



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

Appraisal Stage | Date Prepared/Updated: 17-Mar-2017 | Report No: PIDISDSA20802



BASIC INFORMATION

A. Basic Project Data

Country Mauritania	Project ID P156165	Project Name Health System Support	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 16-Jan-2017	Estimated Board Date 19-May-2017	Practice Area (Lead) Health, Nutrition & Population
Lending Instrument Investment Project Financing	Borrower(s) Islamic Republic of Mauritania	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

The Project Development Objective is to improve utilization and quality of Reproductive Maternal Neonatal and Child Health (RMNCH) services in selected regions, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency

Components

- Improving utilization of quality RMNCH health services through PBF
- Increasing demand for health services
- Capacity building and Project Management
- Contingency Emergency Response Component

Financing (in USD Million)

Financing Source	Amount
Borrower	2.00
International Development Association (IDA)	15.00
Total Project Cost	17.00

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue



B. Introduction and Context

Country Context

Mauritania is a sparsely-populated, arid, and resource-rich country. Its population of 3.5 million people is spread such that the average per km² is 3.9 people, making it the fourth least densely populated country in Africa. The country has undergone a rapid transition from a largely rural and nomadic society (0.5 percent of the land area is arable) towards a sedentary, urban one. Due to intense rural-urban migration, 60 percent of the population is concentrated in urban areas. The capital, Nouakchott, has seen the second-highest urban expansion in Africa over the twentieth century, growing by 10.4 percent per year between 1950 and 2010, and now accounts for up to a quarter of the country's population. Recently, Mauritania has enjoyed political stability after a series of internal shocks with the most recent being the 2008 military coup that deeply affected its political environment and weighed heavily on its economic performance.

The recent increase in economic growth has translated into a faster poverty reduction, but poverty levels are still high and social indicators remain low. Mauritania is a newly lower middle-income country, with a Gross National Income per capita (current US\$, Atlas method) estimated at US\$1,270 in 2014 (from US\$700 in 2007). Over the last five years, Mauritania's Gross Domestic Product (GDP) grew by 22.5 percent in real terms. As in many African countries, Mauritania's recent mineral discoveries have stimulated growth and raised incomes. The anticipated expansion in mining output will play the biggest role in maintaining a sound macroeconomic framework. The latest poverty information shows a decline in poverty from 44.5% to 33% percent, while inequality decreased from 35.3% to 31.9% in the period 2008-14 (Poverty Dynamics and Social Mobility, WB, 2016). Poverty is more concentrated in rural areas (43 percent versus 28% in urban areas) and in the south (ranging from 28 to 49 percent) rather than in Nouakchott (14 percent) or the north (15 to 37 percent).

The level of human development of the Mauritanian population is still among the lowest in the world, Mauritania was ranked 156th out of the 188 countries tracked in the Human Development Index (HDI, 2015 estimates for 2014). Mixed progress has been made on the Millennium Development Goals (MDGs): notwithstanding achievements in reducing malnutrition, primary enrolment, and gender equity in education, the poverty, child malnutrition, and safe water access targets were not met. The information on health outcomes in the latest MICS (2015), indicates there are generally no significant gender differences, which is similar to progress in primary education.

Sectoral and Institutional Context

Mauritania did poorly on the health MDGs and has some of the worst health outcomes in Africa. The only MDG with good progress was tuberculosis. For example, maternal mortality was estimated at 602 per 100,000 live births in 2015 compared to MDG target of 232 per 100,000 live births (41 percent achievement). With this level of progress, Mauritania is among the countries with the highest level of maternal mortality in Africa. It is also one of the very countries where child mortality has not decreased over the last few years. The under-five mortality rate is roughly stagnant at 118 deaths for 1,000 live births in 2011 (MICS 2011) versus 122% in 2007. Key intervention rates have not progressed significantly in recent years. For example, immunization coverage (fully immunized children between 12-23 months old) has been only slowly increasing at 75 percent in 2014 (from 69% in 2008, Mauritania Poverty Profile 2008 and 2014). Most countries have progressed more rapidly. The demographic transition is not yet started in Mauritania, with a total fertility rate of 5.1 (6.1 in rural, MICS



2015). According to the National Health Development Strategy mid-term evaluation report, the epidemiological profile is still marked by the predominance of infectious and parasitic diseases. The primary causes of mortality in 2012 were infectious diseases (35.3 percent), birth-related complications (13 percent), and non-communicable diseases (9.7 percent).¹

