Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 28-Sep-2018 | Report No: PIDISDSC23587

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Mali	P165534		Mali - Accelerating Progress Towards Universal Health Coverage (P165534)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Nov 02, 2018	Dec 20, 2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Mali	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.

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
IDA Grant	50.00

Non-World Bank Group Financing

Trust Funds	10.00
Global Financing Facility	10.00

Environmental Assessment Category	Concept Review Decision
B - Partial Assessment	Track II-The review did authorize the preparation to continue

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 2016[1], 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 2016[2], 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, 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 PopulationDNP) 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

[1] GNI per capita, Atlas Method
[2] INSTAT (2017) Enquête Modulaire Permanente Auprès des Ménages (EMOP).

2015 UN Human Development Index (HDI). Literacy rates have slightly improved over the past decade, but with 34 percent[3] 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 decided[4] to extend the mandate of the MINUSMA for one year.

Sectoral and Institutional Context

Health system

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 private sector plays an important role in the delivery of health goods and services in Mali[5]. 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 access to quality health care, conduct a dialogue with the MoH, commercial banks, and other financing and technical partners. However, a slow and limited PP 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)

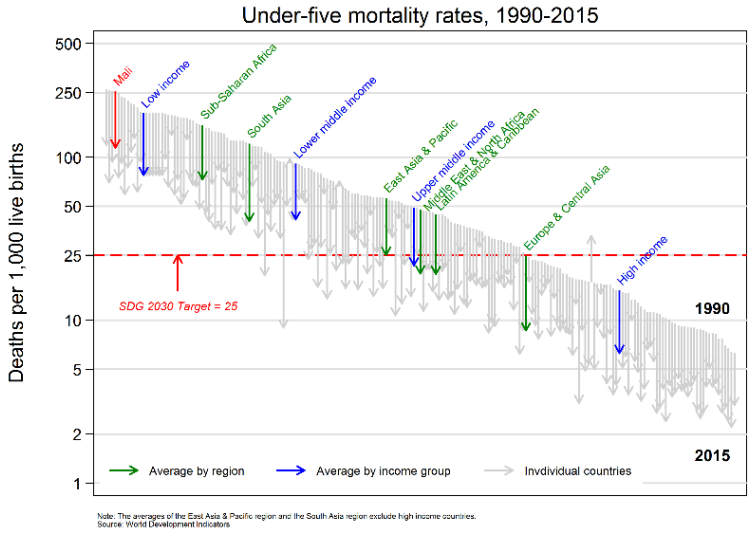
Mali is among the five countries in the world with the largest burden of disease[6]. About 65,000 disability adjusted life years per 100,000 population are lost every year. While the share of non-communicable diseases has been increasing

[3] INSTAT (2017) Enquête Modulaire Permanente Auprès des Ménages (EMOP).
[4] UN Resolution 2364 (2017).
[5] According to the 2017 EMOP, it represents about 30 percent of the contact of the population with health facilities.
[6] 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).

since the 1990s, communicable, neonatal, maternal and nutritional disease still account for about 73 percent of the overall burden.

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 1).

Figure 1: Trends in under-5 mortality



Nutrition outcome indicators such as the prevalence of chronic malnutrition (stunting) among children under the age of five years old have not improved since 2009. The percentage of stunted children increased from 28 percent in 2009 (MICS) to 38 percent in 2012 (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). Childhood stunting is the result of inadequate food intake and repeated disease incidence, particularly in the first 1,000 days of life and below the age of five. Adequate food and care, birth spacing, clean water, sanitation, a nurturing environment and health care during early childhood years are important factors for good nutrition and child development, but access to these factors is limited in Mali. 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 the country, and one of the key markers of poverty and vulnerability.

Insufficient coverage of essential quality RMNCAH and nutrition services

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 Universal Health Coverage (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[7]. 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

[7] World Bank (2017) Implementation Completion and Results Report for the Strengthening Reproductive Health Project (P124054). Indicators for modern contraceptive use among women, 4 or more antenatal care visits, and skilled birth attendance increased in project intervention regions by a larger magnitude compared to the national trend.

implemented by international 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%)[8].

Low, inefficient and fragmented health financing

Low coverage of quality essential health services can be explained by 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.

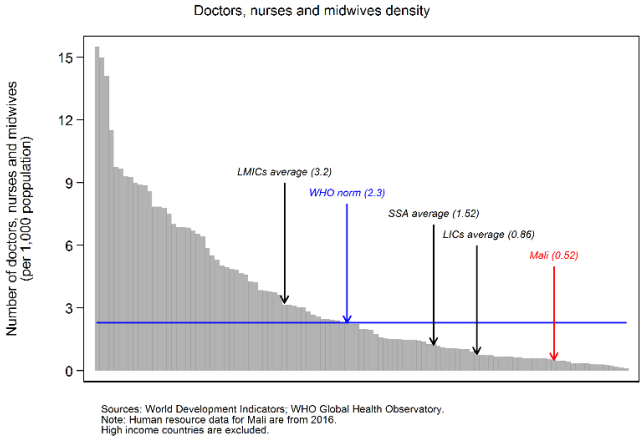
Domestic public resources allocated to the health sector are relatively low and represent about 6 percent of government budget[9], or USD 8 per capita per year, which is far from the 15 percent target set by the government after signing the Abuja Declaration in 2001, and below what countries allocate 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.

