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Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 09-Jan-2019 | Report No: PIDISDSA25414



BASIC INFORMATION

A. Basic Project Data

Country Mali	Project ID P165534	Project Name Mali - Accelerating Progress Towards Universal Health Coverage	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 14-Jan-2019	Estimated Board Date 19-Mar-2019	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Mali	Implementing Agency Ministère de la Santé	

Proposed Development Objective(s)

The objective of the project is to improve the utilization and quality of reproductive, maternal, neonatal, child, adolescent health and nutrition services, especially among the poorest households, in targeted areas.

Components

Strengthening Health Service Delivery through Performance Based Financing at Facility Level
Strengthening Community HealthActivities
Strengthening Stewardship and Health System Performance
CERC

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	60.00
Total Financing	60.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
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IDA Grant	50.00
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Non-World Bank Group Financing

Trust Funds	10.00
Global Financing Facility	10.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

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Other Decision (as needed)

B. Introduction and Context

Country Context

- Mali is a semi-arid, landlocked, low-income country with high demographic growth. With an annual per capita income of about USD 750 in 2016¹,** Mali belongs to the group of 25 poorest countries in the world. The country’s economy is predominantly rural and informal: agriculture and natural resource rents (gold, uranium) represent about 45 percent of GDP, 75 percent of the population reside in rural areas, and 80 percent of the jobs are in the informal sector. Mali’s population is estimated at 19 million (2018) with a high average growth rate at around 3 percent per year and a median age of 16 years. Most of the Malian population lives in the South of the country, and the Northern regions of Tombouctou, Gao and Kidal represent less than 10 percent of total population. With an average population density of about 16 inhabitants per square kilometers (55 in the South and 2 in the North), Mali is one of the least densely populated countries in the world.
- In 2016², about 8.6 million Malians live below the poverty line (46.8 percent of the population).** The average poverty headcount remained relatively stable (around 47 percent) since 2011, but the population living below the national poverty line increased due to population growth (Table 1). In 2016,

¹ GNI per capita, Atlas Method.

² INSTAT (2017) Enquête Modulaire Permanente Auprès des Ménages (EMOP).



the regions of Sikasso, Mopti, Ségou and Koulikoro concentrate most of the poor population (representing over 80% of the 8.6 million poor in Mali).

Table 1: Poverty trends

	2011		2013		2014		2015		2016	
	Population (million)	Poverty rate (%)	Population (million)	Poverty rate (%)	Population (million)	Poverty rate (%)	Population (million)	Poverty rate (%)	Population (million)	Poverty rate (%)
Kayes	2.2	40.0%	2.3	43.3%	2.4	34.9%	2.4	35.1%	2.5	31.3%
Koulikoro	2.6	46.6%	2.8	42.6%	2.9	47.7%	3.0	44.1%	3.1	51.5%
Sikasso	2.9	58.1%	3.1	61.5%	3.1	65.8%	3.2	65.1%	3.3	66.2%
Ségou	2.5	52.2%	2.7	52.4%	2.8	56.8%	2.9	59.1%	3.0	55.5%
Mopti	2.2	60.7%	2.4	67.2%	2.4	60.4%	2.5	63.6%	2.6	64.6%
Tombouctou	0.7	47.0%	0.8	NA	0.8	26.7%	0.8	26.4%	0.9	16.9%
Gao	0.6	34.3%	0.6	NA	0.6	43.2%	0.7	47.7%	0.7	52.5%
Kidal	0.1	4.4%	0.1	NA	0.1	NA	0.1	NA	0.1	NA
Bamako	2.0	10.7%	2.1	10.3%	2.2	11.1%	2.2	11.2%	2.3	7.4%
MALI	15.8	45.4%	16.8	47.1%	17.3	46.9%	17.8	47.2%	18.3	46.8%

Note: Poverty incidence are from EMOP 2011, 2013, 2014, 2015 and 2016

Population numbers are official Malian estimates from the National Population Division (Direction Nationale de la Population DNP) based on the 2009 census (RGPH)

- Non-income indicators of poverty and welfare, particularly for education and health, are among the lowest in the world, and most Sustainable Development Goals (SDGs) appear hard of reach.** Mali ranked 175 out of 188 countries on the 2015 UN Human Development Index (HDI). Literacy rates have slightly improved over the past decade, but with 34 percent of literate adults, Mali remains one of the countries with the lowest literacy rates in the world. Moreover, gender inequalities persist with adult male literacy rates being about twice as high as for adult women.
- The political and security situation in Mali has been volatile since the 2012 coup d'état and following the implementation of the Algiers Peace Agreement in 2015.** Particularly, the northern half and central areas of the country have faced significantly Fragility, Conflict and Violence (FCV). Mali is classified by the World bank as an FCV country since 2014 due to the establishment of a UN peace keeping mission (United Nations Multidimensional Integrated Stabilization Mission in Mali, MINUSMA) in the country since April 2013. In June 2017, the UN Security Council decided³ to extend the mandate of the MINUSMA for one year.
- The incumbent President Ibrahim Boubacar Keita won a second term in the run-off vote of the 2018 presidential election.** Turnout on the second round (August 12th) was 34%, was well down on the first round, when it was 43%. Mr Keita won 41% in the first ballot on July 29th, more than double that secured by the opposition leader Mr Soumaila Cissé, and his final victory was anticipated by most political analysts. Before the result was announced Mr Cissé had rejected the outcome of the run-off, alleging widespread fraud. The head of Mali's EU observer mission reported irregularities but no fraud, although international observers were not able to monitor polling stations in highly insecure northern and central regions.

³ UN Resolution 2364 (2017).



