision of health, education, water and electricity is envisioned as a poverty reduction strategy and a means to usher in sustainable and inclusive economic growth in the Five-year Program for Economic Reforms 2015-2019.

1.1.2 Sudan's National Health Policy 2017-2030 emphasizes the adoption of a multi-sectoral approach and people-centred health systems for achieving the Sustainable Developmental Goals and Universal Health Coverage as a means of contributing towards the social and economic development of the country. The two recommended areas for intervention are addressing the social determinants of health and health systems strengthening. Some key features of the policy include a bottom-up, community approach for health service delivery, comprehensive and integrated health care based on a primary health care model linked to functional referral systems, promotion of disease prevention and well-being instead of curative care alone and reduction of out-of-pocket health expenditures among the marginalized and vulnerable populations. A plan for expanding the primary health care network and the national health insurance coverage is currently underway. Public health is also included as a priority area of adaptation in Sudan's Nationally Determined Contribution to the Paris Agreement.

1.1.3 The Women's Empowerment Policy 2016 of Sudan includes health as a pillar and advocates for empowering women by improving health knowledge and access to services. The National Nutrition Strategic Plan 2014-2018 has further emphasized nutrition security of the population, particularly that of women, children and vulnerable groups. The government has unfailingly demonstrated commitment to improving women and children's health by endorsing timely and evidence-based policies. To facilitate the transition from the MDGs to SDGs, the "Ten in Five Strategy" was formulated to achieve ten strategic objectives for reproductive, maternal, newborn, child and adolescent health in five years through a community-based approach. The global SDG 3 agenda, "Ensure healthy lives and promote well-being for all at all ages", is echoed in the government's commitment to women and children's health.

1.1.4 Pillar I of the Sudan Country Brief 2017-2019 supports Institutional Capacity Building for Improving Service Delivery. Access to and quality of public services remains poor, especially in remote rural areas. Improving service delivery is a priority for the government but challenges such as brain drain are impeding factors. Weak public services contribute to inequalities, poverty, poor health outcomes, which in turn, increases the development gap between the center and the regions. The Bank aims to build capacity in areas that address the root causes of fragility and improve social service delivery in the health, education and water and sanitation sectors. Related Pillar I outputs include

improving the capacity of health facilities by training health workers and upgrading skills and technology in health. The “Pipeline of Projects” in the Sudan Country Brief 2017-2019 includes the proposed project.

1.1.5 The project objectives are in conformity with the priorities outlined in the Sudan Country Brief 2017-2019 and the national health and gender policies of Sudan. The project design, geographical coverage and interventions have been informed by country-generated evidence and sector policies. The project’s strategic thrust on community-based health service delivery, health systems strengthening, health knowledge promotion for disease prevention and delivery of an affordable and integrated package of health services are also reflected in national health policies.

1.1.6 By aiming to improve health outcomes, the project seeks to operationalize the Bank’s High 5 priority of “Improving the Quality of Life of Africans.” The project is aligned with the Human Capital Development Strategy 2013-2017, which aims to improve access to, the quality and efficiency of service delivery and the Feed Africa Strategy goal of reducing malnutrition. Furthermore, the project will contribute to the creation of jobs for health providers, a priority outlined in the Jobs for Youth in Africa Strategy 2016-2025 and upgrading their skills, which resonates in the Ten Year Strategy’s pillar on Skills and Technology. Improvements in health and well-being will encourage women to seek gainful employment and engage in economic activities, an agenda reflected in the Ten Year Strategy 2013-2022 where Gender is an area of special emphasis and the Gender Strategy 2014-2018 focusing on women’s economic empowerment.

1.2 Rationale for Bank’s Involvement

1.2.1 Much progress has been made in improving health in Sudan but several challenges remain and new priorities are emerging. The life expectancy has shown increasing trends over the past few decades averaging at 63.7 years in 2015. Women and children’s health indicators also showed noteworthy improvements but mortality and morbidity still remain high. The maternal mortality ratio declined from 744 in 1990 to 311 per 100,000 live births in 2015ⁱ. Although the Total Fertility Rate has declined from 6.1 in 1990 to 4.2 in 2015ⁱⁱ, the pace of decline is slow and there is a high level of unmet need for family planning among women of reproductive age (26.6 percent)ⁱⁱⁱ. Repeated, unwanted pregnancies deplete women’s health and undermine their survival prospects. The under-five mortality rate declined from 128 to 70 per 1,000 during the MDG period^{iv}. In 2016, an infant mortality rate of 77 per 1,000 and the neonatal mortality rate of 29.9 per 1,000 was lower than the regional average for Sub-Saharan Africa^v. However, high rates of malnutrition are prevalent as about one-third (33 percent) of children under age five are underweight, 38.2 percent are stunted, and 16.5 percent suffer from moderate to severe wasting^{vi}. Malnourishment during infancy and childhood is associated with poor growth, cognitive development and an increased risk of mortality. Due to the prevailing health system gaps, sustaining health improvements and advancing further gains remains a formidable challenge.

1.2.2 As Sudan is undergoing an epidemiological transition, it is experiencing a double burden of communicable and non-communicable diseases. Characteristic of countries at the early stage of the transition, mortality rates are declining while fertility is still high. Disease patterns are undergoing a shift as the prevalence of communicable diseases is decreasing and that of non-communicable diseases is increasing. Non-communicable diseases account for 34 percent of all deaths, with cardiovascular disease and cancer contributing the largest number of deaths. Malignant breast cancer was the most commonly diagnosed cancer accounting for 29.4 percent of all cancer registrations. The increasing rates of overweight and obesity are major drivers of cancer along with tobacco consumption and changes in reproductive patterns. The Sudan Cancer Registry for the period 2009-2013 showed a higher incidence of cancer among women as compared to men and the incidence gap between men and women doubling during that time-period.

1.2.3 Progress on health indicators has been uneven and sustaining the progress made in recent decades remains a major challenge. About 71 percent of the population lives within 5 kilometers of a health facility in Sudan, ranging from 88 percent in urban areas to 61 percent in rural areas. Health care utilization is low due to the geographical distance to facilities, lack of reliable transport, prevalence of taboos and superstitions, reliance on traditional health care providers and the cost of seeking care. Some of the key gaps in health services include deficient quality of care at health facilities, disparities in the distribution of the health workforce, gaps in health provider knowledge and skills, shortage of medical equipment and supplies, and a high attrition rate among health providers. A large number of doctors are trained in Sudan; for example, in 2013-2014, 4,100 medical graduates were trained, out of which 2,644 (64.4 percent) were female. However, the high rate of attrition poses a significant challenge to the capacity of the health system to address the health care needs of the growing population.

1.2.4 Improving health and nutritional outcomes of the population is fundamental to the success of development goals such as the SDGs. Investments in health services are necessary for empowering the workforce and increasing productivity for economic growth. Sudan spends 6.5 percent of its GDP on health and government expenditure on health as a proportion of total government expenditure is 6 percent. Public expenditure on health (as a percentage of GDP) is estimated to be 1.8 percent. About 46.3 percent of the population is covered by the National Health Insurance Fund. However, out-of-pocket expenditure on health is high at 70 percent and about 4.1 percent of households suffer catastrophic health expenditures. The health system is under-financed resulting in a large proportion of the population with no access to services and low coverage of the essential package of health services.

1.2.5 The Ministry of Health is the main provider of health services but other providers include the military, police, private sector and non-governmental organizations. Access to diagnostic services and treatment is a challenge for patients residing in the remote areas. For example, the large majority of women (72.3 percent) deliver at home. Due to lack of knowledge of early screening for cancer among women, most cases of breast and cervical cancer are detected at a late stage, leading to poor prognoses and outcomes. Tertiary health care for specialized treatment for diseases such as cancer tends to be concentrated in the big cities like Khartoum, Madani and Shendi. Long distances and travel time between the large cities and the peripheral states poses a significant barrier to timely care seeking. Most public hospitals have obsolete and non-functioning equipment due to which essential services cannot be provided consistently. Public hospitals tend to be overcrowded as infrastructure is deficient and inadequate to cater for the patient load.