Supply-side factors

Health provision in Mauritania is pyramidal in nature. The public sector has 693 health posts that refer to health centers (112) and onwards to regional and national hospitals (26). There is also a small private sector (140 health care facilities), that is heavily concentrated (76%) in the capital, Nouakchott. Using WHO Global Health Workforce statistics, Mauritania has most nurses and midwives per (0.672 per 1,000 people) and ranked second in physicians (0.13 per 1,000 people) compared to a peer group of the Ivory Coast, Mali, Niger, Senegal, and The Gambia.²

Public health service provision in Mauritania is unequally distributed. Facilities and staff are concentrated in urban areas, particularly Nouakchott and Inchiri to the detriment of other areas such as Gorgol, Guidimagha, Hodh Charghi, and Hodh el Gharbi. Despite efforts made during the last few years to increase the production of qualified health workers (creation of a school of medicine and five public health schools in remote regions), Mauritania is still characterized by a lack of qualified health workers.

Health resources remain low compared to the region. Total health spending (public and private) increased sharply by 27 percent in 2013, to US\$120 million or 2.4 percent of GDP, which is around the regional average. However, the amount of spending in 2013 remained below the funding needed to finance the interventions identified in the National Health Development Plan - PNDS. Per capita spending at US\$48 is well below an average of US\$95 for selected African countries.

The allocation of health expenditures is inefficient. A comparison of health outcomes in these countries (using the example of infant mortality) shows that Mauritania has some scope to use its resources more efficiently (Public Expenditure Review- PER 2015 and Systematic Country Diagnostic - SCD 2016). The low technical efficiency is aggravated by a weak allocative efficiency: public health spending is biased in favor of curative care rather than prevention, and particularly at the hospital level. Hospitals consume 60 percent of the health ministry budget, primary health centers receive 21 percent, and preventive programs (immunization, reproductive health, malaria, etc.) receive only 4 percent. However, the share of primary health care rose gradually over the 2010-13 period.

Coverage of high impact health interventions is still low, especially for the poorest and in rural areas. Even with some progress during the recent years, malnutrition is still an important issue and an obstacle to improve health outcomes with 12.1 percent of wasting prevalence, 21 percent of stunting and 20.4 percent of moderate underweight in 2015 (SMART Survey 2015). The percentage of pregnant women whose deliveries were assisted by qualified health workers is strongly inequitable by regions, urban or rural areas and level of wealth. Nationally, 69 percent of births were assisted by trained staff, but only 52 percent of rural births were assisted as compared to 91 percent in urban areas. Looking at the regional variation, Nouakchott has 96 percent assisted

¹ WHO country profile, accessed January 24, 2017.

² Data are for 2010, the last year in which there is data for all countries. WHO data are used to facilitate comparison across countries, although the latest available year and data may differ from national data.



deliveries, while Guidimagha (32 percent) is the worst region. The use of modern contraceptive methods shows similar patterns and remains very unequal between regions, especially between southern (range of 3.1 to 11.5 percent), Nouakchott (28 percent), and northern regions (16.3 to 33 percent). Women from the wealthiest quintile (26 percent) are 6.5 times more likely to use modern contraceptives than the women from the poorest quintile (4 percent). The differences between urban-rural are striking: even the richest rural women lag behind the poorest among the urban poor.³

Low utilization of health services and poor health outcomes result also from the weak quality of care because of lack of essential drugs and equipment, unequal distribution of human resources and low level of financing at the peripheral level. The average availability of essential drugs is only 33 percent (approximately four out of 13 tracer drugs), no health facility has all of the 13 essential drugs, and only 47 percent of health facilities have basic essential equipment (health facility Service Availability and Readiness Assessment survey, 2016).

Demand-side factors

The poor health results stem from both systemic performance and demand problems, where financial and geographical obstacles to access health services are important factors.

Physical and cultural barriers to health care. More than 66 percent of the population lives more than 5km away from a functional health facility or more than one hour away (Mauritania Poverty Profile Report 2014); this is partly due to the low population density. The joint WB-UNICEF Results-Based Financing feasibility study (2015) for the RBF strategy shows that linguistic and cultural obstacles were also mentioned in some of the regions where focus groups were organized with the population. For example, in Hodh El Gharbi, women from nomad groups do not deliver at the health facility because of male health workers. In urban areas, the very rapid urbanization of Mauritania has put pressure on social services, worsened living conditions of population, and weakened traditional support networks (in 2014, 51 percent of the population lived in cities in comparison with only 9.1 percent in 2000).