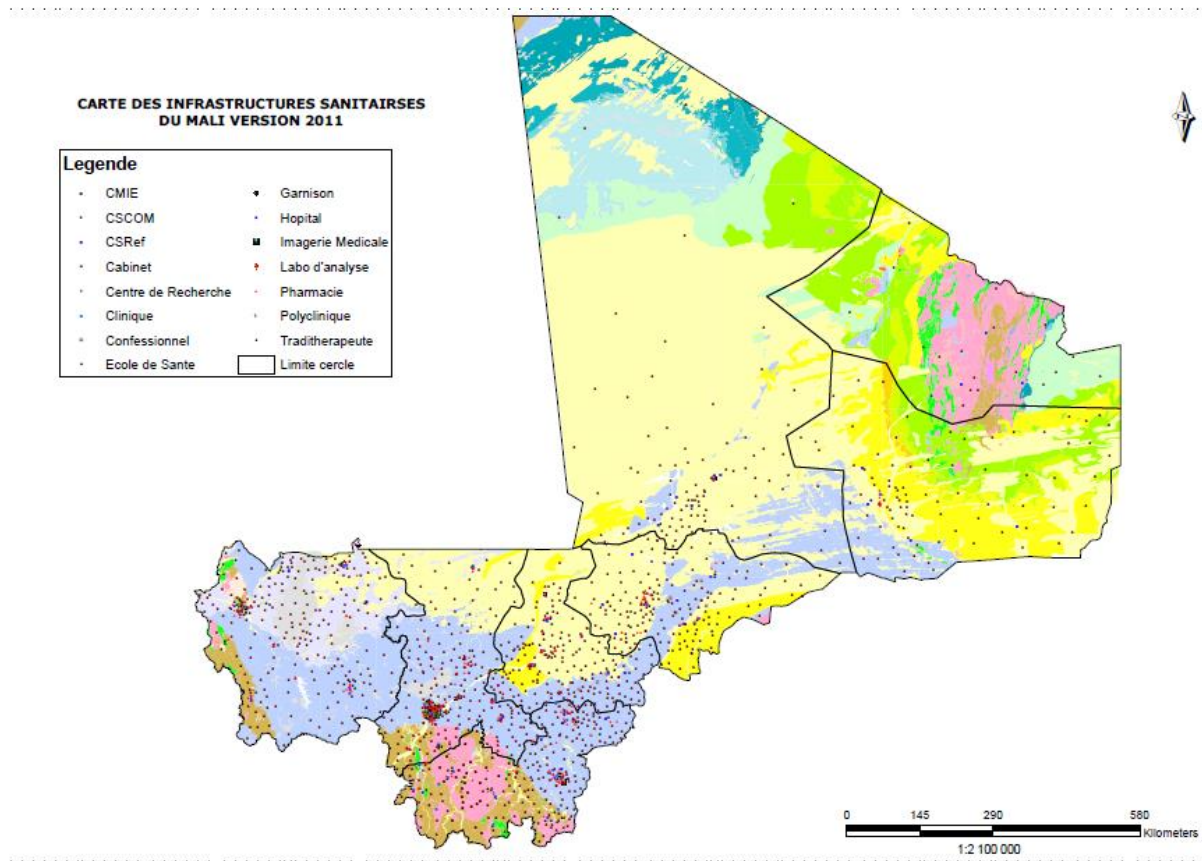
Sectoral and Institutional Context

Health system

6. **Health care in Mali is organized in three levels.** The first level has two layers. Primary care is provided by the 1,294 Community Health Centers (Centres de Santé Communautaires, CSCoM) which are private non-profit entities contracted by the communes to provide basic health care. The basic benefit package (Paquet Minimum d'Activités, PMA) is also provided by semipublic, confessional facilities, by rural maternities, and by private for-profit facilities. A second layer of care is covered by 63 first referral facilities (Centres de Santé de Référence, CSRef). The second level of care is provided by the 7 regional hospitals (Établissements Publics Hospitaliers, EPH). At the third level, specialized care is provided by 5 EPH. The geographical distribution of health facilities in Mali is depicted in Figure 1 below.



Figure 1: Sanitary Map of Mali (2011)



Source: Cellule de Planification et de Statistique Secteur Santé

7. **The private sector plays an important role in the delivery of health goods and services in Mali⁴. However, the contribution of the private sector to improving health outcomes is constrained by several bottlenecks:**

- **Inadequate regulation**, leading to poor and uneven quality of goods and services. It takes on average between 3-12 months to obtain a health business license in Mali, and this leads to health businesses to operate informally without proper license.
- **The modalities of public-private partnership in financing health services, such as contracting, are non-existent.** The private sector in Mali is not systematically integrated in the provision of essential public health services. One reason behind this lack of integration is the fact that health entrepreneurs (mostly health professionals) seldom have the necessary skills to develop and manage business projects, and as a result, financial institutions tend to be very cautious in their lending decisions.
- **Mali has no official policy on collaboration with health SMEs.** The private sector has a unified body called the private sector alliance and is now engaged with the public sector on expanding

⁴ According to the 2017 EMOP, it represents about 30 percent of the contact of the population with health facilities.



access to quality health care, conduct a dialogue with the Ministry of Health (MoH), commercial banks, and other financing and technical partners. However, a slow and limited public-private dialogue platform undermines the level of policy engagement by the private sector, thus perpetuating their exclusion from the policy making processes and structures in the country.

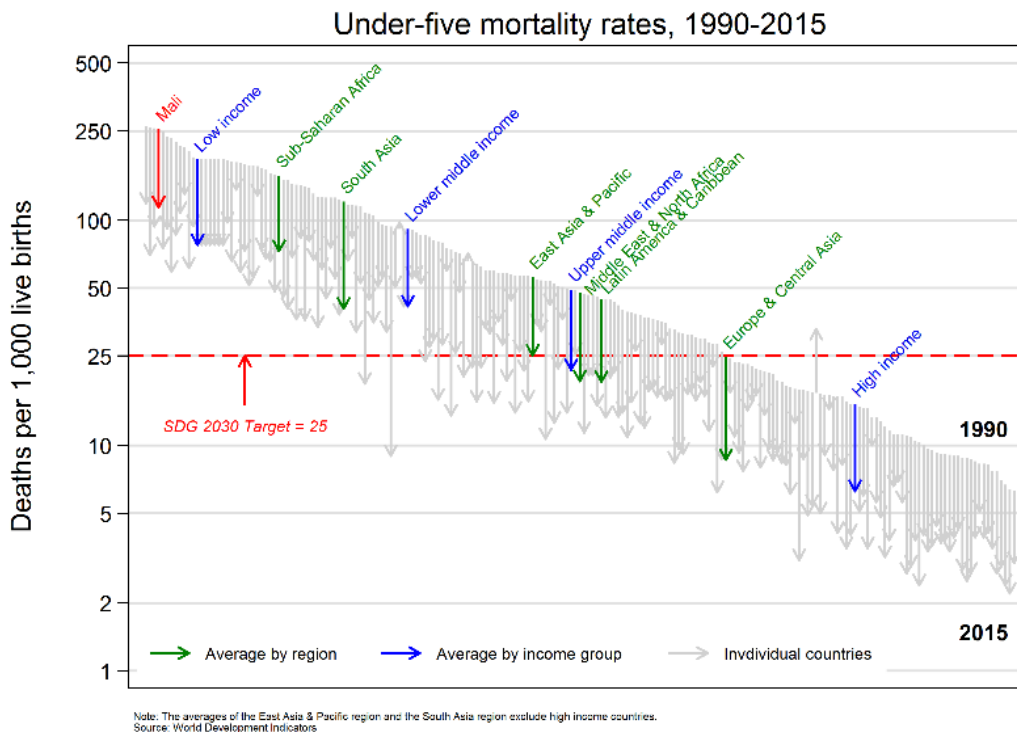
Low health outcomes and slow progress towards Universal Health Coverage (UHC)