1.2.6 Sudan was under sanctions in accordance with the Revised Policy on Loan Arrears Recovery (the “Sanction Policy”). Effective October 12, 2017, certain sanctions with respect to Sudan and the Government of Sudan were lifted. In line with Legal Note Concerning the Implementation of the Fragile State Facility (FSF) (ADF/BD/WP/010/08/Rev.1/Approval) and Operational Guidelines for the Implementation of the Strategy for Addressing Fragility and Building Resilience in Africa and for the Transition Support Facility (ADF/BD/WP/2014/30/Rev.3/Approved), the use of TSF Pillar I for activities related to institutional capacity building are justifiably exempted from the Sanction Policy. The Board, on 18th October 2017, approved the Sudan Country Brief 2017-2019 along with the approval of the country’s eligibility to TSF resources, which will be used to finance this operation.

1.3 Aid Coordination and Harmonization and Bank Group Positioning

1.3.1 In 2013, the AfDB Country Office led the creation of a Development Partners Group (DPG) and co-chaired it between 2014 and 2015 together with the World Bank (WB). The DPG has since given rise to Thematic Working Groups (TWG) and has facilitated exchange of information and experiences through sector-specific coordination meetings of key donors. In 2015, the Government created a new Ministry of International Cooperation (MoIC). The MoIC in close collaboration with the Ministry of Finance and Economic Planning (MoFEP) and other relevant sectors is responsible for the coordination of development partners’ (DPs) support to the country. Currently this responsibility does not involve any systematic regular or formalized meetings between the government and DPs, nor do DPs themselves

have such a formal framework for coordination. There is a need for clear coordination mechanism encompassing all development partners in the health sector as well as other relevant sectors.

1.3.2 In 2014, the AfDB’s financing of the PRSP process led to the creation of the PRSP Coordination Forum, the highest level for coordinating development efforts in the country, co-chaired by the Bank, the World Bank and the State Minister of Finance. The active participation at this high level has uniquely positioned the Bank to underscore the priorities of the High 5s and articulate their proven alignment with the SDGs and Agenda 2063. These well-established mechanisms of coordination will play a central role in implementing the new Country Brief.

1.3.3 Various DPs such as the Bank, European Union (EU), Global Alliance for Vaccines and Immunization (GAVI), Global Fund, Japan International Cooperation Agency (JICA), United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank (WB), World Food Program (WFP) and World Health Organization (WHO) among others are involved in the health and nutrition sector.

Table 1: Summary of the Sector Financing

	Sector or subsector	Size		
		GDP	Per Capita	Total
	<i>Health and Nutrition</i>	%	<i>USD</i>	USD
		8.4	282	4.793 b
	Government	DPs	Out of pocket	Private Sector
USD \$	721.1 m	83.8 m	3.8 b	188.7 m
%	14.95%	1.74	79.4%	3.91%
Level of Donor Coordination				
Existence of Thematic Working Groups				<i>Yes</i>
Existence of SWAps or Integrated Sector Approaches				<i>Yes</i>
AfDB's Involvement in DPs coordination				<i>In process</i>

II – PROJECT DESCRIPTION

2.1 Project Objective

2.1.1 The overall objective of the Improving Health Access and Systems Strengthening Project is to increase the demand for health care and improve the supply of health services in order to reduce the high rates of mortality and morbidity among women and children. The project will address the key health priorities in the country including reproductive and child health, nutrition and cancer control.

2.2 Project Components

2.2.1 The three main project components are: Component 1) Institutional Capacity Building of Health Systems including subcomponents a) Capacity Building of Human Resources for Health and b) Support for Health Service Delivery; Component 2) Demand Generation for Health Care Utilization and Component 3) Project Management. The scope of Component 1 will be national, whereas Component 2 will focus on the four project regions.

Table 2: Project Components

Component & Outputs	Est. cost UA' m
A. Institutional Capacity Building of Health Systems	18.12
A. I) Capacity Building of Human Resources for Health	3.99
A-1 Strengthening training institute capacity	0.53
A-2 Training of primary health workers	1.17
A-3 Training of clinical providers	1.70
A-4 Nutrition training	0.14
A-5 Training of medical technicians	0.32
A-6 Development and enforcement of regulatory frameworks for clinical care	0.14
A. II) Support For Health Service Delivery	14.13
A-7 Surveillance, monitoring, evaluation and research	0.90
A-8 Procurement of medical equipment	7.83
A-9 Food fortification and micronutrient supplementation	3.34
A-10 Recurrent costs	1.80
B. Demand Generation for Health Care Utilization	1.60
B.1 Mobile health intervention	0.61
B-2 Mobile health clinics	0.04
B-3 Mass media campaign	0.95
D. Project Management	1.24
D-1 Project Implementation Team	0.63
D-2 Audit	0.02
D-3 Operation Cost	0.59
	Total Base Cost
	20.58
	<i>Contingencies</i>
	1.70
	Total Cost
	22.28

Technical Solution Retained and Other Alternatives

2.2.2 Technical solutions retained are based on data, evidence generated from public health studies, and lessons learned from health sector operations. The selected project design is in conformity with WHO recommended standards and global best practices for women and children's health. An integrated community-based approach for delivering a package of reproductive and child health care, nutrition and cancer control strategies is appropriate for Sudan given its geographical spread that entails travel over long distances to reach health facilities and cultural restrictions on women's mobility. Furthermore, prevailing gaps in the Sudanese health system necessitate capacity building of health professionals and health facilities to encourage health workforce retention and ensure provision of high quality health services.

2.2.1 The introduction of a mobile health (mHealth) campaign will be an innovative feature of this project to be implemented with support from the World Health Organization (WHO) and International Telecommunications Union (ITU). The use of mobile phone technologies to improve health knowledge and access to services has been successfully implemented by WHO-ITU in many countries. The project will include an mHealth program for sensitizing women with health knowledge and information. As currently there are limited options for women to receive accurate and evidence-based health information, an mHealth component can be a low-cost and effective means of generating awareness about key health priorities and improving access to health services. Mobile phone coverage is considerably high in Sudan

(68.6 subscriptions per 100 inhabitants). Health information will be transmitted on mobile phones via SMS-based texting to sensitize women about disease awareness, prevention, timely care seeking, appropriate nutrition, importance of early screening for cancer and treatment options available at health facilities. The mHealth strategy will help circumvent cultural barriers that tend to restrict women’s mobility and participation thereby facilitating access to reliable health information and services. Alternative methods such as voice messaging via SMS will be used for reaching women who are illiterate. The mHealth program will draw upon the experience of a currently ongoing project on mCervical Cancer being implemented by WHO-ITU in Zambia. The mCervical Cancer project is being financed by the Bank through the Nigeria Trust Fund. (Details in Annex C1.1).

2.2.2 The project will support the operating costs of mobile health clinics that have been procured by JICA. The mobile health clinics are equipped with essential medical equipment and communication systems. They allow doctors to visit remote areas for provision of primary health services, conduct disease screening, immunization camps, eye camps and attend to patients with limited mobility. The operating costs of four mobile clinics will be supported under the project. These clinics will be operational in the project areas for the project duration and will facilitate provision of reproductive health care, cancer screening and nutrition screening and treatment. (Details in Annex C1.2)

*Table 3:
Analysis of the Various Alternatives Considered*

Alternative	Brief Description	Reasons for Rejection	Selected Option
Construction and rehabilitation of hospitals.	Several health facilities are in state of disrepair and need to be rehabilitated to improve conditions and accommodate patient load.	The government is rehabilitating health facility infrastructure across the country. The initiative that started in 2013 is implemented according to yearly targets.	The project will finance a small amount of civil works for rehabilitating or adapting certain sections of hospitals to install equipment as needed.
Support interventions to control communicable diseases.	A double burden of communicable and non-communicable diseases exist. Malaria and diarrhea are high prevalence.	Interventions targeting communicable diseases are being funded by other donors including the Global Fund and GAVI and existing funding allocations have not been adequately spent.	The prevalence of NCDs such as cancer is increasing but there is limited funding in the country. There are several gaps in technical capacity for cancer control so this was identified by the government as an urgent priority.

2.3 Project Type

2.3.1 The proposed project is a standalone operation which will finance community-based health and nutrition service delivery and facility-level health systems strengthening efforts for improving health and nutrition outcomes among women and children. This modality was chosen because the implementation strategy is integrated into the MoH’s national health program and necessitate detailed monitoring and supervision of project activities to measure progress and impact.