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.

As a result 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 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 2: Health personnel density

[8] SMART Survey 2017.
[9] Mali 2014 National Health Accounts (2016).



Services are also underutilized because prepayment schemes are 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).

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.

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 de 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.

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).

Table 3: Financial protection from large health expenditures

Year	Health budget share (% total household consumption)	% people spending more than 10% of their budget on health	% people spending more than 25% of their budget on health	% people pushed below the $1.90 poverty line because of health payments	# people pushed below the $1.90 poverty line because of health payments (thousands)
2006	1.8	3.4	0.1	1.9	253.3
2011	2.3	4.2	0.8	1.8	277.4
2013	2.5	1.6	0.1	1.8	296.9
2014	3.4	4.8	0.4	2.2	388.2
2015	3.3	3.3	0.3	2.3	413.4

Source: ELIM 2006, EMOP 2011, 2013, 2014, and 2015.

Sectoral strategies and promising pilot interventions

The Government of Mali is currently evaluating its third social and health development program (PRODESS[10] III, 2014-2018), which is the first 5-years implementation program of the longer term social and health development plan (PDDSS, 2014-2023)[11]. The draft evaluation reports underlines that the design and the strategic objectives pursued by the PRODESS III remain relevant, but also that the implementation of the program has not been satisfactory with weakness points identified with the governance structure of the PRODESS III, the lack of strategical leadership and stewardship of the government, the fragmentation of external assistance efforts, and insufficient capacity to plan, implement and monitor policies at the decentralized level.

PBF has been identified as a promising strategy for health system strengthening[12] that will contribute towards improving the efficiency of public health expenditures, increasing the volume and quality of essential health service provision, lowering financial barriers to service access for the poorest, and ultimately towards accelerating progress to achieve UHC in Mali. PBF has been implemented as a pilot in the region of Koulikoro 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

[10] Programme de Développement Socio-Sanitaire, 2014-2018.
[11] Plan Décennal de Développement Sanitaire et Social, 2014-2023.
[12] See section 3.3.1 in the PRODESS III.

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.

The PBF experience in Koulikoro was implemented on a short timeframe (8 months) but the endline assessment of the pilot suggested 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[13]. 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.

Mali's MoH has partnered with civil society to create a national plan for the scale up of Community Health Worker (CHW)-led health care delivery, with the initial goal of deploying approximately 5,000 CHWs to connect more than 3 million of the country's most vulnerable patients with care over the course of five years. Based on the MoH plan, over 2,700 CHWs have been recruited, trained, and deployed across the country with the support of multiple NGO partners, and co-funding from the Global Fund, USAID, and other donors. There is currently a strong alignment between the different partners working in this space and implementation actors dedicated to promoting the institutionalization of CHWs within the health system.

Proactive community case management (ProCCM) is an innovative model of door-to-door visits by community health workers designed to intensify case detection, diagnostic and timely treatment of child illnesses (such as malaria, diarrhea, respiratory infections and malnutrition) and it has recently been shown to be associated with a 95 percent reduction in under five child mortality in Mali. ProCCM relies on the intense supervision of CHWs by supervisors attached to CSCOMs and on the use of mobile health (mHealth) technology to improve the efficiency of the CHWs workload. In March 2018, an article published in the British Medical Journal Global Health[14] presented the result of a pilot ProCCM, conducted in collaboration with the MoH in a peri-urban area of Yirimadio, Mali, and covering a population of about 177,000 people. In the area of intervention, under five mortality decreased from 154/1,000 in 2008 to 7/1,000 in 2015. This represents an annual decrease in mortality of about -14%, compared to -3.2% per year on average in Mali and to -3% per year on average in Africa[15]. ProCCM is a health system strengthening intervention designed to improve child survival by increasing (i) the coverage volume of prevention and treatment services, but also (ii) the quality of service coverage through a focus on timely access to care. The intervention costs between $8 and $13 per person per year and is delivered through the national health system, relying on the network of Community Health Workers (CHWs) and supervisors attached to the primary care facilities. The training, monitoring, and supervision model for the CHWs to ensure that they can effectively deliver the services could easily be adopted by the government after a period of coaching by NGOs.