8. **Mali is among the five countries in the world with the largest burden of disease⁵.** About 65,000 disability adjusted life years per 100,000 population are lost every year. While the share of non-communicable diseases has been increasing since the 1990s, communicable, neonatal, maternal and nutritional disease still account for about 73 percent of the overall burden.
9. **On average, about 160,000 women and children under the age of 5 die every year.** Despite improvement in recent years on key health outcome indicators, trends in progression remain slow and insufficient in relation to investments and expected targets. The maternal mortality ratio dropped from 1,010 per 100,000 live births in 1990 to 587 in 2015 (with an SDG target of 70 for 2030), while the under-five mortality rate fell from 254 per 1,000 live births in 1990 to 114 in 2015 (with an SDG target of 25 by 2030). Mali has the world's sixth highest national under-five child mortality rate in 2015 (Figure 2).

⁵ Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2017. Available from <http://vizhub.healthdata.org/gbd-compare>. (Accessed March 18th, 2018).



Figure 2: Trends in under-5 mortality



10. **Nutrition outcome indicators have not improved since 2009.** The percentage of stunted children increased from 28 percent in 2009 (**Multiple Indicator Cluster Surveys, MICS**) to 38 percent in 2012 (Demographic and Health Survey, DHS) and 30 percent in 2015 (MICS). Stunting rates are especially high (above 30 percent) in Tombouctou, Mopti, Ségou and Gao, as well as among the poorest children (40 percent among the poorest quintile). Acute malnutrition rates also remain high and constant since 2009 around 10% of all children under 5. Malnutrition in the early years is known to impair cognitive, physiological and socioemotional development, thereby undermining educational performance during school age, health, and earning potential as an adult. In sum, child malnutrition remains a major impediment to ensuring optimal accumulation of human capital in Mali, and one of the key markers of poverty and vulnerability.

Fertility and demographic trends are an important policy concern in Mali

11. **The demographic transition (the shift from high to low mortality and fertility levels) and demographic dividend are central to the discussion on both health and economic growth in Mali.** While Mali has started its demographic transition, the pace is too slow and is at high risk of not harvesting the demographic dividend. The demographic dividend is characterized by a period in a country's demographic transition when the proportion of working age population is higher compared to the number of dependents. This period corresponds to an extra economic boost through increased savings and private investments. 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 good jobs. According to the 2015/2016 Global Monitoring Report classification, Mali is a pre-demographic dividend country.

12. **Mali has the highest adolescent age-specific fertility rate in the world with 17 births per 1,000 women aged 10-14, and with 15.1 percent of female adolescents aged 15 to 19 who already had given birth in 2015.** The regional disparities are significant: in Kayes and Koulikoro, respectively, 20 percent and 18 percent of young women 15 to 19 years of age had already had a child in 2015, while in Bamako this rate was only 7.4 percent. Here too, education and poverty are determining factors: nearly 44 percent of women aged 20 to 24 without any education had a live birth before the age of 18 years old, versus 28 percent among girls with a secondary education. Similarly, 34.4 percent of young women aged 15 to 19 in the poorest quintiles had begun their reproductive life, while 18.8 percent of young women in the richest quintile had done so.

Insufficient coverage of essential quality RMNCAH and nutrition services

13. **Mali has achieved some improvements in specific RMNCAH and nutrition services, but these are insufficient and important coverage gaps remain to accelerate progress towards achieving UHC.** Important progress in terms of family planning coverage, coverage of Insecticide-Treated Bed Nets (ITN), in-facility deliveries and births assisted by skilled attendants have been observed between 2009 and 2015, and part of this progress can be attributed to the previous WB health project. Unmet need for family planning dropped down from 30 percent to 17 percent. Despite these observed improvements, there has been a lack of improvement in early (adolescent) childbearing, in the percentage of pregnant women having completed 4 antenatal care visits, a decrease in the percentage of children benefiting from an adequately diversified diet, and in the percentage of children treated for fever or malaria (Table 2).



Table 2: Levels, trends and inequalities in selected health, nutrition and population indicators (2009-2015)

	2009	2012	2015	Change between 2009 and 2015	2015	
	National	National	National	National	Urban	Rural
Health outcomes						
Infant mortality rate (per 1,000 live births)	81.8	75.1	69.6	++	-	-
Under five mortality rate (per 1,000 live births)	141.7	126.6	114.2	++	-	-
Maternal mortality ratio (per 100,000 live births)	652	617	587	++	-	-
Total fertility rate	6.6	6.1	6.0	NC	-	-
Stunting (%)	27.8	38.3	30.4	NC	16.7	33.8
Anemia (% 6-59 months old)	71.9	81.7	NA	--	-	-
Service coverage						
% Unmet demand for FP	30.8	26.0	17.2	++	14.8	17.8
% Women in union using modern contraceptive methods	8.0	9.9	15.1	++	27.6	12
% Adolescent having started childbearing	33.4	39.3	31.6	NC	19.3	36.6
% Women receiving at least 4 ANC	34.9	41.2	38.0	NC	64.7	31.8
% Deliveries in facilities	55.5	55.0	64.5	++	95	57.3
% Skilled birth attendance	29.1	58.6	60.4	++	91.3	53.1
% Full immunization	20.4	31.4	24	++	32.5	22
% Exclusive breastfeeding (children 6 months old or younger)	20.4	32.9	32.6	++	32.2	32.6
% Households using adequately iodized salt	64.4	91.7	77.5	++	81.3	76.3
% Treated for diarrhea	32.3	34.4	28.7	--	36.1	27.2
% Treated for ARI	55.9	31.2	23.0	--	8.7	26
% Children 6-23 months with adequately diversified diet	NA	21.6	13.5	--	22.2	11.3
% Children under 5 sleeping under ITN	45.6	69.0	79.3	++	83	78.4
% Pregnant women sleeping under ITN	45.8	73.2	66.2	++	70.7	65.1
Water and sanitation						
% households with access to improved water sources	56.7	66.0	69.2	++	93.2	62.7
% households with access to improved sanitation	27.1	22.0	33.3	++	53.0	28.0

Note: (-) relative deterioration by 10% or more ; (++) relative improvement by 10% or more; NC: no change.

Source: WHO estimates, DHS 2012, and MICS 2009, 2015.