Poverty creates financial barriers to access, particularly in rural areas, that are not offset by insurance schemes. According to the joint World Bank-United Nations Children's Fund (UNICEF) Results-Based Financing (RBF) feasibility study (2015), the primary reasons given by women not seeking care at health facilities were that costs for care and drugs are too high. In addition, women said quality of care was low given absenteeism of health workers and bad greetings at the facilities. Out-of-pocket spending (direct payments by households) represents approximately 44 percent of health spending. Although this is the average for Sub-Saharan Africa (SSA) (NHA, 2014), the World Health Organization (WHO) benchmark indicates that 1.5 percent of the population is likely to fall into poverty because of catastrophic health spending (more than 160 people a day). Insurance schemes do not provide sufficient coverage, whether the National Health Insurance (*Caisse Nationale d'Assurance Maladie*; 15 percent of the population) or the Community-Based Health Insurance (*Mutuelles de Santé*; 0.3 percent). The inefficient and underfunded free and subsidized health care programs (malaria and obstetrical care) are insufficient to address these effects.

Despite a quasi-inexistence of a significant disparity between women and men, a gender approach remains crucial for the health sector. Except for full immunization coverage where boys are better covered than girls,

³ Contraception and assisted deliveries are from MICS 2015, poverty and rural data are from the 2014 EPCV poverty survey.



40.3 percent versus 36.5 percent, there is no significant difference between males and females in terms of health indicators (access to health care services and health status). However, empowerment of girls and women remains very important in the health sector in order to achieve a positive change behavior and a demographic transition (as supported by the Sahel Women's Empowerment and Demographic Dividend - SWEDD project P150080 – see below for more information).

Government's response

Government developed a National Health Development Plan (*Plan National de Développement Sanitaire, PNDS 2012-2020*). The PNDS states that Health System Strengthening strategies and reforms as the most important approach and focus will be on: (i) improving physical and financial access; (ii) revitalization of the national community health policy (Community Health Workers); (iii) reforming the pharmaceutical sector; (iv) developing a hospital reform; (v) developing a strategic plan for human resources for health; (vi) improving social health protection; (vii) reinforcement of institutional capacities and improving efficiency, which includes a RBF strategy (see Box 1, below).

Progress to date on the PNDS is mixed. The PNDS defined three sets of indicators to analyze its results: effect (coverage), impact (morbidity and mortality), and products (resource requirements). In terms of coverage, the ministry added 152 health facilities between 2010 and 2015 (25 percent increase), which contributed in an increase in population living within 5km of a health facility from 73.5 to 82 percent.

Outcome indicators show some progress, although the mid-term objectives were not achieved. No objective has been achieved despite a trend of improvement for infant mortality. No data are available on maternal mortality in 2015 and evolution shows a slow downward trend.

Resources for health. The amount of central government spending between 2012-2015 remained below the funding needed to finance the interventions identified in the PNDS (2012–20). Health as a proportion of government expenditure rose 30 percent between 2012 and 2015, but represents 6 percent of total government expenditure, which is far below the Abuja Declaration (2001) target of allocating at least 15 percent of the budget to the health sector. Over the same period, external financing rose from 6.7 to 11.9 percent of total health expenditure. The annual gap between projections and disbursements for donor funding is chronic and relatively high.

To improve efficiency and access to quality health services, the government developed and adopted a RBF strategy. Government recognizes the need to address the weak allocative and low technical efficiency of its public health expenditure. One of the recommendations of the Health Public Expenditure Reviews carried out by the WB and the Ministry of Health in 2011 and 2015 was to explore the potential of RBF mechanisms to address the efficiency and effectiveness issues at primary health care and hospital levels. With support from the WB, UNICEF and WHO, the Government of Mauritania developed a health results-based financing strategy (validated by the National Health Steering Committee in September 2016 and the Council of Ministers in October 2016). This strategy aims at ensuring efficiency of the health system and better access to health services, with a focus on Reproductive, Maternal, Neonatal and Child Health. Mauritania's RBF Strategy is composed of two components: the supply side RBF (Performance-Based Financing/PBF) and the demand side RBF (Conditional Cash Transfers/CCTs).