Community for Development programs are complementary to ProCCM and also rely on CHWs promoting behavior changes that lead to improvements in children's development, strengthening care for children in safer, happier and healthier families, and supporting healthy life choices to reduce risk of infectious illnesses and non-communicable diseases. Previous experience in Mali has demonstrated the importance of having in place a strong C4D program targeting

[13] World Bank (2017) Implementation Completion and Results Report: Mali Strengthening Reproductive Health Project.
[14] Johnson AD, Thiero O, Whidden C, et al. Proactive community case management and child survival in periurban Mali. BMJ Global Health 2018; 3:e000634. DOI: 10.1136/bmjgh-2017-000634.
[15] The evaluation conducted in Yirimadio was based on a repeated cross-sectional design with no control group, so the observed reduction in under 5 mortality cannot be entirely attributed to the intervention. A range of intermediary outcome indicators have however evolved in a direction suggesting some degree of causality. A randomized control trial (RCT) is currently implemented for this intervention in the rural area of Bankass, and the results should be available by 2020.

women, youth, men, local authorities, health personnel, community health agents, and community leaders to influence the enabling environment, attitudes and acceptance of RH use, as well as actual use of services by women and adolescents.

Relationship to CPF

Through strengthening health service delivery performance and improving financial protection, the proposed project will directly address some of the binding constraints identified in the SCD, especially the exposure to uninsured risks. As indicated in the SCD, health shocks are the main risks affecting poor households in Mali along with exposure to conflict for those living in the North. This exposure to uninsured shocks takes a big toll on poverty reduction and pushes households into poverty traps. Public investment in health can contribute to increase resilience, to larger accumulation of human capital, and create long term opportunities for economic transformation

Building on the SCD, the interventions under the project remain consistent with, and aligned to, the strategic area of the Country Partnership Framework (FY16-FY19), which focuses on; (i) building resilience through improvements in Mali's low human capital and strengthening safety nets for the poor and the vulnerable, and (ii) improving governance through increased involvement of citizens in public affairs. More particularly, in line with the CPF, this project will support the Bank's two -pronged approach to human capital improvement in education and health and will focus on improving access to quality health care (including reproductive health and family planning) and nutrition services, with a specific attention to the poorest and to women and girls, while supporting improving financial protection to the poor. It also aims to improve the ability of citizens to demand accountability to improve public service delivery, especially among the poor through citizen engagement and grievance redress mechanisms.

The proposed project will seek to maximize synergies and complementarities with other WB investments in Mali. Within the health sector, the project will complement the **Sahel Women's Empowerment and Demographic Dividend (SWEDD)** which objectives are to: (i) accelerate the demographic transition and the reduction of gender inequalities in the Sahel region to benefit from the Demographic Dividend; (ii) improve the level of empowerment of women and adolescent girls and enable them to have access to quality reproductive, child and maternal health services. The project will also complement the **Regional Disease Surveillance Systems Enhancement (REDISSE)** to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness as well as the **Sahel Malaria and Neglected Tropical Diseases which** objective is to increase access to and use of harmonized community-level services for the prevention and treatment of malaria and selected neglected tropical diseases. Beyond the health sector, the proposed project will also complement the **Mali Reconstruction and Economic Recovery** project, and the **Urban Local Government Support** project, both of which includes activities related to the maintenance and rehabilitation of health centers. The proposed project will also seek synergies with the ongoing **Safety Net Project (*Jigisemejiri*)** by relying on the same identification mechanisms to target the poorest households. Finally, it will complement the **Fiscal Decentralization for Better Service Delivery** project under preparation by supporting the planning, budgeting and financial governance functions related to health activities in Malian communes and by introducing incentives for communes to allocate sufficient resources to support the provision of essential health services.

The proposed project is also fully in line with the World Bank Group's (WBG) twin objectives of reducing poverty and promoting shared prosperity and with the Sustainable Development Goals (SDG), in particular *Goal 3*: Ensure healthy lives and promote well-being for all at all ages. Goal 3 of the SDGs has several targets for which the proposed project directly supports: reduction of maternal mortality (Target 3.1), reduction of under-5 and neonatal mortality (Target 3.2),

achieving universal access to sexual and reproductive health-care services (Target 3.7), achieving Universal Health Coverage (Target 3.8), and increasing health financing and the recruitment, development, training and retention of the health workforce (Target 3.c). The project also supports achievement of *Goal 1*: End poverty in all its forms everywhere through its links with social safety nets programs and improved financial protection from health expenditures among the poor and vulnerable; and *Goal 2:* End hunger, achieve food security and improved nutrition and promote sustainable agriculture, through its activities related to supporting high impact nutrition interventions.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The objective of the project is to improve the utilization of quality RMNCAH and nutritional services, especially among the poorest households, in targeted areas.