2.4 Project Cost and Financing Arrangements

2.4.1 The total cost of the project for the components defined above is estimated at UA 22.28 million net of taxes and duties. Of this, UA 16.23 million or 73 percent is foreign cost and UA 6.05 million is local cost. The Bank’s contribution from ADF-14 TSF Pillar I resources is UA 20.05 million and the counterpart contribution by the GoS is UA 2.23 million. Tables 4 to 9 provide a summary of project costs by category:

*Table 4
Project Cost Estimates by Component in million UA*

Component	Foreign Cost	Local Cost	Total	Foreign Currency %	% Total
A. Institutional Capacity Building of Health Systems	14.07	4.05	18.12	77	88
B. Demand Generation For Health Care Utilization	0.44	1.16	1.60	27	8
C. Project Management	0.62	0.24	0.86	72	4
Total Base Cost	15.13	5.45	20.58	74	100
<i>Contingencies</i>	1.10	0.60	1.70		
Total	16.23	6.05	22.28		

*Table 5
Sources of Financing in million UA*

Source	Foreign Cost	Local Cost	Total	%
ADF - TSF-Pillar I	16.23	3.82	20.05	90
GoS	0,00	2,23	2,23	10
Total	16.23	6.05	22.28	100

*Table 6
Project Cost by Category of Expenditure in million UA*

Category of Expenditure	Foreign Currency Cost	Local Currency Cost	Total	% Foreign
A. Works	-	0.29	0.29	0
B. Services	12.59	-	12.59	100
C. Goods	3.10	3.48	6.58	47
D. Operating Cost	0.54	2.28	2.82	19
Total	16.23	6.05	22.28	73

*Table 7
Expenditure by Component and Source in million UA*

Component	TSF-Pillar I	GoS	Total
A. Institutional Capacity Building of Health Systems	16.32	1.80	18.12
B. Demand Generation For Health Care Utilization	1.43	0.17	1.60
C. Project Management	0.80	0.06	0.86
Total Base Cost	18.55	2.03	20.58
<i>Contingencies</i>	1.50	0.20	1.70
Total	20.05	2.23	22.28

*Table 8
Category of Expenditure by Funding Source in million UA*

Category of Expenditure	TSF-Pillar I			GoS	Total
	Foreign Cost	Local Cost	Total		
A. Works		0.29	0.29	-	0.29
B. Services	3.10	3.29	6.40	0.18	6.58
C. Goods	12.59		12.59	-	12.59
D. Operating Cost	0.54	0.24	0.78	2.04	2.82
Total	16.23	3.82	20.05	2.23	22.28

Table 9
Expenditure Schedule by Component in million UA

Component	2018	2019	2020	2021	2022	Total
Institutional Capacity Building of Health Systems	1.98	5.52	7.29	1.81	1.52	18.12
Demand Generation For Health Care Utilization	0.46	0.35	0.35	0.28	0.17	1.60
Project Management	0.29	0.21	0.12	0.12	0.12	0.86
Total Base Cost	2.73	6.08	7.76	2.21	1.81	20.58
<i>Contingencies</i>	0.18	0.40	0.60	0.27	0.25	1.70
Total Costs	2.91	6.47	8.36	2.47	2.07	22.28

2.5 Project’s Target Area and Population

2.5.1 The project will be operational in four states, namely Al Gezira, Khartoum, Northern State and River Nile. In addition, certain project activities will have an impact at the national level. The selection of the states was informed by data from the National Cancer Registry Report, according to which, these states have the highest incidence of cancer. The proposed project will increase the demand for and supply of health services for reproductive health, cancer and nutrition in these four states. The direct beneficiaries of the project will include women and children and the indirect beneficiaries will be men. At the end of the interventions, approximately 5,113,944 women and 4,287,512 children are expected to benefit from improved access to health services. Although the primary beneficiaries will be women and children, men will also benefit from the improved health system capacity and outreach of community health programs. The project benefits include: (a) improved knowledge on health issues including disease prevention and treatment, optimal nutrition and appropriate care seeking; (b) improved health system capacity including functioning health facilities and skilled providers; (c) increase in health care utilization for reproductive health and cancer; and (d) decrease in mortality and morbidity among women, children and men.

2.6 Participatory Process for Project Identification, Design and Implementation

2.6.1 Extensive consultations were conducted with primary stakeholders, including patients seeking treatment at hospitals, health providers such as doctors, nurses and community health workers at the state and national level and health policy makers. The identification, preparation and appraisal missions also met with various stakeholders at the federal and state level: MoH, MoSWS, non-governmental organizations, women’s groups, private sector, academic and research institutions, as well as donors and technical agencies working in the health sector. Health facilities in each of the project states were visited during the missions.

2.6.2 The stakeholders identified health priorities in Sudan, challenges faced in seeking and providing health care, suggested priority areas of intervention and collaboration. Issues related to the socioeconomic and cultural determinants of health were also discussed during the consultations. Cultural barriers to health care seeking exist at the household and community level. Among these are myths and misconceptions about diseases and appropriate treatment. Poor conditions of health facilities including malfunctioning equipment, crowding due to high patient load, attrition of health providers and resource constraints affect routine health service delivery. The high rate of attrition among the health workforce emerged as one of the biggest challenges confronting the health system in Sudan. Although large numbers of highly skilled medical providers are trained in the country, a large proportion migrate to countries in the Gulf region that offer higher salaries.

2.6.3 The project will engage stakeholders during project implementation for greater synergy and effectiveness. Civil society organizations, in particular, will be key partners in implementing the community health program. Civil society organizations have a deep community presence and experience

with community mobilization strategies. Women's groups will also be engaged for disseminating health information through community networks and creating support systems for overcoming cultural and household barriers to care seeking. Private sector stakeholders such as private hospitals will support implementation by meeting the additional demand for health care especially for cancer treatment. At the technical agency level, the project is engaging WHO for implementation of the mobile health program. Additionally, UNFPA will provide technical assistance for implementing the reproductive health and cervical cancer interventions. The involvement of multiple stakeholders is likely to contribute to project sustainability.

2.7 Bank Group Experience, Lessons Reflected in Project Design

2.7.1 As of October 2017, the Bank Group's portfolio in Sudan comprised 10 projects with a total commitment of UA 162.659 million mainly focused on TA, capacity building and knowledge work. All the implementation progress reports (IPRs) are up to date and there is no outstanding project completion report (PCR). The performance of the Bank's current portfolio of projects was assessed as satisfactory, with an overall rating of 3. There are no Problematic Projects (PPs), no Potentially Problematic Projects (PPPs) and no effectiveness delays in the portfolio. Conditions precedent to first disbursement for previous projects were satisfactorily met.

2.7.2 Some of the key lessons learnt from on-going and past interventions in the country by the Bank and other DPs are taken into account in the design of the project. Lessons learned from operations in other fragile states include: (i) ensuring strong country commitment and ownership of operations; (ii) flexibility and simplicity of project design, (iii) need to ensure a clear transitional strategy to consolidate the gains made; (iv) importance of aid coordination and management in countries with weak institutional and human capacity and v) timely transfer of funds.

2.7.3 Lessons from Bank and other projects taken into account in the project design include: (i) developing focused interventions that have been piloted or implemented; (ii) ensuring ownership of project by the government; (iii) clearly delineating responsibility for implementation at the federal and state levels; (iv) developing evidence-based strategies and interventions; (v) ensuring synergies between project components and (vi) setting realistic and precise outcomes.

2.7.4 Key operational issues considered during project design include capacity constraints in the health sector, high rates of attrition among health providers, challenges involved in procurement and maintenance of medical equipment due to the sanctions, and low rates of health care utilization in the population. The project design incorporates strategies to retain health workers, expand community outreach of health services, use mass media and mobile technology, improve capacity of the implementing agency and utilize alternate procurement arrangements if needed. Partnerships will be sought with the private sector particularly private health facilities that provide specialized treatment for cancer, to meet the anticipated increase in demand for medical care.

- i) *Ownership by the Government:* The PIU will be embedded within the MoH, its offices will be located in the MoH premises and the project technical team will largely be comprised of officials currently working within the MoH. This will ensure ownership of the project by the Implementing Agency and facilitate smooth implementation of project activities. The project will include provisions for developing the capacity of the PIU team through trainings and study tours.
- ii) *Project Implementation Strategies:* The project implementation strategies will rely on the existing structures of the national health program and will not seek to create alternative or parallel mechanisms for service delivery. The project is intended to expand the scope, coverage and effectiveness of the existing health program to achieve maximum impact and minimize the risk of inefficiency.