RBF will be one of the key instruments for Universal Health Coverage in Mauritania. RBF has a positive impact on the UHC agenda, in general, through mainly three areas (Fritsche G.B. et al., 2014): defining the basic and complementary health package and delivering these packages; expanding coverage of health services for the general population and especially for the poorest; and improving access to good-quality health services. With the assistance of its partners, including the World Bank, the government is preparing a National Health Care Financing Strategy. This strategy, which will include RBF, is expected to be finalized and adopted by the government in early 2017. The World Bank will support this activity through a GAVI-financed Trust Fund.

To support poverty reduction and improve human development outcomes, Mauritania developed a National Social Protection Strategy that includes a Social Registry and a Social Transfer Program (STP – “Tekavoul Program”). The Social Safety Net System Project (P150430) is funding the development of these key instruments that will assist the government to enhance expenditure efficiency and poverty reduction. Among other aspects, the project supports good practice approaches to the development of the Social Registry and its use for unconditional cash transfers to the poorest households in Mauritania. The Social Registry is completed in Gorgol region; work has started in Guidimagha (2016) and may continue in Hodh El Gharbi (2017 and/or 2018). The Tekavoul Program paid the first cash transfer in December 2016.

Based on relevant criteria (such as poverty, rural, institutional deliveries, rural population...), the government has decided to pilot the RBF Strategy in Guidimagha and Hodh El Gharbi. The indicators used to determine the pilot regions are: Poverty and the share of rural population are major barriers to access, reducing deliveries outside facilities are a key objective of the project, and the low physical access to health care create a need for demand-side activities (cash transfers). Since these regions are in the bottom three for health expenditure per capita, the project will be pro-poor and support the marginalized. In fact, the regions are located in the poverty triangle called “*Le Triangle de la misère*” (the misery triangle).

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The Project Development Objective is to improve utilization and quality of Reproductive Maternal Neonatal and Child Health (RMNCH) services in selected regions, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency

Key Results

- i. Pregnant women who received standard antenatal care during visits to Health Facilities (number).
- ii. Births attended by skilled health staff (number).
- iii. Children 12-23 months fully immunized (number).
- iv. Average score of the quality of care checklist (percentage).

D. Project Description

Component 1: Improving utilization of quality RMNCH health services through PBF (US\$8.5 million IDA and US\$1 million counterpart)



Sub-component 1A: PBF payments to providers

Health services in public facilities (posts, centers and hospitals)⁴ will receive PBF subsidies which will include nutrition services, prevention services, maternal, neonatal, adolescent, infant and child health services, along with malaria, HIV/AIDS, tuberculosis, and family planning. As the program evolves and more funding becomes available, the package may be adjusted. Services and performance indicators will be clearly defined by the RBF manual that differentiates the list of Minimum Package of Activities (MPA) for health posts/centers from the list of Complementary Package of Activities (CPA), for hospitals.

PBF payments will be linked to pre-defined qualitative and quantitative indicators. The quality assessment will be undertaken (i) at the community level to evaluate the quality perceived by the population as well as (ii) at facilities level (technical verification). PBF payments will then be used to (i) strengthen motivation of health workers through bonuses based on the performance of the health workers and (ii) improve the utilization and quality of care based on the development of a “business plans” where key investments will be identified. Such activities could include conducting outreach activities, purchasing light equipment, commodities, drugs, etc. The share of health workers’ bonuses in the PBF payment will not exceed 40%, with the remaining funds allocated to pre-agreed activities in the facility business plans.

Small investment grants will be provided to public health facilities that meet certain criteria (to be defined in the RBF manual). These payments, in form of small lump sums will finance small-scale upgrades to eligible facilities before starting the PBF process. Examples of eligible expenditures, to be fully-detailed in the manual, are technical equipment, computers, software, desk supplies, and minor renovation works focusing on small-scale upgrading. Funds will be released to eligible health facilities once their investment plans are approved by the National Technical Unit in charge of Results-Based Financing.

Once the community health plan is ready, the project will support it. Project proceeds will support the Ministry of Health to complete its community health strategy (under preparation), which will be the basis for the community PBF. Performance of community health workers (CHW) will be linked to community-level activities that will be defined in the RBF manual. Examples of possible activities include: (i) health promotion and prevention, (ii) simple and basic curative services, (iii) referral services to appropriate health centers, and (iv) community-based distribution of some inputs (e.g. nutritional ingredients, condoms, and bed nets). The performance of CHWs will be assessed through a double evaluation grid to measure both the quantity and quality of services provided.

Once evaluated, the CHW will be paid through the health facility to which they are linked, to reduce transaction costs. Each quarter, the performance of CHWs will be consolidated at concerned health facility. Payment of the performance will be done in one operation directly to the facility. In turn, this one will transfer the funds to CHW who will be paid according to their individual performance.