Key Results

Progress towards the PDO in the targeted areas will be monitored through the following key indicators:

1. Average score of the quality of care checklist (percentage)
2. Number of children (0-5 years) fully vaccinated
3. Number of children under 5 with confirmed malaria who received antimalarial treatment
4. Percentage of pregnant women receiving at least 4 antenatal care visits from health provider
5. Percentage of institutional deliveries
6. Number of people who have received essential health, nutrition, and population (HNP) services (corporate result indicator)

Proposed Intermediary Indicators:

- Average score of the quality of care checklist (percentage)
- Facilities receiving strategic purchasing credits on time (percentage out of total facilities supported by PBF)
- Percentage of RAMED beneficiaries receiving free care for essential health services
- Percentage stock outs of tracer drugs in health centers
- Percentage of women in union with FP demand satisfied
- Percentage of women giving birth before the age of 18
- Number of contraceptive services provided
- Number of new RAMED beneficiaries covered (i.e. identified and provided with card)
- Health facilities reporting health management data on time
- Number of NHAs produced
- Percentage of commune budget allocated to health
- Work plan budget execution rates at commune level

D. Project Description

The proposed project will seek to support Mali in accelerating progress towards Universal Health Coverage by expanding innovative and high impact interventions, by strengthening health system stewardship and financial governance, and by maximizing synergies with ongoing WB investments, both within and beyond the health sector. 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 (using mHealth products), and the data infrastructure (mobile data collection, platform integration, and big data analysis).

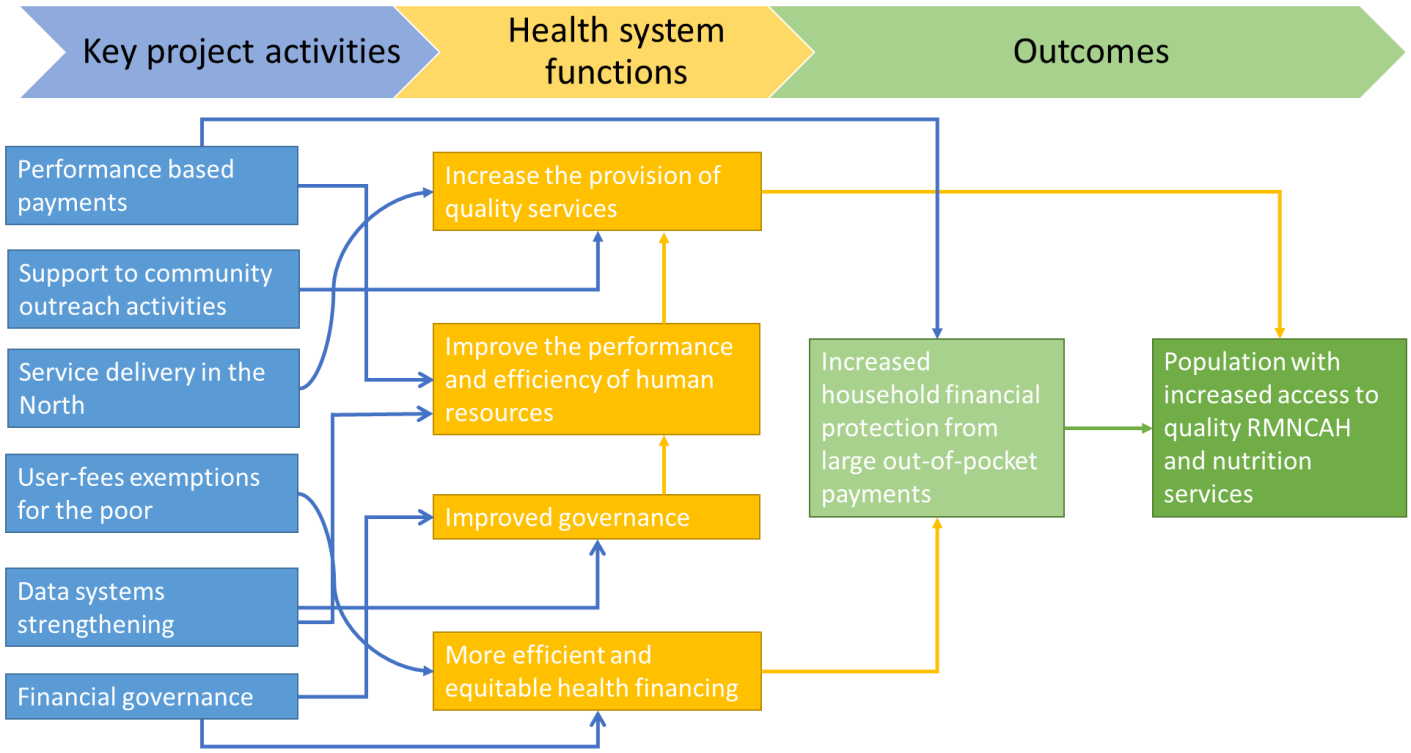
The lessons learned from the previous *Strengthening Reproductive Health Project* are embedded in the design of the current project. The Implementation Completion and Result report of the previous project highlighted the successful and transformative role of Performance Based Financing (PBF) and of Community 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.