- Important inequalities persist for some essential health service coverage indicators.** In 2015, women in union are more than 6 times more likely to have access to modern contraceptive methods if they are better off compared to the poorest 20 percent, and pregnant women are twice more likely to benefit from 4 antenatal care visits in urban areas, and three times more likely to benefit from it if they come from the richest 20 percent compared to the poorest quintile. Skilled attendance at birth is also five almost times higher among the urban compared to the rural population (Table 2).
- Providing access to quality essential RMNCAH services remain challenging in the North and center of the country where the humanitarian assistance approach still dominates longer term development objectives.** The northern crisis has had significant health, social and economic consequences. The inadequacy of medical personnel, the unavailability of drugs and products and other basic inputs have contributed to the decline in the functioning of health services. Attendance at the centers as well as the quality of perinatal referral-evacuation significantly reduced the availability of emergency obstetric and neonatal care (SONU). The Ministry of Health has established free care schemes for specific populations implemented by international Non-Governmental Organizations (NGOs). Since the outbreak of the crisis, acute malnutrition rates have reached critical levels in the conflict-affected regions of Timbuktu (17.7%), Gao (15.2%) and Taoudenit (14.3%).
- Zooming in on Mali's gender inequity** as the gap between men and women continues to be a burden on



the health and other sectors. Fundamental difference between men and women is one of the drivers of the country's instability. Despite the many attempts by the Government to address gender disparities, cultural and traditional practices remain anchored in the social fabric and increases bottlenecks in financial and equitable access to quality health services. GBV is exacerbated by the conflict in the North, the inability of the Government to determine clear and implementable policies. Young girls and women, are subjected on to early marriage and pregnancies which in turn increases the risks for complications at birth, fistulae and low birthweight in children. In addition to early marriage female genital mutilation is still prevalent in Mali. With an estimated 94.1% of girls and women ages 15-34 having been mutilated (cut), the country ranks among the population with the highest number of victims. This phenomenon is partially due to a lack of legislation, cultural and social beliefs and the absence of social measures to curb the practice. The project will give special provision to women who have undergone the practice by putting in place support groups to care for women suffering from the consequences of FGM, women suffering from the consequences of GBV and women in prison.

17. **Equity in access to health services.** The gender gaps have narrowing in Mali, despite hopes raised by the 2009 discussions around the Family Code; discussions were unsuccessful and in 2012 president Amadou Toumani Toure (ATT) withdraw the law from parliament. This action was daunting as the code was set to raise the age of marriage (now officially 16 for girls) and 18 for boys and a way to preventing more maternal and child mortality. The Code also was set to give women in the younger generation 15-34 age group; increase access to land and thus paving the way for women to acquire and income and be able to purchase much needed health services and improve the overall health their families. The uproar from conservatives caused the law to be withdrawn and the gender gap did not cease to widen.

Low, inefficient and fragmented health financing

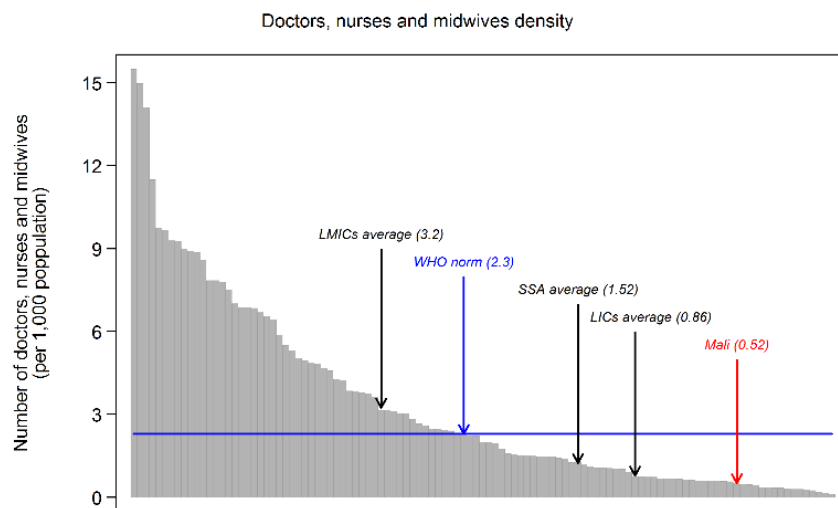
18. **Coverage of quality essential health services is low partly because of a low volume of financing resources for health.** With less than USD 50 per capita year available for current health expenditures, Mali is one of the 25 countries in the world for which health financing per capita is the lowest (USD 42 per capita according to WHO in 2015). Domestic resources represent 64 percent of annual current health expenditures, but only 16 percent come from public sources, while household out-of-pocket (OOP) health payments represent 46 percent of current health expenditures.
19. **Domestic public resources allocated to the health sector are relatively low and represent about 6 percent of government budget,** or USD 8 per capita per year, which is far from the 15 percent target set by the government after signing the Abuja Declaration in 2001, and below what countries allocate at similar level of income. Hospitals represent 36 percent of public spending, while 30 percent is allocated to ambulatory care, and 20 percent goes to preventive care services. Public funding for health remains low at the decentralized level with local collectivities contributing to less than 0.2 percent of overall current expenditures.
20. **The devolution of responsibilities for health functions from the central level to the local collectivity level has had mixed results.** The decentralization policies put in place in 2005 have translated in a devolution of responsibilities for health functions from the central level to the commune level. However, this decentralization process has had mixed results in the health sector, because (i) local authorities are still often unaware of the details of the responsibilities transferred by law, (ii) because of low capacity at



the local collectivity level for resource planning and management, and (iii) because the transfer of fiscal resources to local governments are still insufficient. While the government committed to transfer 30 percent of fiscal revenues to local and regional authorities, the actual amount transferred are below target.

- 21. **Because of low domestic revenue mobilization for health, inputs into the health system are below international norms and constitute a major constraint for the provision of quality health services.** On average, less than half of the Malian population lives within a 5-km distance of a health facility, and close to 30 percent of the population are not within a 15-km reach of a health facility. Moreover, Mali counts on average about 0.52 doctors, nurses and midwives per 1,000 population, which is below the World Health Organization (WHO) norm (2.3) and below the average low-income countries (0.9) and in Sub-Saharan countries (1.5) (Figure 2). Moreover, the geographic distribution of health personnel in Mali is uneven, with higher densities in urban areas and in some regions (Bamako has almost 2 personnel per 1,000 population while Taoudénit, Gao, Sikasso and Mopti count less than 0.3 personnel per 1,000).