Criteria for a facility to sign an RBF contract are the existence of an oversight body that includes civil society (e.g. a facility management committee) and a bank account in the name of the facility. Facilities that do not

⁴ According to the 2017 Ministry of Health work plan, there are very few private sector facilities in the two regions (two “clinics” and five “cabinets”, concentrated in the regional capitals). Two “clinics” (one each) and five “cabinets” (four in Hodh el Gharbi in these regions.



meet these conditions will be combined for RBF purposes with the facility to which they are administratively linked.

Project proceeds will finance payments to facilities and providers for services rendered based upon the criteria set out in the RBF manual and as validated by the verification and counter-verification activities described in sub-component 1B.

Sub-component 1B: verification and counter-verification

Rationale and types of verification. Since payments are linked to the volume and quality of pre-defined services, there are incentives to inflate the reporting. Verification, done by the ministry, and counter-verification, done by third parties, will minimize the risk of fraud and errors in reporting. Furthermore, sanctions to be included in the contract with health facilities will mitigate the risk of fraud and over reporting. There will be two aspects to the verification: the "ex-ante" verification will be done, every quarter, before the payment is made and counter verification or "ex-post" verification will be done every semester, after payment is made. If phantom patients or over reporting is identified as a result of the counter verification, health facilities will be deducted the PBF amount from their subsequent payment and will receive a first warning so as to mitigate the risks of fraud.

Verification agents will include (i) the Provincial Verification Committees in Guidimagha and Hodh El Gharbi which will conduct the quantitative verification; (ii) the two regional health directorates (*Direction régionale de l'action sanitaire*; DRAS) and District Health Offices will evaluate the quality of services provided by health centers/posts; (iii) peers will assess the quality at the two hospitals; (iv) local organizations (community-based) are in charge of community verification (accuracy of health services provided) and the quality of health services perceived by users; (v) Regional Verification Committees/Units and Health Centers/Posts will be in charge of the verification related to CHWs; and (v) counter verification will be undertaken by independent entities.

Project proceeds will finance the verification and counter-verification activities and will pay performance bonuses to PBF implementing bodies (Regional Verification Committees in Guidimagha and Hodh El Gharbi, the Provincial Health Offices (DRAS), District Health Offices, and the Coordination of the RBF program). These entities play a key role in the RBF operations and success of the program. They will receive bonuses for performance according to rules defined by the RBF Manual.

Surveys undertaken by local NGOs on perceived quality of health care by the users/population will be used to construct an indicator pertaining to the satisfaction of the beneficiaries. Each quarter, this indicator will be automatically calculated through the PBF database. It will be a good indicator to monitor regularly the voice of the community under the INAYA project.

Component 2: Increasing demand for health services (US\$2.5 million IDA)

The second component of the INAYA Project will support activities on the demand-side to promote and facilitate access to health services, especially for the poorest. Demand-side RBF activities were identified in the National RBF Strategy as key to complement supply-side RBF intervention and impact health outcomes (financial barriers to access to health services were identified as the main exclusion in the qualitative survey under the RBF feasibility study). Demand-side RBF interventions will build on the existing national social registry system and cash transfers program (implemented by Tadamoun with support from the World Bank-financed Social



Safety Net Project (P150430), the Tekavoul Program) and provide additional cash transfers to poorest families with health utilization conditionality.

Sub-component 2A: Conditional cash transfers to stimulate demand for health care

Helping the most vulnerable to access services. In light of the poverty and rural nature of the selected regions, the demand-side RBF feasibility study recommended that households receive financial support to facilitate their access (cost of services and travel) to health care. Thus, through this sub-component, poorest households will receive quarterly payments upon utilization of health services (estimated to be between US\$ 50 and US\$ 100 per year). Eligible households will be the ones already identified by Tekavoul program (households in extreme poverty) and with children under the age of four,⁵ as cash transfers conditions will be related to child health services. For these households, health conditional cash transfers will be additional to cash transfers received with the Tekavoul program. The Tekavoul program made its first payments in December 2016 and is expected to develop further in the coming years.