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. Table 4 below provides an overview of the financing of each component/sub-component, and Figure 3 summarizes the underlying theory of change linking the intervention to the development objectives.

Table 4: Overview of components and financing by component in USD million

Project Components	Project cost
1. Strengthening Health Service Delivery through Performance Based Financing at Facility Level	**28.0**
1.1 Performance-based payments	22.0
1.2 Support to the implementation and supervision of Performance-Based Financing	6.0
2. Strengthening Community Outreach Activities	**12.0**
2.1 Expanding Proactive Community Case Management and Community for Development Programs	7.0
2.2 Service delivery in the North	5.0
3. Institutional strengthening for improved stewardship and health system performance	**10.0**
3.1 Strengthening data system for precision public health	5.0
3.2 Strengthening stewardship and financial governance	2.0
3.3 Project management, and monitoring	3.0
4. CERC	**0.0**
Total Project Cost	**50.0**

Figure 3: Summary of theory of change between project activities and outcomes



A. Project Components

Component 1: Strengthening Health Service Delivery through Performance Based Financing at Facility Level (USD 28 million)

***Subcomponent 1.1. Performance-based payments (USD 22 million)*:** Through this subcomponent, the project will provide top-up performance payments to health facilities (CSCOMs and CSRefs) conditional on the quantity and quality of services provided for the delivery of a package of essential health services in targeted areas. Payments to health centers will be linked to their performance in the delivery of services based on preset indicators which will be measured through a set of standardized supervision checklist. Based on a preset agreement, the MoH will issue payments to the commune governments contracting with CSCOMs and CSRefs, once the targets have been achieved. Payments will be made on monthly or quarterly bases. The package will focus on cost-effective RMNCAH and nutrition interventions. The team will work closely with the MoH to review the existing RMNCAH and nutrition service package and will define and estimate the cost of the package of services that will be covered under this project.

This subcomponent will also introduce financial mechanisms to improve access among poor and vulnerable households to essential health services at the health facility levels. The project will introduce fee-waivers for certain essential services for identified vulnerable households as a demand-side mechanism to further support households' use of health services. The mechanism used to identify the poor that will be applied will build on both the experiences from the Mali Emergency Safety Nets Project *Jigisémèjiri*. In the zones covered by both the health and safety nets project, the methodology for identification will use a combination of community-based targeting and proxy-means testing, while in zones that are not covered by the Emergency Safety Nets Project, identification will rely on a combination of community-based targeting and identification at the point of service delivery by service providers.

Subcomponent 1.2. Support to the implementation and supervision of Performance-Based Financing (USD 6 million): To support PBF implementation and supervision (capacity building, verification and counter verification, IT system, etc.), the project aims to streamline the flow of funds, reporting and verification arrangements between the MoH, commune governments, and health centers through the following: (i) introducing the list of quantity and quality indicators that will be monitored at the health center (ii) developing aggregate performance scores and payment methods; (iii) developing health facility management tools (such as supervisory and coaching checklists, individual performance evaluations); (iv) developing a data management system for data capturing, reporting, and payment; (v) contracting an independent agency for verification and community-based organizations for counter-verification; and (ix) strengthening governance through the introduction of a decentralized PBF Steering Committee at the district level.

With a budget of USD 28 million, we are limited to offer PBF based services to a population of about 5 million Malian. On average, the Malian have 0.4 contacts per year with health facilities. This mean that on average we can expect the PBF to provide services to about 2 million individuals per year for 4 years with a cost of USD 3-3.5 per capita/year. This corresponds to a lower bound of effective PBF incentives based on the international experience. In order to be able to provide PBF based services to a larger population, the allocated budget would need to increase (a USD 25 million increase would allow coverage to approximately double from 5 to 10 million Malian). A more detailed presentation of the PBF intervention, including a finer estimation of the costs and scope of services, will be possible after organizing a dedicated workshop in Mali to discuss in depth about the design with the Malian stakeholders as well as with international experts.

Following up on technical discussion with the MoH and with partners in Mali, the team considered the following criteria to identify intervention districts for PBF:

- **Previous experience** with PBF pilot
- **Strategic influence** (the region of Mopti is considered as a stability buffer between the still volatile northern areas in Timbuktu and Gao and the southern rest of the country, as well as a forward-leaning platform for pushing resilience and development efforts northward as and when security conditions allow.
- **Poverty incidence**
- **Ongoing planned rehabilitation of CSComs/CSRefs**
- **Safety net project**

The proposed targeted areas for PBF are:

- **Koulikoro**: all 10 districts
- **Mopti**: 4 districts (Bandiagara, Bankass, Mopti, Karo)

Table 5 below summarizes the rationale underlying the proposed districts targeted for PBF and the estimated population covered.