Figure 3: Health personnel density



Sources: World Development Indicators; WHO Global Health Observatory.
Note: Human resource data for Mali are from 2016.
High income countries are excluded.

- 22. **Services are also underutilized because prepayment schemes have so far been fragmented and only cover about 13 percent of the population.** Formal sector employees and civil servants are covered by a mandatory health insurance scheme administered by a semi-autonomous public insurance agency (Caisse Nationale d'Assurance Maladie, CANAM) in charge of managing the contributory insurance scheme (Assurance Maladie Obligatoire, AMO). By 2016, about 1,143,437 individuals were registered with the AMO, representing about 6.2 percent of the population, and about a third of the target population. Funding for the CANAM and the AMO comes from employer and employee contributions. The Régime d'Assistance Médicale (RAMED) is a non-contributory scheme for the indigents administered by the Agence Nationale d'Assistance Médicale (ANAM). The status of indigence is considered temporary



and the insured members' cards are renewed annually. Identification of beneficiaries is conducted by social services using means and proxy-means testing. In 2016, about 134,875 individuals are registered as RAMED beneficiaries, which represent less than 1 percent of the population for a target number of 5 percent of total population. Moreover, 193 community-based health insurance schemes (Mutuelles) target the informal sector with ability to pay and offer voluntary health insurance to the population. In 2016, these Mutuelles cover less than 5 percent of total population (or 6.3 percent of the target population). Pooling of funds among the various schemes is currently not done systematically, only about 30 of these schemes are pooling funds through the Union Technique de la Mutualité (UTM). Finally, in addition to these prepayment schemes, the government support free care schemes (gratuités) by subsidizing specific services (e.g. caesarian-section, malaria treatment, HIV-AIDS).

23. **In July 2018, the Government of Mali has adopted a law to consolidate these different schemes under a unique universal health insurance regime (Régime d'Assurance Maladie Universelle, RAMU) to be managed by the Caisse Nationale D'assurance Maladie (CANAM).** The law will establish a unique universal health insurance regime to cover the provision of a basic benefit package to the Malian resident population. Affiliation to the new regime will be partly contributory, and partly non-contributory. Full coverage will be provided for RAMED beneficiaries. The new regime will integrate the AMO, the community-based health insurance schemes, and the RAMED under one umbrella. The CANAM will oversee the management of the RAMU and with a delegation of management to (i) the Institut National de Prévoyance Sociale (INPS), (ii) the Caisse Malienne de Sécurité Sociale (CMSS), (iii) the Union Technique de la Mutualité (UTM), and (iv) the Agence Nationale d'Assistance Médicale (ANAM). MOH is associated in the reform for the definition of the package of services and for aspects related to the regulation and control of the service provided. Conventions will be established between the CANAM and the service providers to define the tariffs and the services covered. Financing will come from public resources (central and decentralized), contributions, generated revenues, and innovative financing sources.
24. **External agents contribute to 26 percent of current health expenditures in Mali.** There are 13 main development partners financing health in Mali. There is also an important number of emergency donors and NGOs which are important actors in the field, especially in the North of the country where they deliver 80 to 90 percent of health services. Donors finance different health areas from basic health care and nutrition, reproductive health, to infectious and non-infectious diseases. They also support institutional reforms, human resources training and administrative management. Though, there is a great diversity of donors, a lot of projects are pilot projects or target specific regions or population. There is a concentration of financing in 2014 and 2015, with four donors (USAID, The Netherlands, Canada, and UNICEF) providing 77 percent of all partners funds disbursed in health sector in Mali. From 2016 to 2019, twelve donors have planned to intervene in the health sector for a total amount of USD 667 million. The largest contributors to this sector would be UNICEF (USD 152 million) and USAID (USD 148 million) while other donors like GAVI (USD 69 million) or France (USD 55 million) will increase their contributions.
25. **Low public health expenditures imply a heavy reliance on private out-of-pocket (OOP) expenditures for health financing.** In 2015, household OOP health payments represent 46 percent of current health expenditures in Mali. Cost recovery through user fees often represent up to half of the revenues in primary health care facilities (CSCOMs). This represent a major financial barrier to health care access and



often translates into high forgone care for economic reason. According to the 2017 EMOP survey, 46 percent of the population in need of health care said they did not use health services because it was too expensive. High financial barriers also frequently result in auto medication.

26. **In addition to deterring use of services, OOP also impose an important financial burden on the Malian families and contribute to pushing people in poverty.** For those who can afford to pay for health services, OOP can impose a heavy burden on household budget, and it can push vulnerable households below the absolute poverty line (USD 1.90 per capita/day). According to the ELIM and EMOP surveys conducted in Mali, the number of people pushed below the poverty line has increased steadily since 2006. In 2015, more than 400,000 individuals were impoverished because of OOP health expenditures, this corresponds to an increase in the national poverty headcount of 2.3 percentage points. This rising trend is due both to an increase in the percentage of people being impoverished, and to population dynamics (Table 3).
27. **In summary, financial governance is a main bottleneck in the health sector:** low mobilization of public domestic resources, high reliance on out-of-pocket private payments, input-based financing, fragmentation of prepayment schemes, and rigidity of public spending procedures are prevalent. This contributes to significant geographic and socio-economic inequities in access to essential health services and to low quality of service provision. Consequently, there is a need to increase efficiency and prioritization in public spending to improve health outcomes.

Sectoral strategy

28. **In 2014, Mali adopted a 10 years multisectoral development plan (Plan Décennal de Développement Sanitaire et Social, PDDSS) to develop its population, health and social strategies for 2014-2023.** The PDDSS was developed under the joint leadership of the Ministry of Health, the Ministry of Social Affairs, and the Ministry for the Promotion of Women, Family and Children, with the Planification and Statistical Agency (Cellule de Planification et de Statistique, CPS) coordinating the effort. The PDDSS defined 11 strategic objectives including the promotion of women and child health (objective #1), strengthening health service provision and quality of health services (objective #6), health financing (objective #9), strengthening the health information system (objective #10), and supporting decentralized governance (objective #11).
29. **The implementation of specific social and health policies to achieve the PDDSS objectives was articulated in a 5 years plan (Programme de Développement Socio-Sanitaire, PRODESS III 2014-2018 which was recently evaluated.** Within the first component of the PRODESS dedicated to public health policies, (i) strengthening community health services, (ii) introducing PBF, (iii) improving governance and (iv) strengthening the health information system are identified as key strategic sectoral priorities. The evaluation of the PRODESS III highlights important bottlenecks related to low performance, fragmented financing, and weak governance of the health system which hindered the achievement of some of the key objectives set in 2014. The next 5 years plan (PRODESS IV) is currently in development and is expected to be finalized in the first half of 2019.
30. **Additionally, Mali has recently joined (June 2018) the Global Financing Facility in support of Every Women and Every Child (GFF).** The GFF Trust Fund acts as a catalyst for financing, with countries using