- iii) *Timely transfer of funds:* Prior to the removal of the US sanctions in October 2017, difficulties were encountered in transferring funds into Sudan. In that regard, despite the acquisition of the Office of Foreign Assets Control (OFAC) license by the Bank, rejection of transfer of funds by intermediary banks persisted. The Bank had also tried to open accounts with the Bank of Khartoum which also has an OFAC license but this did not resolve the problem. It is anticipated that the recent lifting of the sanctions will now ease the flow of development financing into the country.

2.8 Key Performance Indicators

2.8.1 The project will be monitored using Key Performance Indicators (KPIs) reflected in the project's Results Based Logical Framework which also includes the indicators defined in Bank's Results Measurement Framework 2016-2025. The KPIs will broadly measure the impact, outcomes and outputs of the project. Key indicators for measuring impact include the Maternal Mortality Ratio, Female Adult Mortality Rate, Infant and Child Mortality Rate, Total Fertility Rate, and the prevalence of underweight and stunting among children under five.

2.8.2 Outcome 1 related to health providers' knowledge, competence and performance will be measured by indicators on reproductive and child health service delivery: antenatal and postnatal care, cesarean deliveries, emergency obstetric care, neonatal resuscitation, infection prevention, referral provision and management of victims of gender-based violence. Outcome 2 indicators related to health system capacity will measure changes in the rates of cesarean deliveries, breast and cervical cancer screening and emergency obstetric care provision. Outcome 3 will focus on population-based indicators including antenatal care and coverage, institutional delivery rate, knowledge of childhood disease symptoms among women, contraceptive prevalence rate and exclusive breastfeeding rate among infants under 6 months.

2.8.3 Output indicators are intended to capture progress of key activities under the project. Under the output related to strengthening human resource capacity, the indicators include completion of trainings of different categories of health providers including trainers of health providers, clinical and non-clinical providers, nutrition providers and medical technicians. The service delivery output will be measured by the number of facilities equipped by medical equipment and uptake of nutrition supplements among children. Finally, the demand generation output will be measured by the population-level coverage of the mobile health and mass media campaigns as well as the mobile health clinics.

III – PROJECT FEASIBILITY

3.1 Economic Performance

3.1.1 The economic assessment of the project considers the beneficial effects of the proposed intervention and highlights the wider impacts associated with the project interventions. The project will deliver the following benefits in the project areas: (a) improved knowledge about health issues including disease prevention and treatment, optimal nutrition and appropriate care seeking; (b) improved health system capacity including functioning health facilities and skilled providers; (c) increase in health care utilization for reproductive health and cancer; (d) decrease in mortality and morbidity among women and children; and (e) increase in household savings from better health leading to higher productivity.

3.1.2 Beneficiaries and the wider community will benefit from knowledge generated from the project, leading to reduced mortality and morbidity. Improved health system capacity will reduce the incentive to seek medical care overseas, thus saving the country much needed foreign currency.

3.1.3 Improved health provision will have the multiplier effect of allowing women and youths more time to focus on income generation activities, instead of spending resources on health and medical

services. The benefits from improving health systems and facilities will be felt across the whole health spectrum, thus enhancing the GoS' capacity to cater for the health needs of the population.

3.2 Environmental and Social Impacts

Environmental Impacts

3.2.1 The project category has been validated as Category 3 as activities will mainly focus on capacity building, media campaigns and training of health providers which do not have inherent significant negative environmental and social impacts. Moreover, a project seeking to improve health access will render positive environmental and social benefits. Improvements in health knowledge is expected to have a positive impact on environmental sanitation. In addition, trainings of Community Health Workers will include sensitization on the environmental aspects of public health, including medical waste management, which will lead to an overall positive environmental impact.

Climate Change and Green Growth

3.2.2 Climate Safeguards System and GHG accounting and reporting: The project is not expected to be vulnerable to climate change impacts.

3.2.3 GHG mitigation: GHG emissions will come from mobile clinics but this impact is expected to be minimal as only four mobile clinics will be operational under the project.

3.2.4 Climate adaptation: This project can help to reduce vulnerability to climate change by raising awareness of a) spread of disease due to changing temperature and rainfall conditions; and b) malnutrition – where this is the result of loss of food and nutrition security due to changing climate. Climate change awareness and the health impacts of poor indoor air quality linked to the use of solid biomass will be included in the Community Health Worker training package. Therefore, the cost of components A1 through A5 and B2 can be identified as climate adaptation finance.

Gender

3.2.5 The project aims to improve gender equality by addressing women's health priorities including maternal and reproductive health, nutrition and breast and cervical cancer. The increasing burden of poor health and malnutrition poses a significant risk to women's empowerment. Improvements in women's health will empower women to seek better life choices, pursue higher education, gain skills and enter the workforce to acquire economic independence. The project will improve women's knowledge about healthy behaviors during pregnancy, childbirth and newborn care and improve their access to health and nutrition services. Women will be mobilized through peer networks and women's groups to collectively seek and share health knowledge and information about appropriate care seeking. Access to reproductive health care will allow women to make informed decisions about planning their families and reducing unwanted pregnancies. Improved access to health knowledge and services and adoption of healthy behaviors will have a beneficial impact on the health of women, children and families. As a long-term benefit, better health outcomes and smaller family size will encourage women to seek economic opportunities resulting in improved income, savings and economic empowerment.

3.2.6 The project aims to improve women's health knowledge about disease prevention, nutrition, appropriate treatment and timely health care seeking. Health information will be broadcast on radio and television and reinforced through mobile text messaging. Women's access to health care will be improved through the community health program. Community health workers and women's groups will be used to promote health behavior change and provide support to women for addressing household and community barriers to health care seeking.

3.2.7 The project will contribute to gender equality by training and employing female health workers. Both male and female health workers will be trained under the project. However, training of female health workers such as midwives and nurses will be prioritized for certain types of care, including skilled deliveries and screening for breast and cervical cancer, for which women tend to prefer female providers.

Social

3.2.8 The project will provide training and capacity building to health workers both in communities and at the health facility level. Jobs will be created for trained health workers for providing clinical and non-clinical health services. Both male and female health workers will be trained but larger numbers of female health providers will receive training because of the cultural preferences for female providers among women clients. The skills of community midwives, for example, will be upgraded and their services will be formalized and integrated into the project. By doing so, the project will provide a source of employment and income to health workers functioning within the project areas.

3.2.9 The project will result in several sociocultural, socio-economic and health benefits. The direct benefits will be improvements in health outcomes due to an increase in health care utilization and improved quality of health services. As women will be sensitized with health information and participate in community mobilization activities, improved levels of health knowledge will have a beneficial impact on their empowerment and consequently, the health and well-being of their families. Health information transmitted through mass media and mhealth channels will dispel harmful myths and misconceptions and encourage adoption of healthy behaviors. Improvements in nutritional status of is expected to improve their growth and cognitive abilities, thus encouraging school attendance and retention. The combined effect of better health, education and employment opportunities will have a positive impact on the socioeconomic status of households and communities in the project areas.

3.2.10 Prevention and treatment of acute malnutrition among children will support the “grey matter infrastructure” that will lead to better productivity in the long term. The project will increase appropriate knowledge and practices on infant, young child and maternal nutrition. Promotion of food diversification as well as home food fortification will strengthen the capacity of women, households and communities to adopt the optimal nutritional practices for improving the nutritional status of the most vulnerable. Promotion of awareness on water-related diseases will also have a beneficial impact on the health status of communities.

3.2.11 The project will promote inclusive growth by supporting activities that will equitably benefit communities. In particular, several project activities will be implemented in areas that are have poor and marginalized households and are geographically remote with poor access to health care.

Fragility and Resilience

3.2.12 Drivers of fragility identified to be relevant for this project includes: (i) weak devolution system that has produced underfunded and undermanaged states and localities with low human and institutional capacities; (ii) inequalities in access to health care between the rich and the poor and between rural and urban populations; (iii) high incidence of poverty and limited economic opportunities; (iv) prevalence of cultural beliefs and practices such as FGM that heighten women’s vulnerabilities; (v) real or perceived economic and political marginalization in resource management and distribution; (vi) limited investments and financial resources in expanding public services to vulnerable groups; (vii) high out of pocket health expenditure; and (viii) competing demands for resources in the health sector.

3.2.13 By investing in improving demand and supply of health care, the project aims to improve the quality of life of the beneficiaries. In addition, by training health providers and improving the working conditions at hospitals, the project will aid in retention of the health workforce. Employment opportunities generated for community health workers will serve as a viable poverty reduction strategy.