Table 5: Targeting criteria for PBF districts

Targeted regions and districts for PBF	Rationale	Population covered (million)
KOULIKORO (all 10 districts)	• Poverty headcount above national average • Previous experience with pilot PBF • Safety net project (*Jigisémèjiri*)	3.2

MOPTI Mopti (district) Bandiagara	• Strategic position of Mopti • AFD project of facility rehabilitation	0.8
MOPTI Bankass Koro	• Strategic position of Mopti • Poverty headcount above national average • Safety net project (*Jigisémèjiri*)	0.8
	TOTAL	**4.8**

Component 2: Strengthening Community Outreach Activities (USD 12 million): The project will support strong and innovative community outreach approaches leveraging mobile technology to increase demand for essential health services. This will entail supporting high impact interventions such as Proactive Community Case Management (ProCCM) and building on several successful community multi-sectoral nutrition interventions and Community for Development (C4D) programs.

Subcomponent 2.1. Expanding Proactive Community Case Management and Community for Development Programs (USD 7 million):

The activities financed under this subcomponent will include the support to the national CHW scale up plan to reach its goal of deploying 5,000 CHWs by 2020, the optimization of CHW impact through workflow innovation, and the integration of evidence-based performance management into the national scale up of CHWs. Innovative approaches using mobile health applications to support the work and the supervision of the CHWs, and to facilitate the transfer and analysis of data from the field to the doctors at the health facility, will be financed and expanded.

This subcomponent will also finance training of community health workers and community volunteers, awareness-raising activities, capacity building workshops, leadership training of local authorities.

With a budget of USD 7 million, community outreach interventions such as ProCCM can be extended to cover a population of approximately 875 thousand Malians. The intervention was recently costed at around USD 8 (between USD 6 and USD 13) per person per year. To be able to provide ProCCM to a larger population, the allocated budget would need to increase in proportion of the unit cost. The areas of interventions to support the expansion of C4D and of ProCCM activities will be defined in collaboration with the authorities and with technical partners during project preparation.

Subcomponent 2.2: Strengthening health service delivery in the North (USD 5 million): This subcomponent will include activities related to supporting the Government in developing and building *cost-effective solutions* for health service delivery the North Mali to transition from a humanitarian approach to longer term sustainable development (nexus humanitarian-development). Supporting the expansion of CHW-led health strengthening efforts in Northern Mali will be considered. CHWs, as members of the communities they serve, are uniquely placed to address the unmet need for quality health services in the north of Mali since they will likely be subject to relatively fewer security concerns and restrictions compared to external actors entering the communities. The delivery of quality health services in high population density areas in the North (particularly Timbuktu and Gao) is different than in dispersed and low-density population areas and insecure regions where mobile models would be more adapted (mobile clinics or CHW mobile sites). The issue of adaptability in face of potential sources of insecurity including robbery of health materials and vehicles, kidnaping and threats from terrorist groups must be discussed.

To tackle increasing acute malnutrition rates in the North, this subcomponent will also finance (ii) the integration of quality nutrition services into routine health care in the North (training for detection, assessment tools, anthropometric tools, treatment, counselling and psychosocial stimulation by mobile CHW and NGOs, management of evacuation of severe cases) due to increasing rates of acute malnutrition, (iii) the cost of some supplies to decrease acute malnutrition rates, such as micronutrient supplements, drugs, and therapeutic and supplementary foods, for adults and children for acute malnutrition (moderate or severe).

Component 3: Institutional strengthening for improved stewardship and health system performance (USD 10 million)

Subcomponent 3.1: Strengthening data system for precision public health **(USD 5 million):** This subcomponent will include activities related to (i) integrating existing data collection platforms (including real time data collected by CHWs equipped with Android-based applications) into the DHIS2 to increase the degree of interoperability across different country information systems (ii) expanding the scope of facility level data covered by the DHIS2 (e.g. incorporating information from private service providers), (iii) improving existing survey instruments (e.g. incorporating quality of care in facility based survey, or using lighter and more frequent data collection instruments for household surveys, such as Surveys of Well Being via Instant and Frequent Tracking (SWIFT) surveys, or Iterative Beneficiary Monitoring (IBM) surveys), (iv) the institutionalization of National Health Accounts, and (v) the development of machine learning programs to improve data quality, to produce geospatial and easy-to-use analytics allowing decision makers at the central level, and at the level of local collectivities to plan more effectively and to take evidence-based decisions in relation to populations needs.