modest GFF Trust Fund grants to significantly increase their domestic resources alongside the World Bank's IDA and IBRD financing, aligned external financing, and private sector resources. Each relatively small external investment is multiplied by countries' own commitments – generating a large return on investment, contributing to lives saved and to the accumulation of human capital. A governance structure spearheaded by the Malian government will be established to oversee the preparation of an Investment Case for reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH). The GFF presents considerable opportunities for the country, on several fronts. First, the country's response to RMNCAH has been fragmented, with separate analytical work and strategies for various aspects of the RMNCAH continuum. Second, some key technical elements that the GFF emphasizes – such as frontline service delivery, equity, financial protection and efficiency – have been under-addressed in Mali. Third, progress on health financing and on achieving value for investment in health has been limited.

31. **PBF is a disruptive health system strengthening reform which has been introduced in many low, lower-middle income⁶, and in fragile and conflict-affected settings⁷.** The foundation of PBF is based on a contractual relationship between the different actors of the health system. PBF is implemented to address critical impediments confronting the delivery of services at frontline health facilities. These challenges include the (i) shortage of funds to meet operating expenses, (ii) lack of autonomy to manage resources to procure drugs and attract and motivate qualified human resources; (iii) lack of focus on results and limited use of performance data at all levels (health facility, district; regional and national) (iv) lack of accountability and transparency of the health system; and (v) weak managerial capacity at all levels. Instead of allocating physical and human resources (physical inputs) through central planning, PBF is addressing the above-mentioned challenges by allocating financial resources to frontline health facilities based on results achieved to enhance the availability, the accessibility and the quality of essential services. In addition, PBF leverages existing sunken investments (building, equipment, and centrally planned human resources), vertical program investments and other resources. PBF has been associated with improvements in both the quantity^{8,9} and the quality¹⁰ of services provided. Pragmatic adaptation of the textbook PBF model is however important^{11,12} to maximize the likelihood of sustainable success.
32. **PBF was piloted in Koulikoro “à la Malienne” and has been identified as a central strategy for health system strengthening that will contribute towards achieving UHC.** The PBF experience in Koulikoro was implemented on a short timeframe (8 months) but the endline assessment of the pilot suggested

⁶ Dimitri Renmans et al. (2016) Opening the 'black box' of performance-based financing in low- and lower middle-income countries: a review of the literature. *Health Policy and planning*, 31, 1297-1309.

⁷ Maria Paola Bertone et al. (2018) Context matters (but how and why?) A hypothesis-led literature review of performance-based financing in fragile and conflict-affected health systems. *PLoS ONE* 13(4).

⁸ Paul Gertler and Giovagnoli, P.I. (2014) Rewarding provider performance to enable a healthy start to life: evidence from Argentina's Plan Nacer. *World Bank Policy Research Working Paper* #6884.

⁹ Maria Steenland et al. (2017) Performance-based financing to increase utilization of maternal health services: Evidence from Burkina Faso. *SSM – Population Health*.

¹⁰ Omer Zang et al. (2015) Impact of performance-based financing on health care quality and utilization in urban areas of Cameroon. *African Health Monitor*.

¹¹ Maria Paola Bertone et al. (2018) Performance-based financing in three humanitarian settings: principles and pragmatism. *Conflict and Health*, 12:28.

¹² Elisabeth Paul et al. (2018) Performance-based financing to strengthen the health system in Benin: challenging the mainstream approach.



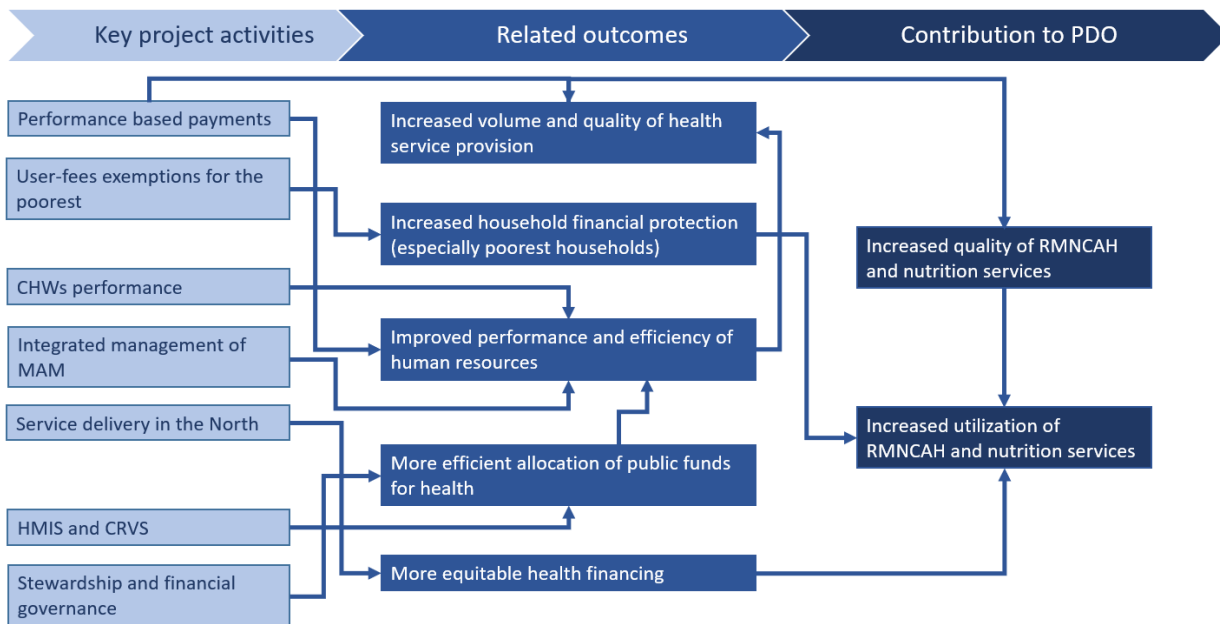
promising impact on (i) health service utilization, (ii) quality of services, (iii) motivation of personnel, (iv) coordination of health services, and (v) strengthening of the health information system. The PBF operation was piloted in all the 10 health districts of the region of Koulikoro with USD 1.8 million support through the previous Bank lending operation, and it targeted 60,000 women of reproductive age. At the end of the pilot, structured interviews and focus group discussions were conducted by the PBF agency and suggested a range of positive results despite the short implementation period. After the experience of the Koulikoro pilot, the government has identified PBF as a key strategy to improve the efficiency of the allocation and use of resources, to improve health worker performance through increased motivation, satisfaction and autonomy for decision-making at the point of service delivery, and to increase the population’s use of essential health services through an increase in the quality of health services and reduction in the out-of-pocket costs for these services. Expanding PBF was explicitly adopted as one of the strategic priorities¹³ in the PRODESS III (2014-2018).