The project will train 40,000 CHWs and once trained they are expected to be employed within the national health program. More importantly, the capacity development component will address the issue of capacity deficit in the health sector and enhance institutional capacity towards building resilience.

Involuntary Resettlement

3.2.14 The project will not result in any form of displacement (both physical and/or economic) as the component works will not require any land resulting in involuntary resettlement of communities and/or assets.

IV – IMPLEMENTATION

4.1 Implementation Arrangements

4.1.1 The institutional architecture in Sudan is split between federal and state level institutions. Implementation of this project will involve key federal and state institutions who are critical stakeholders tasked with delivery of key projects like this one.

4.1.2 The MoH will be the recipient of the grant, on behalf of the GoS. A PIU will be established and staffed with qualified personnel who will be selected from the MoH. The PIU will be based in and will report to the MoH on the technical implementation of the project.

4.1.3 The PIU will be composed of the following full-time staff: Project Coordinator, Procurement Specialist, Accountant, M&E Officer, Secretary and two drivers. The team will also include five part-time Technical Specialists in each of the following areas: Reproductive Health, Maternal and Child Health, Non-Communicable Diseases, Nutrition and Human Resources for Health.

4.1.4 The positions of the Project Coordinator, Accountant, Secretary and Drivers will be open to internal candidates within the MoH. Other positions including the Procurement Specialist and M&E Specialist will be recruited externally since candidates for these positions are not available internally within the MoH. In order to accelerate project implementation, the recruitment of PIU staff will commence ahead of project approval, through advance procurement procedures.

4.1.5 The contracted project staff will be hired on contracts renewable every two years based on satisfactory performance. The salaries will be in local currency equivalent to the amount budgeted in USD in the project appraisal report, applying the prevailing exchange rate at the date of signature of the employment contract.

4.1.6 For high level oversight of project implementation and to provide strategic direction to project implementation, a Steering Committee will be created. The Steering Committee will be chaired by the MoH and will include representatives from MoFEP, MoSWS, NHIF, civil society and officials from states that are represented in the project. The committee will meet at least once every quarter to monitor progress of project activities and offer guidance to resolve bottlenecks.

Implementation Schedule

4.1.7 The expected board approval date of the project is December 2017. The project will be implemented over a period of 57 months from March 1, 2018 to December 31, 2022. The grant agreement will be signed and declared effective by the Bank in January 2018 and the conditions of first disbursement will be met by February 2018. The activities are expected to commence in March 2018 following the launch workshop. The mid-term review of the project will be carried out in June 2020. The project completion is set for December 31, 2022 and the deadline for last disbursement will be June 30, 2023.

Procurement Arrangements

4.1.8 The procurement of goods, works and the acquisition of consulting services, financed by the Bank for the project, will be carried out in accordance with the “*Procurement Policy for Bank Group Funded Operations*”, dated October 2015, as amended from time to time, and following the provisions stated in the Financing Agreement. Specifically, procurement shall follow Bank Procurement Methods and Procedures using the relevant Bank Standard or Model Solicitation Documents, for any category of procurement.

4.1.9 The assessment of procurement risks at the project level and procurement capacity of the executing agency, were undertaken for the project and the outputs have informed the decisions on the procurement regimes to be used for specific transactions or groups of similar transactions under the project. The appropriate mitigation measures have been proposed to reduce any fiduciary risk in project implementation

Financial Management and Audit Arrangements

4.1.10 The overall authority and fiduciary responsibility for the Project will rest with the Undersecretary of the MoH or his delegate. The project will make use of the Country’s Public financial management systems as provided for in the Financial and Accounting Act (2007) and the Financial and Accounting Regulations (2011) as well as the Bank Rules and Procedures. The Project Steering Committee will be constituted to provide strategic, policy and implementation oversight including the review and approval of the project annual work plans and budgets. Detailed Financial Management Assessment report is presented in section B4 of the Technical Annex.

4.1.11 The day to day financial management (FM) functions including budgeting, accounting, banking arrangements, internal controls, financial reporting and audit arrangements will be handled by the Project Implementation Unit (PIU) to be constituted within the MoH. The EA will assign one of the Accountants in the General Directorate of Financial and Administrative Affairs, or will competitively recruit an Accountant with qualifications and experience acceptable to the Bank, to be part of the PIU. The PIU shall maintain separate records and ledger accounts in respect of the project transactions using the Tally Accounting Software, an accounting package which is being used by on-going projects financed by the GAVI Fund and the Global Fund. All expenditures and related supporting documents will be properly and physically archived by the PIU for supervision and auditing purposes. The internal auditors assigned to the MoH by the Internal Audit Chamber (IAC) shall include the project in the internal audit programs and will conduct regular audits of the systems, processes and transactions. The internal audit reports will be shared with the Bank during supervision missions of the Bank. In addition, the Bank will field supervision missions to provide additional FM implementation support.

4.1.12 The PIU shall prepare interim financial reports (IFR), as part of the Quarterly Progress Reports (QPR), which will be submitted to the Bank, not later than 45 days after the end of each quarter. In addition, Project specific financial statements shall be prepared in accordance with the National Accounting Standards on an annual basis, with the year end of 31 December. The project financial statements shall be audited by the National Audit Chamber (NAC) or a private audit firm competitively recruited, based on the Bank’s standard audit terms of reference (TORs). The audited Financial Statements shall be submitted to the Bank no later than six (6) months after financial year end. The project resources will cover the cost of the Audit, if carried out by a private audit firm.

Disbursement Arrangements

4.1.13 The Project shall use the Direct Payment method and the Special Account Method for disbursements. The project will use the direct payment method for the bulk of the financial transactions using a centralized payment system based at the Federal MoH level with limited funds flow to the States.

The other two disbursement methods, namely the Reimbursement and Reimbursement Guarantee methods can be used if the need arises and after consultation with the Bank and prior approval. In the case of special account method, one (1) USD denominated Special Account and one (1) local currency (Sudanese Pound) denominated account will be opened by MoH, at the Central Bank of Sudan (CBS) or in a commercial bank acceptable to the Bank, to receive funds. The opening of accounts will be an action prior to the first disbursement. The Bank will issue a disbursement letter, which will provide specific guidelines on key disbursement procedures and practices. Disbursement will follow the requirements of the Bank’s Disbursement Handbook, and the Bank will provide continued guidance to government officials in enhancing their understanding of the disbursement methods through training workshops, supervision missions and fiduciary clinics.

4.2 Monitoring and Evaluation

4.2.1 The project will be monitored using key KPIs at input, output, impact and outcome levels reflected in the project’s results based logical framework. Overall responsibility for M&E will rest with the PIU. The PIU will consist of a M&E Specialist who will monitor all the activities, consolidate data from the states including community and health facility data. An M&E system for collecting data from the communities is already in place and this system will be strengthened by training and capacity building of relevant staff. The HMIS system will also provide data from health facilities on a regular basis which will be used for monitoring the progress of the project. and prepare periodic reports including implementation progress, fiduciary status, stakeholder participation, safeguards, risks and mitigation measures.

4.2.2 The PIU will prepare the project quarterly progress reports. The Project Coordinator would then avail these reports to the Bank. The Bank’ country office in Sudan (COSD) will closely monitor day-to-day implementation of the project. The Bank will carry out at least two supervision missions annually, including financial management and procurement assessments reviews. In addition, the Bank will also carry out a mid-term review of the project and a PCR will be prepared at the end of the project. The implementation progress will render an account on the changes in indicators which will be used to monitor the progress of the project.

Table 10: Key Project Milestones

Timeframe	Milestone	Monitoring Process
December 2017	Board approval	Project approved by the board.
January 2018	Signing and effectiveness	Grant agreements signed and declared effective by the Bank
February 2018	Conditions for first disbursement met	PIU staff contracts signed
March 2018	Launch implementation of activities	Project launch workshop conducted
June 2020	Mid-term review	Mid-term review undertaken
June 2022	Completion of project	Project completion report

4.3 Governance

4.3.1 Sudan is improving its governance system to better control corruption, maintain the rule of law and increase government effectiveness. Weaknesses identified in the field of governance include: (i) major concern on value for money rationale for investing in Sudan is related to the risk and costs associated with conflict escalation; (ii) limited implementing capacity of public services and the risk of slow disbursement due to weak enforcement of the policy for removal of the sanctions, (iii) the unequal allocation of public resources between the center and peripheral states; (iv) socio-economic marginalization of disadvantaged rural populations that threatens the stability of the country and (iv) weak institutional capacity at the state level.