Strengthening existing mechanisms to support demand-side interventions. The Social Safety Nets Project (P150430) is supporting the establishment of key building blocks of the national social safety net system and to providing targeted cash transfers to extreme poor households. Most relevant for the targeting of the poorest is the proxy means test that the Tadamoun Agency is implementing in a phased approach. The INAYA project will utilize the results of this process, which will have gone through the start-up phase prior to the beginning of INAYA's implementation. To strengthen coordination, reduce the burden on beneficiaries, and increase the impact on the poorest households, the project will rely upon the Tekavoul program's implementation arrangements and targeting. This will be supplemented through additional community-based engagements as needed. The project will finance modifications to the Tekavoul database and applications to enable their use for INAYA and will support the costs of the database hosting and management.

Conditionality and monitoring. Tekavoul organizes quarterly sessions that are mandatory for its beneficiaries; INAYA will use these to inform households of the INAYA conditionality and to monitor households' adherence. Cash transfers from the INAYA demand side program will be conditional on children under the age of four receiving their vaccinations (until age two) and having routine growth monitoring visits (until age three). The Tekavoul session leader will monitor this through the child's health booklet, which will also be part of the RBF quality dimension. Information will be updated in the Tekavoul database through the existing Tekavoul reporting mechanism and subsequently shared with the RBF unit for processing, verification, and payment. Tadamoun Agency will receive the payment orders and funds from the RBF unit and will use their payment arrangements to add the funds to the safety net-financed transfers. Project proceeds will finance the health conditional cash transfers payments, the additional costs to Tadamoun Agency in terms of staff time, and the verification and cross-verification.

Sub-component 2B: Strengthening community health

Support to operationalize the community health approach. The national community health strategy provides a vision to strengthen the use of preventive and high-impact services, but does not provide a clear statement on

⁵ Early growth monitoring is undertaken for children aged 0-36 months, however, the lag in reporting requires eligibility to be extended another 12 months in order to capture all eligible households. Likewise, vaccinations are for children aged 0-12 months, but monitoring is done after the vaccination, so the window of eligibility is extended accordingly.



the implementation of the strategy and the roles and requirements for community health workers (*Agent de santé communautaire*) and local volunteers (*relais communautaire*). In the first phase (2017-2018), project resources will support the development of a budgeted action plan with necessary implementation elements such as training manuals, profiles, and terms of reference. Once the plans are in place, the project will provide performance-based financing to community health workers and volunteers for actions related to their terms of reference (through component 1).

Strengthen local organizations' capacity to increase demand for service and accountability. Local health committees and community-based organizations are in charge of explaining to their communities their rights and obligations, and help particularly vulnerable groups to access health services. In the South, NGOs are very active in the health sector. Through these community organizations and media, the component will provide information on the RBF program, with a particular focus on raising awareness among women about their rights and obligations as INAYA project beneficiaries. This will also serve to make the conditional cash transfers component better-known to all possible stakeholders.

Quarterly sessions organized by the Tekavoul Program will also be used as an opportunity for health awareness and empowerment of women and mothers on the importance of:

- (i) Reproductive, maternal, newborn, child and adolescent health;
- (ii) Gender equality in the use of health services, and
- (iii) Elimination of harmful traditional practices affecting girls such as female genital mutilation, in conjunction with SWEDD-financed activities.

Component 3: Capacity building and Project Management (US\$4 million IDA and US\$1 million counterpart)

The third component will finance project management and comprehensive capacity building activities, including a substantial technical assistance.

Strengthening MoH capacity in various areas. The project will support the strengthening of Ministry of Health's capacity and other entities involved in RBF and the project management in various areas that include monitoring and evaluation (M&E), public financial management (PFM) and Procurement, health management information system (HMIS), and RBF methods, and database management.

The project will also support (in collaboration with the WHO, Global Alliance for Vaccines and Immunization-GAVI and other Development Partners) the government to prepare and implement the universal health coverage policy along with continuous quality improvement oversight through technical assistance. The project will support the following activities: health financing assessment framework, feasibility and actuarial studies, workshops, UHC strategy, road map and action plan, and preparing laws and their related decrees.

Project proceeds will finance operating costs and some equipment of the RBF Unit and salaries of international and national consultants who will be hired by this unit. The project will support also operating costs of the Verification Provincial Committees as well as the coordination of the project. The Financial Affairs Directorate (DAF) will receive financial and technical support, including appropriate staffing to ensure compliance with World Bank Group fiduciary requirements. Financing will also cover comprehensive technical assistance, including one international firm/NGO and two international experts (one based in Nouakchott and the second in the one region in the targeted areas) during at least the first years of the project (2017-2019). The international NGO or Consulting Firm specialized in RBF will be hired, during the initial phase of implementation, to (i) coach



all institutions and teams involved in RBF verification and counter-verification processes and (ii) help the government, to undertake a massive training at all levels: central, provincial, district, and facility.