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

- 33. The objective of the project is to improve the utilization and quality of reproductive, maternal, neonatal, child, adolescent health and nutrition services, especially among the poorest households, in targeted areas.

Key Results



¹³ Programme de Développement Sanitaire et Social 2014-2018, Priority 3.3.1.4.



D. Project Description

34. **The proposed project will seek to support Mali in accelerating progress towards Universal Health Coverage** by expanding innovative and high impact interventions, and by strengthening health system stewardship and financial governance. The innovations supported by the proposed project will affect the health financing mechanisms (moving from input based to performance-based financing), the delivery of community outreach services and the data systems.
35. **The lessons learned from the previous Strengthening Reproductive Health Project are embedded in the design of the current project.** The Implementation Completion and Result report of the previous project highlighted the successful and transformative role of Performance Based Financing (PBF) and of Community for Development activities (C4D), and these interventions will be further strengthened by the proposed project. Further lessons related to project design and to implementation arrangements are also considered during project preparation.
36. **The project intends to achieve its objective through interventions at the community, primary, and central level that are organized into four complementary components:** 1) strengthening health service delivery through PBF at facility level; 2) strengthening community outreach activities to support demand for RMNCAH and nutrition; 3) institutional strengthening for improved stewardship and health system performance; and 4) a Contingency Emergency Response Component (CERC) to allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis.

E. Implementation

Institutional and Implementation Arrangements

37. **At the highest level, the Project will be coordinated by a Steering Committee headed by the Minister of Health or his designee.** The Director of the CPS, as well as representatives from key ministerial lines (including MEF, Ministry of Solidarity, Ministry of Women, Children and Family, and relevant technical and financial partners will also be part of the Project Steering Committee. The Steering Committee will provide high level strategic and technical guidance and will participate in the evaluation of the progress of the Project. The Steering Committee will convene bi-annually to evaluate and monitor the implementation of the costed annual action plan.
38. **To support the oversight of the Project Steering Committee, a Technical Working Group will be created.** The Technical Working Group will be headed by the CPS and will be composed of technical managers of the line ministries represented in the Steering Committee. The Technical Working Group will define the project's work program and budget and provide technical support to all levels of implementation. A PBF National Technical Unit (Cellule Technique Nationale FBR) will also be created to oversee day to day implementation of the PBF component and for informing the Technical Working Group and the Steering Committee of the progress achieved in implementing the PBF model. The Director of the PBF National Technical Unit will be part of the Technical Working Group. The Technical Working Group will convene quarterly to monitor activities agreed upon for implementation set forth in the costed action plan. Allocation funds for activities and monitoring of expenses will be further detailed in the Project



Implementation Manual.

39. **A dedicated Project Implementation Unit (PIU) will be created to manage day to day implementation and coordination of Project activities.** The PIU will be staffed by a multidisciplinary team including a dedicated coordinator, a financial management specialist, an M&E specialist, a data specialist, a safeguard specialist, an accountant, a procurement specialist, an internal auditor, a communication specialist, and administrative assistants. Day-to-day project coordination, implementation and management at the central level will be handled by the project implementation unit (PIU) reporting to the Technical Working Group. The APUHC project PIU will collaborate as much as possible with the current project implementation units managed by the Ministry of Health: Malaria and Neglected Tropical Disease Project (M/NTD) which will close in 2020 and the REDISSE project effective in October 2018 to avoid financing duplication. The APUHC PIU will assume, among others, fiduciary management responsibilities, overall planning, internal auditing and M&E. The project aims as much as possible to align with Government systems and integrate into existing structures rather than creating parallel systems. The recruitment of PIU staff will be supported through the PPA and the PIU staff will be recruited prior to presentation to the World Bank Board.
40. **The Project will rely on regional and district health authorities to supervise and coordinate the activities at decentralized levels,** including management of inputs, oversight of health facilities to supervise and verify the quality of services provided under PBF contracts; they will also be responsible for data collection at decentralized levels. CSCOM workers will be responsible for delivering the PBF and community services as presented under the project description. In addition, they will support the mobilization of communities and their selection in relation with the NGO.
41. **Performance frameworks will also be introduced at all levels of the health system.** These contracting mechanisms will hold regional health directorates (DRS – *Direction Régionale de la Santé*), Health Zone Teams (ECD- *Équipe Cadre de District*) accountable for their results through strong incentive mechanisms. Internal performance frameworks will clearly outline the expected performance of the different DRSs and ECDs vis-à-vis their roles in the health system and lead to successfully scaled up PBF approaches. Results from the organizational performance will be benchmarked on a publicly visible website.
42. **A Project Preparation Advance (PPA) has been requested by the Ministry of Health (MoH)** to engage in the following project preparation activities: (i) purchasing of RMNCAH services from public and private health facilities; and (ii) specific technical support from the regional and district entities. The PPA will cover: (i) evaluation of health center's needs; (ii) finance a technical workshop to define the package of PBF services, their subsidy level and relative weights; (iii) conducting an implementation analysis of the new nutrition protocol inside health facilities (PCIMA); (iv) support technical assistance and recruitment of a Contract Development and Verification Agency (CDVA) for the PBF technical assistance; (v) conducting analytical work to prepare the GFF investment case; (vi) baseline impact evaluation survey; (vii) first round of SDI survey and (viii) preparation of project documents such as safeguards instruments, medical waste management plans and bidding documents related to the rehabilitation of health center and hospitals; (ix) mapping of health SMEs; (x) a gender analysis.



F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project will focus on health facilities in 14 targeted districts for PBF (Koulikoro, Mopti, and Sikasso) and on selected health facilities in the North. The most important environmental and social impacts remain the increase of hospital wastes that will need adequate management. The PBF indicators will consider this concern and capacity building session will be provided to the targeted CSCOMs and CSRef.