4.3.2 The risk of poor governance on this project mainly concerns procurement and contract execution. This risk will be mitigated by: (i) the recruitment of a PIU led by a Project Coordinator who will serve as the liaison between the Bank and the Implementing Agency; (ii) training sessions on financial management and procurement for PIU staff; (iii) close monitoring by the Bank of various stages of the procurement process through the issuance of “no-objection” opinions; (iv) direct payment for the procurement of high value goods such as medical equipment; and (v) project supervision and financial audits.

4.3.3 The Bank will closely monitor the project as per the new DBDM. COSD will provide the PIU with on-site procurement, contract and financial management support. The sectors at the HQ will work with the operations department at RDGE to oversee and support project implementation.

4.4 Sustainability

4.4.1 Project sustainability has been taken into consideration in the project design. Since the project activities have been integrated into the MoH’s program, they have a high likelihood of sustaining beyond the project period. The project will catalyze the existing capacity of the health system including health providers who are expected to continue functioning beyond the project period. High quality training received under the project can also enable health providers to train future cadres of health personnel thereby ensuring sustainability in health care provision. Similarly, health knowledge imparted to women beneficiaries and community health workers is likely to disseminate through social networks and sustain beyond the project period. Additional institutional and financial sustainability will be strengthened by providing technical assistance, training and on the job capacity development for the project staff.

4.4.2 The National Health Insurance Fund will contribute towards financial sustainability of the project by reducing the burden of health expenditures among poor and vulnerable groups. Currently, 46.3 percent of the population is covered by the national health insurance including 2.9 million poor families. Health financing reforms are underway to move towards Universal Health Coverage and expand the range of services covered. As larger numbers of people are insured by the NHIF and the range of health services covered is expanded, prospects of project sustainability will be enhanced.

4.5 Risk Management

4.5.1 Table below presents the main risks and mitigation measures.

Table 11: Risks and Mitigation Measures

Risk	Probability/ Impact	Mitigation measures
High health workforce attrition	Medium to high probability/ high impact	Provision of high quality training to upgrade provider skills and upgrading health facilities to improve working conditions will encourage retention of the workforce.
High out-of-pocket health expenditures	Medium probability/ high impact	The coverage of the National Health Insurance Fund is expanding and it aims to cover all health expenditures related to women’s and children’s health.
Delay in disbursement due to the sanctions	Low probability/ high impact	The sanctions were partially lifted in October 2017. The Bank’s has acquired an OFAC license and the GoS will open special accounts with the Bank of Khartoum which also as an OFAC license.
Limited geographical access to health facilities	Medium probability/ high impact	GoS is in the process of rehabilitating health facilities which will improve access to care. Referral linkages and community outreach of health services will be strengthened under the project.
Slow pace of project implementation	Low probability/ medium impact	MoH officials will be recruited as PIU staff to allow them to dedicate time for project implementation.
Weak community ownership of the project	Low probability/ medium impact	Use of community mobilization approaches in collaboration with Gender Directorate, MoWSS.

4.6 Knowledge Building

4.6.1 The project proposes to undertake research in order to generate knowledge and evidence from studies to be carried out during the course of implementation. The following operations research studies are proposed in the key areas of interest:

- (i) Study on building capacity for breast and cervical cancer control: The objectives are to:
 - a) develop tailored educational content on breast and cervical cancer control;
 - b) train a competent cadre of community midwives (CMWs) to perform high quality breast and cervical cancer screening with supportive supervision, task-sharing, and cascade training approach;
 - c) develop and test a mobile phone-enhanced strategy for quality assurance and rapid deployment of competent CMWs who report to a common electronic “dashboard” for monitoring and evaluation; and
 - d) implement a ‘transition to scale’ program by end of project period with 100,000 women screened.
- (ii) Qualitative research study on the barriers to reproductive health care utilization: The study will explore the key determinants of the low levels of reproductive health care utilization including family planning use and health facility delivery. In-depth interviews and focus group discussions will be carried out with women of reproductive age, their husbands and key decision makers at the household and community level that influence care seeking behavior.
- (iii) Study on the levels, prevalence and trends of nutritional security: The study will examine the correlates of malnutrition, reproductive health behaviors and cancer risk factors. The study will be based on a multi-donor nutrition survey that is currently being planned in 18 states. The project will support the survey in the four states covered and integrate additional modules on reproductive health and cancer.
- (iv) Study on the Community Health Worker Component: The study will assess baseline levels and impact of training on the knowledge, skills, attitudes of CHWs and CMWs for community-based health service delivery.
- (v) Study to evaluate the impact of the mHealth intervention: Changes in knowledge, attitudes and behaviors related to cancer, reproductive health and nutrition resulting from the mHealth intervention will be examined. This study will be a part of the M&E activity to be carried out by WHO under the mHealth component.
- (vi) Health systems study on the quality of health service provision at facilities for maternal and newborn health care: A health facility survey will be conducted at the end of the project in 2022, using the 2017 survey conducted by the MoH as the baseline to determine the impact of the project on changes in the quality of health systems.
- (vii) Health systems study on quality of information systems: The study will include a pre and post assessment of information and registration systems at health facilities including the health cadres working at the facility and community catchment areas in the four states.
- (viii) Impact assessment of health provider training programs: The study will conduct an evaluation of training programs on changes in the skills and motivation levels of health providers. The study will be integrated with the HRH workforce account electronic system.

4.6.2 In addition to these research studies, the project will strengthen M&E and HMIS systems to improve the quality and reliability of health data. Reports generated by the studies and the M&E systems

will be disseminated among key stakeholders for knowledge sharing. Scientific papers will be published in national and international journals for wider dissemination. In line with Bank's Knowledge Management Strategy 2015-2020, the knowledge obtained will be captured, documented and shared within the Bank and with other DPs and RMCs.

4.6.3 The IPR, quarterly progress reports, audit, and completion reports will also provide information on various aspects of the project for generating knowledge and documentation of lessons learned.

V – LEGAL INSTRUMENTS AND AUTHORITY

5.1 Legal Instrument

5.1.1 The project will be financed by a TSF Pillar I grant.

5.2 Conditions Associated with Bank's Intervention

A. Condition Precedent to Entry into Force of the Grant Agreement

- (i) TSF-Pillar I: The grant Protocol of Agreement for the TSF-Pillar I Grant shall enter into force upon signature by the parties thereto.

B. Conditions Precedent to First Disbursement of the Grant

The obligations of the Bank to make the first disbursement of the grant shall be conditional upon the entry into force of the grant agreements and the fulfillment by the recipient, in form and substance satisfactory to the Bank, of the following conditions:

- (i) Provide evidence of having appointed Technical Specialist staff for the PIU in each of the following areas: Reproductive Health, Maternal Health, Non-Communicable Diseases, Nutrition and Human Resource Development.

C. Undertakings

The recipient undertakes to:

- (i) Ensure that counterpart funds by GoS will be available during project implementation;
- (ii) Provide evidence of the opening of a foreign currency Special Account and a local currency account in a bank acceptable to the Bank, prior to a request for disbursement into a special account;
- (iii) Maintain close communication and coordination with federal and state line ministries to maximize benefit of the project;
- (iv) Deliver to the Bank project quarterly and all other reports in form and substance acceptable to the Bank, and
- (v) Develop a robust and reliable M&E system for collecting data from communities and health facilities and establishing a feedback loop for health providers.

5.3 Compliance with Bank Policies

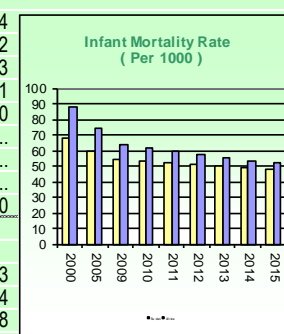
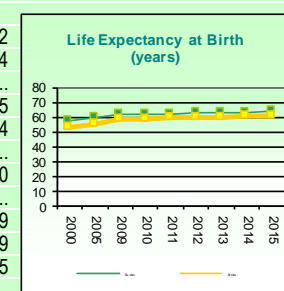
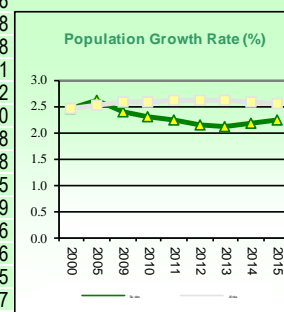
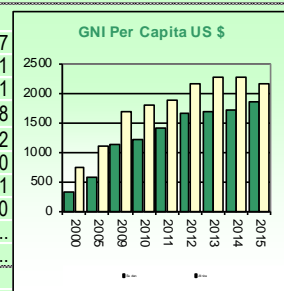
5.3.1 This project complies with all applicable Bank policies.