Subcomponent 3.2: Strengthening stewardship and financial governance (USD 2 million): This subcomponent will focus on providing support in the areas of planning, budgeting, targeting of beneficiaries, and program execution at central level and at the level of local collectivities. Supported activities will include (i) strengthening the capacity of the ANAM to target and enroll the poor in the RAMED, (ii) analytical work to inform the health financing strategy (e.g. equity and financial protection, benefit incidence analysis, efficiency, PFM), (iii) support donor coordination and bolster capacity strengthening towards national processes in the area of health financing, economics and social health protection for UHC, (iv) support the establishment of public-private partnerships by streamlining health regulation processes, by expanding the accreditation of private health facilities, and by building managerial capacities for health SMEs, and (v) strengthening local governments functions in terms of resource planning and management (e.g. budgeting, contracting, procurement and financial management) for health, and in terms of monitoring and supervision.

Subcomponent 3.3: Project management, and monitoring (USD 3 million): The objective of this subcomponent is to ensure an effective and efficient technical and judiciary management and implementation of the project.

Component 4: Contingent Emergency Response (USD 0 equivalent): A Contingency Emergency Response Component (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.

Project Cost and Financing

The total project cost is US$50 million, and the financing instrument is an Investment Project Financing with the use a set of disbursement linked indicators (DLIs) to disburse against targets achieved on health system strengthening measures. Table 4 provides an overview of the components and its financing.

Component 1 and 2 will rely on a mix of performance-based financing at the health facility level with a focus on quality and traditional investment financing. DLI financing will be based on achieving a set of tracer indicators aimed at measuring performance against health system strengthening actions related to component 3. These indicators will be chosen to provide incentives for local governments (communes) to mobilize, allocate and manage resources for the provision of essential health services in alignment with health needs at local level. Specific DLI indicators will be further discussed during project preparation with the Authorities, and in coordination with the WB team working on Fiscal Decentralization for Better Service Delivery as this project will also rely on DLIs targeted to the Ministry of Finance in order to strengthen financial management in local governments.

2. Overall Risk and Explanation

The overall risk rating is **Substantial**, mainly due to the conflict situation, the general political and institutional instability that could jeopardize the expected outcomes of the operation. The risks associated to the technical design, the environment and social factors and the stakeholders are also rated as substantial.

Political and Security Risks are high. Lack of progress in the security situation in the North, and/or its extension to the Center (through terrorist attacks) and upcoming elections in 2018 could distract Government's attention and divert resources from its recovery and development agenda. At the operational level, theft of equipment and goods, in particular vehicles, and threats are common in the North and Center Mali. The official prohibition of motorbike and pick-up use in some northern and central districts of the country may create some difficulties to achieve some health activities, although exceptions are possible.

Governance risk is rated Substantial. Governance of the health sector has been constrained by (a) limited ability of the government to manage and coordinate multiple initiatives; (b) proliferation of several types of schemes, tried, implemented, or funded by different DPs; and (c) ineffective regulation of public and private providers. The project, along with other key donors, intends to support the consolidation of all the initiatives, moving toward a common system to achieve UHC.

Fiduciary risks are substantial. In spite of progress made through the adoption of various regulations to improve PFM, recent procurement issues and the weaknesses reported on the compliance with the internal control rules as well as the external scrutiny and audits make evidence that fiduciary risks remain substantial.

Institutional capacity risks are also rated substantial. There are many entities (The MoH, ANAM (RAMED), Ministry of Solidarity and Social Action, a contracting agency to run the PBF scheme, the communes, the ASACOs, District hospitals (Csref) and NGOs) in charge of the implementation of the activities, most of them being endowed with limited well-qualified, in-house resource personnel.

Technical design risks associated with contracting and PBF implementation and sustainability is substantial. There is a risk of gaming and having health workers manipulating results indicators. Also, health care facilities are not used to receiving "block grants" (i.e. non-earmarked grants), and this may lead to embezzlement or misuse of funds by ASACOs. A specific procedure for financial audit will be designed during appraisal. There are also potential errors and fraud in enrollment of beneficiaries.

E. Implementation

The project will be implemented by the Direction Générale National de la Santé (DSG) with support from the existing Project Management Unit (PMU) established for the World Bank-funded Malaria/neglected tropical

diseases (NTD) project within the Ministry of Health and Social Welfare. The same PMU was also responsible for implementing the PSR reproductive health project.

The PMU is staffed by a multidisciplinary team including a Coordinator, a Financial Management Specialist, an Accountant, a communication specialist, an internal auditor, a Procurement Specialist and an administrative assistant. Through their work on the NTD and PSR projects, the team has built the skills and experience in procurement and fiduciary management. To further strengthen the PMU, additional staff will be hired or assigned by the MoH. This includes: (i) one health economist; (ii) one public health specialist; and (iii) two monitoring and evaluation specialists.

The project will be overseen by the existing Steering Committee established for the Malaria/NTD project, which is chaired by the General Secretary of the Ministry of Health, and includes Directors of all major departments, donors (excluding the World Bank) and technical assistant partners. The project policies and procedures will be incorporated in a Project Operations Manual (POM) which will be a condition of effectiveness.