Implementation of the environmental safeguards activities will be financed by the project. The Public Hygiene Directorate is responsible for all environmental safeguards activities in the health sector. The project will support the directorate to implement the biomedical waste management plan in intervention areas (Guidimagha and Hodh El Gharbi) by financing technical and material support. The project will also finance revisions and improvements to project-related safeguards instruments.

Implementation of the environmental safeguards activities will be financed by the project. The Public Hygiene Directorate, which will be responsible for implementation of the National Health Care Waste Management Plan will receive technical assistance to assess and improve the plan, and support the installation of adapted waste disposal systems (e.g. Montfort-type incinerators) as needed in order to improve biomedical waste management in Guidimagha and Hodh El Gharbi. The directorate will also work in close collaboration with the Directorate of Pollution Control at the Ministry of Health for the application of the project's Environmental and Social Management Framework. The project will also finance revisions and improvements to project-related safeguards instruments.

Component 4: Contingent Emergency Response (CERC) (Total financing: US\$0 million IDA). A CERC will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

E. Implementation

Institutional and Implementation Arrangements

The Ministry of Health will be responsible for project coordination and execution, through the Office of the Secretary General, which will be supported by the RBF unit. Technical support to the RBF unit will be provided by the ministry's directorates. Project oversight will be handled by the Ministry of Health Steering Committee created by *Arrêté* MS 202/2012 to oversee implementation of the National Health Development Plan-PNDS, which will meet regularly for this purpose. The Project Implementation Manual will detail the roles and responsibilities of the various parties and make explicit any adjustments to national procedures required by IDA.

The RBF unit will be staffed with civil servants nominated or appointed competitively and consultants recruited where civil service cannot provide the skill sets. A performance-based financing specialist will be assigned to the RBF unit in Nouakchott to support coordination. Another one will be based in one of the two regions to support implementation in both regions, including verification and validation processes.

Counter-verification, as required for RBF, will be undertaken every semester by contracted community-based organizations and independent agencies. The UN-RBF will be responsible of the hiring process with a technical support from the Financial Affairs Directorate. Counter-verification will be undertaken every six months.



Conditional cash transfer activities will be contracted to the Tadamoun agency. The Tekavoul program is receiving support from the Social Safety Net project (P150430) and INAYA activities will use this platform to target those evaluated to be among the poorest in the project areas.

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

The project will be implemented in 2 regions (Wilayas of Guidimagha and Hodh El Gharbi), comprising approximately 16% of the overall population of Mauritania and having the highest poverty and morbidity prevalence. The activities will mainly be implemented in rural areas. The area of intervention of the project, known as the Pilot Zone of the Results Based Performance program (RBF) is divided administratively in 6 Moughataas and 45 communes. Guidimagha is an agricultural region producing rice, fruits, etc. It is located in the valley area or the Sudano-Sahelian strip of the south-eastern extremity of the country, occupying only 0.5% of the land and receiving between 400 and 600 mm of rain per year. Hodh El Gharbi is part of the Sahelo-Sahelian zone, covering 12.5% of the territory, with a rainfall of between 100 and 200 mm.

G. Environmental and Social Safeguards Specialists on the Team

Salamata Bal, Dahlia Lotayef

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>The proposed project will induce an increase in the production of health services (primary health care and preventive services for pregnant women, deliveries and post-partum care, immunization services, care for children under the age of 5, family planning, Malaria, TB, etc.) and the provision of medical supplies, light equipment and infrastructure investments in order to upgrade targeted facilities. The infrastructure investments may involve small-scale civil works which could have localized and site specific environmental and/or social impacts. Other activities will also lead to the generation of larger amounts of healthcare waste than usual, and may involve some aspects of vector control under its malaria and TB activities.</p> <p>No large-scale, significant or irreversible impacts are</p>