VI – RECOMMENDATION

Management recommends that the Boards of Directors approve the proposed TSF Pillar I grant of UA 20.05 million to the Republic of the Sudan for the purposes and subject to the conditions stipulated in this report.

Appendix 1: Comparative Socio-Economic Indicators

	Year	Sudan	Africa	Developing Countries	Developed Countries
Basic Indicators					
Area ('000 Km ²)	2016	1,879	30,067	97,418	36,907
Total Population (millions)	2016	41.2	1,214.4	6,159.6	1,187.1
Urban Population (% of Total)	2016	33.5	40.1	48.7	81.1
Population Density (per Km ²)	2016	23.3	41.3	65.1	33.8
GNI per Capita (US \$)	2015	1840	2 153	4 509	41 932
Labor Force Participation *- Total (%)	2016	48.2	65.7	63.5	60.0
Labor Force Participation ** - Female (%)	2016	24.3	55.7	48.9	52.1
Sex Ratio (per 100 female)	2016	100.8	100.1	106.0	105.0
Human Develop. Index (Rank among 187 countries)	2015	165	...	...	...
Popul. Living Below \$ 1.90 a Day (% of Population)	2009	14.9	...	...	...
Demographic Indicators					
Population Growth Rate - Total (%)	2016	2.3	2.5	1.3	0.6
Population Growth Rate - Urban (%)	2016	2.9	3.6	2.4	0.8
Population < 15 years (%)	2016	40.2	40.9	27.9	16.8
Population 15-24 years (%)	2016	20.0	19.3	16.9	12.1
Population >= 65 years (%)	2016	3.4	3.5	6.6	17.2
Dependency Ratio (%)	2016	77.1	79.9	54.3	52.0
Female Population 15-49 years (% of total population)	2016	24.5	24.0	25.7	22.8
Life Expectancy at Birth - Total (years)	2016	64.0	61.5	69.9	80.8
Life Expectancy at Birth - Female (years)	2016	65.5	63.0	72.0	83.5
Crude Birth Rate (per 1,000)	2016	32.2	34.4	20.7	10.9
Crude Death Rate (per 1,000)	2016	7.6	9.1	7.6	8.6
Infant Mortality Rate (per 1,000)	2014	47.6	52.2	34.6	4.6
Child Mortality Rate (per 1,000)	2014	70.1	75.5	46.4	5.5
Total Fertility Rate (per woman)	2016	4.2	4.5	2.6	1.7
Maternal Mortality Rate (per 100,000)	2015	311.0	476.0	237.0	10.0
Women Using Contraception (%)	2014	15.3	31.0	62.2	...
Health & Nutrition Indicators					
Physicians (per 100,000 people)	2005-2015	305.8	41.6	125.7	292.2
Nurses and midwives (per 100,000 people)	2005-2015	115.7	120.9	220.0	859.4
Births attended by Trained Health Personnel (%)	2010-2015	23.1	53.2	69.1	...
Access to Safe Water (% of Population)	2014	55.5	71.6	89.4	99.5
Access to Sanitation (% of Population)	2015	23.6	39.4	61.5	99.4
Percent of Adults (aged 15-49) Living with HIV/AIDS	2015	0.3	3.4	...	...
Incidence of Tuberculosis (per 100,000)	2015	88.0	240.6	166.0	12.0
Child Immunization Against Tuberculosis (%)	2015	88.0	81.8	...	...
Child Immunization Against Measles (%)	2015	87.0	75.7	83.9	93.9
Underweight Children (% of children under 5 years)	2010-2015	33.0	18.1	15.3	0.9
Prevalence of stunting	2010-2014	38.2	33.3	25.0	2.5
Prevalence of undernourishment (% of pop.)	2015-2016	...	16.2	12.7	...
Public Expenditure on Health (as % of GDP)	2014	1.8	2.6	3.0	7.7
Education Indicators					
Gross Enrolment Ratio (%)					
Primary School - Total	2010-2016	70.4	101.2	104.9	102.4
Primary School - Female	2010-2016	66.6	98.4	104.4	102.2
Secondary School - Total	2010-2016	42.7	52.6	71.1	106.3
Secondary School - Female	2010-2016	41.5	50.2	70.5	106.1
Primary School Female Teaching Staff (% of Total)	2010-2016	...	47.1	59.8	81.0
Adult literacy Rate - Total (%)	2010-2015	58.6	66.8	82.3	...
Adult literacy Rate - Male (%)	2010-2015	64.1	74.3	87.1	...
Adult literacy Rate - Female (%)	2010-2015	53.1	59.4	77.6	...
Percentage of GDP Spent on Education	2010-2015	...	5.0	4.0	5.0
Environmental Indicators					
Land Use (Arable Land as % of Total Land Area)	2010	8.4	8.7	11.2	10.3
Agricultural Land (as % of land area)	2010	42.1	41.7	37.9	36.4
Forest (As % of Land Area)	2010	11.5	23.2	31.4	28.8
Per Capita CO2 Emissions (metric tons)	2014	0.4	1.1	3.5	11.0



Sources : AfDB Statistics Department Databases; World Bank: World Development Indicators; UNAIDS; UNSD; WHO, UNICEF, UNDP
 Note : n.a. : Not Applicable ; ... : Data Not Available.

Appendix 2: Macroeconomic Indicators

Indicators	2009	2010	2011	2012	2013	2014	2015	2016	2017
								(e)	(p)
Real GDP Growth Rate (%)	4.5	6.5	0.9	1.4	4.4	2.7	4.9	3.0	3.4
GDP Per Capita (US \$)	1,716	1,929	1,895	1,806	1,733	2,108	2,539	2,650	2,782
Inflation (%)	11.3	13.0	18.1	35.6	36.5	36.9	16.9	13.5	15.6
Fiscal Balance (% of GDP)	-4.5	0.3	0.1	-3.1	-2.2	-1.2	-1.6	-1.8	-1.9
Gross Domestic Investment (% of GDP)	20.5	21.7	24.9	25.1	20.0	15.4	14.1	13.5	13.8
Gross National Savings (% of GDP)	11.4	18.0	18.7	9.5	11.4	10.3	8.8	9.4	...
Real Export Growth (%)	3.0	5.4	-36.4	-57.2	14.0	11.5	19.6	16.0	15.5
Trade Balance (% GDP)	-0.4	3.7	2.2	-7.0	-5.9	-4.4	-5.4	-4.9	...
Current Account (% GDP)	-8.2	-2.5	-1.9	-10.3	-8.1	-5.9	-6.4	-5.3	-4.9
Terms of Trade (%)	-32.2	29.7	133.7	8.2	-16.2	-10.0	-21.9	-9.2	-5.5
Total External Debt (% GDP)	57.6	56.7	59.2	63.4	67.4	54.7	51.2	48.6	...

Source: AfDB Statistics Department, UNCTAD and IMF.

(e) : estimated; (p) : projected

Chart 1: Sudan: Real GDP Growth Rates, (%)



Chart 2: Sudan: Consumer Price Index (Inflation), (%)

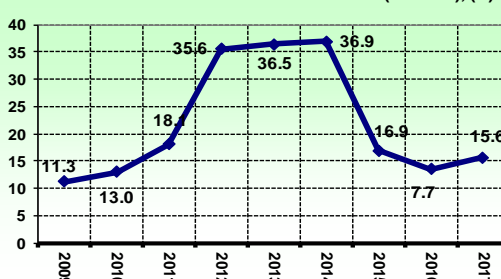


Chart 3: Sudan: Fiscal Balance, (% of GDP)

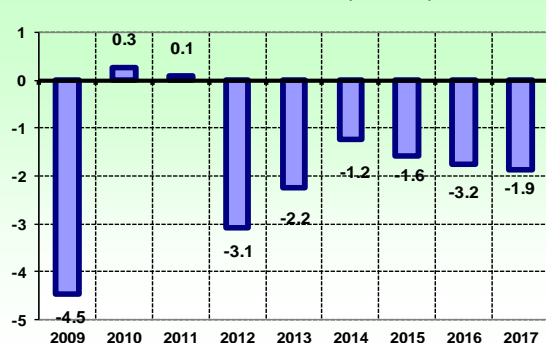


Chart 4: Sudan: Current Account Balance (% of GDP)