G. Environmental and Social Safeguards Specialists on the Team

Emeran Serge M. Menang Evouna, Environmental Specialist
Mahamadou Ahmadou Maiga, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>Despite the fact that this project will not imply civil works activities, it will generate indirectly an increase of hospital wastes. These hospital wastes if not well manage will generate environmental and social adverse impacts and risks that need to be addressed appropriately. Possible environmental risks include the inappropriate handling and disposal of hazardous hospital medical waste, including sharp needles, and especially the inadequate management of disposal sites, poor management of obsolete drugs, increase of nosocomial diseases. The Project will also enhance community ownership for monitoring the quality of basic health services. For this reason, the borrower prepared a draft Hospital Waste Management Plan based on the existing national document plans that are available. Specific actions were proposed to better address nosocomial diseases concerns at the national level.</p> <p>A Hospital Waste Management Plan was prepared was reviewed and disclosed in the country and at the Bank website prior project appraisal.</p>



		Specific indicators related to the implementation of the hospital waste management plan will be incorporated in the Project implementation manual and all healthcare's centers involved in the project will be assessed and paid for.
Performance Standards for Private Sector Activities OP/BP 4.03	No	This policy is not trigger project will not involve private sector as state in the policy.
Natural Habitats OP/BP 4.04	No	The policy is not triggered as the project activities will not take place in or near natural habitats.
Forests OP/BP 4.36	No	The policy is not triggered as the project activities will not involve forest conversion nor large-scale reforestation or afforestation.
Pest Management OP 4.09	No	This policy is not triggered as the project is not expected to purchase the use of pesticides for control of diseases vectors
Physical Cultural Resources OP/BP 4.11	No	This policy is not triggered as the project is not expected to finance civil works that may involve or affect physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	This policy is not triggered as No indigenous people in the sense of this Policy are located in the project areas.
Involuntary Resettlement OP/BP 4.12	No	This policy is not triggered as the project does not anticipate land acquisition or resettlement that would lead to economic or physical displacement of people.
Safety of Dams OP/BP 4.37	No	This policy is not triggered as the project is not anticipating to build new dam or use the existing dams.
Projects on International Waterways OP/BP 7.50	No	This policy is not triggered as the project is not anticipating to affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not triggered as the project is not anticipating to finance activities in the disputed areas as described in this policy.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

As the project objective is to improve the utilization and quality of reproductive, maternal, neonatal, child, adolescent health and nutrition services, especially among the poorest households, in targeted areas, it is expected to generate a positive social impacts. Through the RBF mechanism, the project will provide incentives for health facilities.



Despite the fact that the project will not finance civil works, the improvement of the service quality might entail an increased production of hospital wastes in most of the health care centers. To ensure that this potential increase of hospital wastes will be well mitigated, Environmental Assessment (OP/BP 4.01) policy was triggered and the project has been assigned in Category "B". The Government of Mali prepared a Hospital Management Plan that was disclosed in country and at the Bank website.

The key environmental risks and impacts of this project include the inappropriate handling and disposal of hazardous hospital wastes including sharp needles, inadequate management of disposal sites, poor management of obsolete drugs, and the risk of increase of nosocomial diseases.

The mitigation measures to address these adverse impacts can be easily designed and implemented at the level of each healthcare centers. The PBF system will ensure that these measures are in place and will be regularly assessed and the payment system will provide bonus to centers that are complying with hospital wastes management.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area: The most important indirect potential adverse impact remain the increase of nosocomial diseases due to the increase of activities in the healthcare centers.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts. No other relevant alternatives were considered

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The Government of Mali has prepared a national Biomedical waste management plan (2017-2021) and other national strategies on solid wastes management.

For the purpose of the project and despite the fact that no civil work will be supported by the project resources, the Government has prepared in September 2018 a specific Hospital waste management plan which will be implemented during the project implementation. In addition, health centers will report on hospital waste management since that action will be included as an indicator to be evaluated and purchased in PBF.

To ensure that health centers involved in the project will comply with the hospital waste management plan, a quantified quality checklist used by PBF to pay for performance on the quality will include specific indicators related to hospital waste management. Each health center involved in the project will prepare a specific hospital action plan that will be part of its performance indicators package. Relevant hospital wastes management awareness campaigns will be organized for local communities and health centers involved in the project. The weighting for this aspect will be increased, and the adherence to the guidelines will be checked, and paid for, quarterly. Based on the quarterly assessment, key recommendations will be provided to ensure increase and improvement of hospital waste management in the healthcare centers involved in the project.

Despite the experience in implementation of the health project financed by the Bank, the ministry of Health remains weak in dealing with environmental and social safeguards. To deal with all environmental and social potential negative impacts related mainly to the Hospital waste management, the project implementation unit will include an Environmental and social specialist who will be responsible for following up the implementation of all environmental and social mitigation measures included in the plan. The Healthcare centers will be benefitting also with capacity building sessions on hospital waste management and most importantly on how to avoid nosocomial diseases.



The Environmental and Social Specialist will work closely with the relevant ministries and coordinate with the ministry of Environment, NGOs and local administrative authorities.

The PIU will also prepare a specific consultation plan that will be implemented during the project lifespan period.

Document disclosure: The Hospital Wastes Management Plan was prepared, during preparation and disclosed in-country: <http://www.sante.gov.ml/index.php/component/k2/item/3268-plan-de-gestion-des-dechets-du-projet-accelerer-les-progres-vers-la-couverture-sanitaire-universelle-apcsu>, and at the World Bank website.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The key stakeholder remain the healthcare's centers targeted in the program, the Ministry of Environment Sanitation and Sustainable Development, the Ministry of Public health, local health beneficiaries associations, local NGOs and local administrative authorities. The consultation plan will identify the other key stakeholders.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 24-Oct-2018	Date of submission for disclosure 20-Dec-2018	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure

Mali
20-Dec-2018

Comments

<http://www.sante.gov.ml/index.php/component/k2/item/3268-plan-de-gestion-des-dechets-du-projet-accelerer-les-progres-vers-la-couverture-sanitaire-universelle-apcsu>

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Yes



Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

CONTACT POINT

World Bank

Patrick Hoang-Vu Eozenou
Sr Economist (Health)

Haidara Ousmane Diadie
Senior Health Specialist

Tshiya A. Subayi
Sr Operations Off., Health

Borrower/Client/Recipient



Republic of Mali

Implementing Agencies

Ministère de la Santé

Pr. Samba Sow

Ministre de la Santé et de l'Hygiène Publique du Mali

ssow@som.umaryland.edu

Dr. Mama Coumare

Secrétaire Général (SEGAL), Ministère de la santé

mamacoumare@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank

1818 H Street, NW

Washington, D.C. 20433

Telephone: (202) 473-1000

Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Patrick Hoang-Vu Eozenou Haidara Ousmane Diadie Tshiya A. Subayi
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Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Trina S. Haque	09-Jan-2019
Country Director:	Michael Hamaide	16-Jan-2019



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