The PMU will be responsible for the; (i) coordination and day-to-day management of the health project; (ii) project planning, financial and procurement management, M&E, and internal auditing. The PMU will be supported by a local and/or international firm that will be recruited for capacity building and independent evaluation of PBF. Technical coordination will involve the appropriate technical department of the Ministry of Health and Social Welfare. Health authorities at regional, district, and community levels will be charged with field implementation, activity supervision and coordination, including reporting, grant management, behavioral communication and community mobilization. Health centers and health personnel, as well as community health workers, and the private sector will be involved in project execution. Entities involved in the implementation of health project will sign contracts with the PMU.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The project will be nationwide with a special focus on targeted districts for PBF and on the North.The environmental and social impacts will be local and limited as the project activities will be limited to the targeted CSCOMs and CSRef.

B. Borrower’s Institutional Capacity for Safeguard Policies

The preliminary borrower's institutional capacity for safeguards policies found that , at national level, Mali has a legislative and regulatory framework which is conducive to good environmental and social management. Mali has signed a number of international treaties and conventions and has experience with the Bank’s Safeguard Policies due to Bank-funded projects across different sectors. However, implementation capacity remains limited. Environmental policies and their compliance are governed by the Ministère de l’Environnement, de l’Assainissement et du Développement durable’s Direction Nationale de l’Assainissement et du Contrôle des Pollutions et des Nuisance (DNPACN). The DNAPCN is responsible for safeguards compliance of all projects in the country, but with emphasis on environmental category A project. This agency is familiar with the World Bank safeguard instruments such as the Environmental and Social Management Framework (ESMF) and EMPs, the Resettlement Policy Framework (RPF). However DNAPCN is understaffed and has limited capacity. Despite several donor-funded capacity building initiatives, the unit still largely relies on donor

funds to carry out its field supervision duties. DNAPCN has deconcentrated Units named DRAPCN that are in charge to review and validate Environmental and Social Notices. These regional bodies often do not have the equipment necessary to monitor social and environmental impacts, their staff lacks training, and management capacity is very thin.

The EA archives system remains weak and is mainly manual.

At the level of Ministry of Public Health, the capacity remains also weak despite their experience in implementing several World Bank funded projects. Nosocomial diseases statistic are not available and the project should improve the prevention of such diseases.

The Project implementing Unit will be reinforced by a full time Environmental and Social Specialist in charge to ensure the environmental and social safeguards compliance.

C. Environmental and Social Safeguards Specialists on the Team

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

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	This policy is triggered because the project will support through its sub component 1.1 Physical improvement and rehabilitation of the CSCOMs and CSRef - The rehabilitation activities may have environmental adverse impacts that need to be managed appropriately. As the project will increase the quantity of medical wastes. Prior appraisal, the borrower wil prepare an Environmental and Social Management Framework (ESMF) for the rehabilitation activities and a Medical Waste Management Plan based on the existing national document plans that are available. The ESMF will also cover nosocomial diseases concerns at the national level. The ESMF and MWMP will be prepared, validated and disclosed prior project appraisal.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	The project will not take place in or near natural habitats.

Forests OP/BP 4.36	No	The project activities will not involve forest conversion nor large-scale reforestation or afforestation.
Pest Management OP 4.09	Yes	This policy is triggered because the Project will support reduction of malaria .The Borrower will address OP 4.09 requirements by updating the existing Vector and Pest Management Plan (VPMP) developed for the ongoing REDISSE project. The VPMP will be available and disclosed prior the appraisal.
Physical Cultural Resources OP/BP 4.11	Yes	The project during the rehabilitation activities, is unlikely to involve or affect physical cultural resources and will avoid them. The government will follow its "chance finds" procedures in the event that the project encounters archaeological artifacts, unrecorded graveyards and burial sites, and similar physical cultural resources. This will be cover under OP/BP 4.01.
Indigenous Peoples OP/BP 4.10	No	No indigenous people in the sense of this Policy are located in the project areas.
Involuntary Resettlement OP/BP 4.12	No	As at this stage, the project does not anticipate land acquisition or resettlement that would lead to economic or physical displacement of people. It is that rehabilitation will be supported only on public lands held by the Government. But during the project preparation if new constructions are planned, the team will recommend to prepare the relevant instrument. this decision needs to be taken during the concept note review meeting.
Safety of Dams OP/BP 4.37	No	This policy is not triggered policy 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 policy as the project is not anticipating to collect water from Niger river.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not triggered policy as the project is not anticipating to finance activities in the disputed areas as described in this policy.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

May 15, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The ToRs for the ESMF are expected by the end of April 2018.
In the meantime, the bidding process to hire the relevant consultant will start no later that April 30, 2018.

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