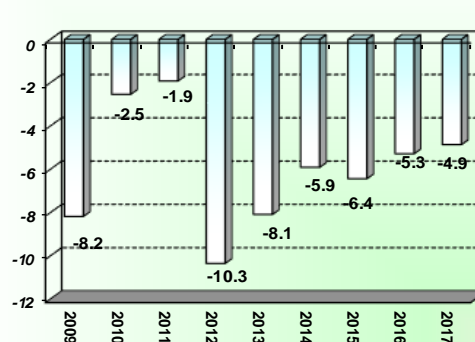


Chart 5: Sudan: Debt Outstanding (As Percentage of GDP)

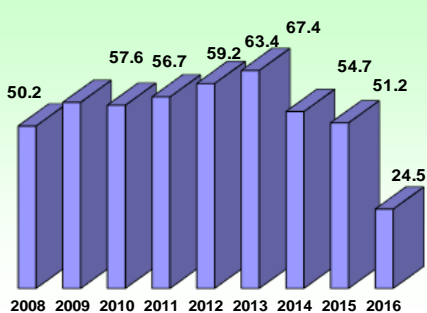
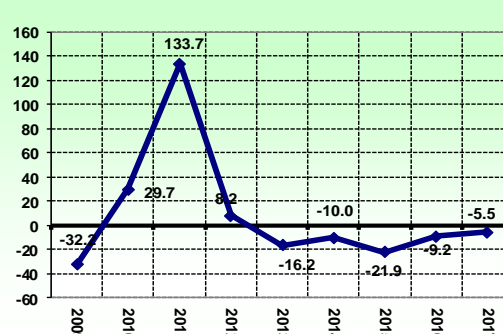


Chart 6: Sudan: Terms of Trade (%)



Appendix 3: Map of Sudan



Appendix 4: Table of AfDB's Portfolio in the Country

No	Project Name	Window	Approval Date	Disburse Deadline	Amount Approved (UA)	Amount Disbursed (UA)	Disbursed Rate (%)
1	Technical Capacity Building for Public Finance and Macroeconomic Management Project	Transition Support Facility Pillar 1 Resources	06.12.2013	05.12.2018	22,190,000	976,360	7.7%
2	African Legal Support Facility (ALSF)	ALSF	09.03.2014	30.12.2017	651,856.49	100,000.00	15.36%
3	Drought Resilience and Sustainable Livelihood Programme Phase II	TSF/RO	14.11.2014	31.12.2020	20,000,000	1,940,000.00	9.70%
4	Building Capacity for Inclusive Service Delivery	50% of PBA	02.03.2015	30.06.2020	27,990,000	163,385.18	3.89%
5	Drought Resilience and Sustainable Livelihood Programme Phase III	TSF/RO	14.11.2015	31.12.2020	10,000,000	520,000.00	5.20%
6	Capacity Building for Improved Quality of Education and Skills Development	TSF Pillar 1	14.05.2015	30.05.2020	15,000,000	570,000.00	3.80%
7	Water Sector Reform Project	TSF Pillar 1	10.07.2015	30.07.2020	15,000,000	480,000	3.2%
8	Capacity Building for Enhanced Women Participation in Peace Building and Economic Activities	TSF Pillar III	02.02.2016	30.02.2021	3,200,000.00	1,280,000.00	40.00%
9	Enable Youth Program	TSF Pillar 1	28-11-2016	28.11.2021	20,960,000	1,330,000.00	6.34%
10	Institutional Capacity Building for Improved Access to Water and Sanitation in Port Sudan	TSF Pillar 1	23.10.2017	31.12.2022	15,000,000	0.00	0%
	Total				149,991,856	7,359,745	5.45%

Appendix 5: Project Fragility Analysis

Fragility Context in Sudan

Sudan's political, economic and social stability are intrinsically intertwined. Conflicts and instability are at the very core of state fragility in Sudan. The country has been struggling to address multiple conflicts, low development and violent crisis for decades. Sudan's conflicts and state fragility is driven primarily by three factors: (i) a contested national identity; (ii) economic inequality between and within states; and (iii) divergent forms of governance at the federal and state levels. A few of these identified drivers of fragility in Sudan relevant for this project include:

- (i) Poverty and inequalities in allocation of public resources and in access to public services: There are significant variations in the allocation of resources between and within states. As a result, some states are better able to provide public goods and services than others. Conflict regions such as Darfur, Kordofan and Nile states have lower access to services and resources due to years of development lost as a consequence of war and forced displacement of the people. This inequality has resulted in greater poverty, especially in the rural localities.
- (ii) A difficult macro-economic environment for providing social goods and services: The Sudanese government has been under sanctions for a long time. With its huge debts preventing borrowing from development agencies at concessional rates, combined with its loss of oil revenue following South Sudan's secession, the country is deeply constrained in providing basic goods and services to all regions. The poor in the rural areas are the most affected.
- (iii) Poor infrastructure and human capital base for economic activity: Over the years, infrastructure and human capital development in Sudan has been constrained by war, violent conflicts and poverty. The significant difference between states in economic development is partly driven by the differential levels of infrastructure and human capital combined with unequal distribution of resources, productive assets and access to economic activity.

Fragility-responsive project design

At the project-level, the design and implementation including the activities at different levels are targeting different drivers of fragility that have been identified. In applying a fragility-lens in this project, the approach was to unpack the relevant drivers of fragility into downside or project-level risks and challenges. The next step was to match the proposed project-level interventions and activities to the identified risks. The underlying assumption in this approach is that by making project interventions address project-level risks, the project ultimately contributes to address the major drivers of fragility affecting the sector and country at large. The table below presents the approach of applying fragility-lens in the project design with the view of making the project contribute to addressing the root cause of fragility in Sudan while contributing to national goals.

Conclusion

By investing in improving health access and systems strengthening, the project will contribute to meeting the huge demand for basic health care in order to reduce the high rates of mortality and morbidity among women and children in Sudan. Through improved access to basic health services, the gap between the rich and poor is shortened. Ultimately, the project will contribute to inclusive economic growth and poverty reduction as part of the national efforts and strategies to address fragility in Sudan.

Drivers of Fragility	Downside risks stemming from the drivers of fragility	Proposed Project interventions
Low coverage of basic health infrastructure	<ul style="list-style-type: none"> • Poor condition of health infrastructure • Lower coverage of states outside Khartoum • Exclusion of rural communities 	<ul style="list-style-type: none"> • Rehabilitation and equipping of four training institutes • Provision of medical equipment such as radiotherapy, CT scanners and MRI • Provision of training materials and construction of laboratories. • Provision of mobile health clinics to reach the rural poor. • Renovation and equipping of technical and vocational schools with modern ICT equipment and technology e.g. use of mHealth
Difficult macro-economic environment	<ul style="list-style-type: none"> • Inadequate investment in the health sector • Migration of trained human resources • Youth unemployment 	<ul style="list-style-type: none"> • Increased investment flows for basic health services to reach many poor and uncovered citizens • Economic opportunities for skilled human resources in the health sector • Skills development for youth and health workers for job creation and entrepreneurship
Low human capacity at supply side	<ul style="list-style-type: none"> • Lack of sufficiently trained health workers and professionals • Poor health system administration • Limited availability of community health workers to reach vulnerable populations 	<ul style="list-style-type: none"> • Development of regulatory frameworks in accordance with international guidelines and standards to ensure compliance • Project will upgrade the capacities of more than 900 pathologists and lab technicians to improve the quality of diagnostic services for cancer. • Training of more than 1000 relevant experts, technicians and community volunteers on nutrition. • Specialized training for medical doctors and nurses on oncology, palliative care, etc. • Build mass of 40,000 community health workers to deliver an integrated package of health care including reproductive and child health, nutrition, etc.
Weak institutional capacity	<ul style="list-style-type: none"> • Poor management capacity of the federal- and state-level basic healthy institutions 	<ul style="list-style-type: none"> • Capacity building for the Ministry of Health at all levels in the fields of planning, policy reforms, decentralization, governance and service delivery • Design policy framework for monitoring and evaluation of basic health decentralization • Technical assistance for disease surveillance, monitoring and evaluation to be strengthened at federal, state and district levels. • Undertake research studies for needs assessment and evaluate impacts of project interventions.

Références

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- iv Idem
- v Idem
- vi Idem