		anticipated.
		An Environmental and Social Management Framework (ESMF) has been prepared, consulted upon and disclosed; and a National Health Care Waste Management Plan (HCWMP) has also been prepared by the Ministry of Health and will be used in conjunction with the ESMF for proper management of the larger amounts of healthcare waste expected to be generated.
Natural Habitats OP/BP 4.04	No	The project will only intervene in existing healthcare waste facilities, and no extension in any critical natural habitat zone is considered.
Forests OP/BP 4.36	No	The project will only intervene in existing healthcare waste facilities, and there are no forests in the vicinity of the area of intervention of the project.
Pest Management OP 4.09	No	The project design doesn't include the acquisition of synthetic chemicals for vector control, even if disease vectors control is intended. Specific guidance are however provided as part of the NHCWMP, in case such chemicals or toxic wastes are encountered.
Physical Cultural Resources OP/BP 4.11	No	The policy is not triggered as the project will only intervene in existing healthcare waste facilities, no expansion in new areas leading to major civil works are planned. Most of the works are related to the rehabilitation of existing facilities.
Indigenous Peoples OP/BP 4.10	No	There are no indigenous people in the project's areas of intervention.
Involuntary Resettlement OP/BP 4.12	No	The policy is not triggered as no civil works requiring land acquisition are planned. Most of the works are related to the rehabilitation of existing facilities.
Safety of Dams OP/BP 4.37	No	There are no dams or dependency on existing dams in the design of the project.
Projects on International Waterways OP/BP 7.50	No	Project not intervening on or affecting any international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project is not intervening in any disputed areas.



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:

The proposed project will induce an increase in the production of health services (primary health care and preventive services for pregnant women, deliveries and post-partum care, immunization services, care for children under the age of 5, family planning, Malaria, TB, etc.) and the provision of medical supplies, light equipment and infrastructure investments in order to upgrade targeted facilities. The infrastructure investments may involve small-scale civil works which could have localized and site specific environmental and/or social impacts. Other activities will also lead to the generation of relative amounts of healthcare waste, and may involve some aspects of vector control under its malaria and TB activities. No large-scale, significant or irreversible impacts are expected.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

There are no potential indirect and/or long term impacts due to anticipated future activities in the project area.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

Not applicable, as the project mainly helps reducing adverse impacts by improving the overall health services in Mauritania, and the related health care waste management system.

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.

In conformity with the World Bank policies and national EIA regulations, an Environmental and Social Management Framework (ESMF) has been prepared, consulted upon and cleared by the World Bank. Specific guidance on safety and security measures during the works (mainly rehabilitation of some facilities in existing health centers) will be included in the technical clauses of the contractors.

The National Health Care Waste Management Plan (NHCWMP), developed by the Ministry of Health will be used in conjunction with the ESMF, for the management of all health care waste generated by the beneficiary health care facilities participating in the project.

The institutional capacity in the country and the overall regulatory framework to undertake and supervise safeguard policies and procedures is however relatively weak in Mauritania.

The Ministry of Health, as the main recipient and executing agency of the project has no previous experience implementing World Bank projects and applying safeguards policies. The borrower has also limited experience applying the concepts of health care waste management, despite the existence of a national Health Care Waste Management Plan (HCWMP). The capacity of the Ministry of Environment and Sustainable Development (and its General Directorate of Pollution Control), mandated by law to enforce environmental regulations and EIA regulations is also relatively weak.

To mitigate this, capacity building and training activities have been included in the project activities. Targeted groups include concerned staff at the ministry of environment, the ministry of health, the ministry of social affairs as well as the beneficiary communities, local health committees and community-based organizations.

A full time environmental/social specialist will be hired during Year 1 of the project, who will be technically responsible for the implementation of the safeguards documents. An assessment, acceptable to the World Bank, will be made at



the end of this year to agree on the needed level of effort for the remaining period of the project (full-time versus part-time). Provisions have been made in the project's overall budget to finance this position.

The review and improvement of the NHCWMP has also been integrated as a specific project's activity.

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 stakeholders are the Ministry of Health, its decentralized services, local NGOs in the 2 targeted regions of intervention, as well as the Ministry of Social Affairs and the Ministry of Interior.

The civil society is involved in all aspects of project activities and assessment of the service delivery results: communities will play a role in the verification of the performance of the participating public facilities, by involving civil society in assessing health service delivery results and by publishing results on a public website;

Consultations with the stakeholders (potentially affected populations and authorities at the central and regional levels) were organized by the Ministry of Health. These instruments have also been published in the municipalities and the web sites of the Ministry of Health and the Ministry of Environment.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission to InfoShop	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
24-Feb-2017	24-Feb-2017	

"In country" Disclosure

Mauritania
23-Feb-2017

Comments

Documents were posted on the website of the ministry of environment, and an announcement made in a daily newspaper to inform the general public.

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's Infoshop?

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

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APPROVAL

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Approved By

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Country Director:	R. Gregory Toulmin	17-Mar-2017

Note to Task Teams: End of system generated content, document is editable from here.