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

Concept Stage | Date Prepared/Updated: 22-May-2018 | Report No: PIDISDSC24063

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Senegal	P162042		Investing in Maternal and Child Health (P162042)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Sep 10, 2018	Oct 18, 2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Health and Social Action	

Proposed Development Objective(s)

The Project Development Objective is to increase utilization and improve the quality in priority regions with a particular focus on reproductive, maternal, adolescent and child health and nutrition services.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	40.00
Total Financing	40.00
of which IBRD/IDA	30.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	30.00
IDA Credit	30.00

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

1. Senegal is located in the western-most part of Africa's Sahel region. It has a national territory that spans 196,712km^2, with 700 km of coast by the Atlantic Ocean and a population estimated at 15.4 million in 2016. Approximately half of the population lives in urban areas (45.2% as of 2016), with 23 percent of the total population living in the greater Dakar region, which accounts for 0.3 percent of the country's geographic territory. Senegal is a stable democracy and has strengthened its democratic structures in recent years. Senegal's democratic tradition has been strengthened with the March 2012 presidential elections. The integrity and the outcome of this process were internationally praised and, ultimately, are a sign of Senegal's democratic maturity. The next presidential election is scheduled for February 2019.

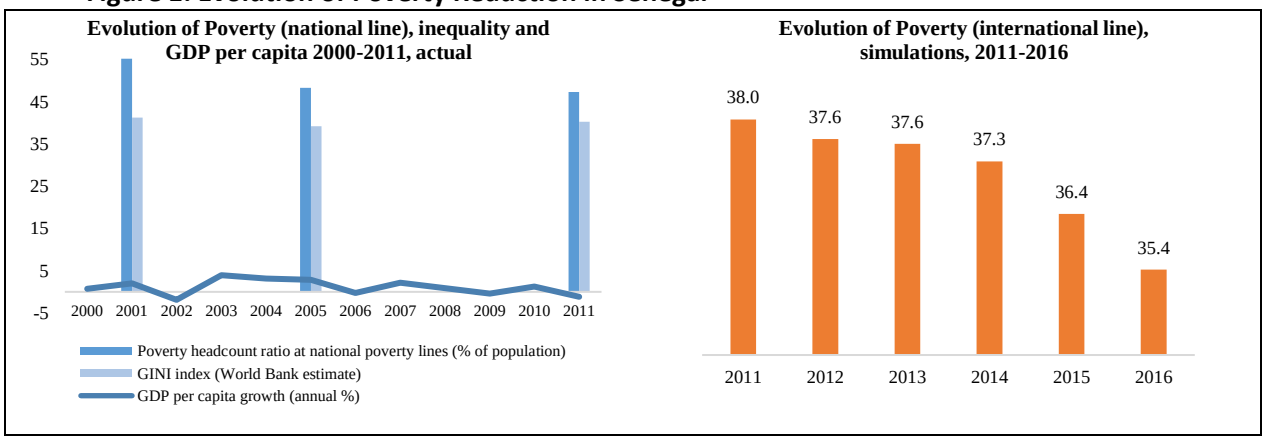
2. With a per capita GNI of 1,056 US$ in 2016, Senegal is classified by the World Bank as a low-income country. The pace of economic growth has recently improved, following long periods of volatility. Senegal's GDP growth reached 6.7 percent in 2016 and may have attained 7.1 percent in 2017, while inflation remains under control. According to official estimates, all sectors contributed significantly to growth in 2017, but the primary sector continues to be the fastest growing, mainly due to agriculture. This is linked to ongoing support programs and the robust external demand. The secondary sector remains dynamic with construction, processed food and chemicals are still growing robustly. Hospitality and financial services are the key drivers behind services. The economic outlook is favorable with progressively higher growth rates expected in the coming years.

3. Senegal has developed an ambitious Plan to reduce poverty and accelerate growth: Emerging Senegal Plan, 2014 - 2035[1] **[*Plan Senegal Emergent (PSE)*.** The PSE established a framework for the country's economic and social policy over the medium to long terms. The PSE focuses on three pillars: (i) structural transformation of the economy to achieve strong and sustainable growth; (ii) human capital, expanding access to social services and social protection, and preservation of conditions for sustainable development; and (iii) enhancing governance, and security through institutional strengthening and promoting peace. The services sector is also growing rapidly, helped by advances in transport and communications.

[1] Emerging Sénégal Plan

4. Over a third of the population in Senegal is considered poor based on the international poverty line, and two thirds live on less than 3.2 US$ a day. Poverty was 47 percent in 2011 (latest national poverty survey), and highly concentrated in rural areas (nearly 70 percent of the poor and 84 percent of the extreme poor lived in rural areas). The rural poor are concentrated in agriculture and suffer from multiple deprivation and chronic poverty. In contrast, in urban areas, the poor are mainly unemployed or working in the informal sector, typically in commerce and other services, and construction. The predominantly young population is confronted with limited access to basic social services or jobs. Geographical disparities are pronounced: almost two-in-three people in rural areas live in poverty, compared to one-in-four in Dakar. Young children are disproportionately represented among the poor. More than 85 percent of the poorest households have children below the age of 5.

Figure 1: Evolution of Poverty Reduction in Senegal



Sources: National Accounts, ANSD poverty survey series, Macro-Poverty Outlook 2017 and World Bank staff calculations (from SCD Senegal)

5. Despite the encouraging evolution of demographic trends, including a decreasing dependency ratio and an increasing labor force, Senegal is only partially taking advantage of its incipient demographic dividend, which accounted for mere 0.5 p.p. of the per capita GDP growth since 2000. Senegal is a pre-demographic dividend country due to its high fertility (4.7 children per woman in 2016), declining mortality (under-five mortality decreased from 121 deaths per 1,000 live births in 2005 to 51 in 2016) and young age structure (half of the population under 24). slow job creation among the youth is another key constraint for Senegal to leverage its demographic transition. As many as 300,000 young people enter the labor market every year, but their productive contribution to the economy is stifled, as they face very limited economic opportunities, showing the highest unemployment rate at 9 percent (against a national average of 6.1 percent), as well as high inactivity and underemployment rates, respectively at almost 60 and 22 percent. The demographic dividend is equally constrained by lagging, although improving, results in terms of maternal and reproductive health, as well as important and persistent gender inequalities in accessing basic services and productive inputs, hampering women's capacity to accumulate human capital and pursue economic opportunities (SCD Senegal).

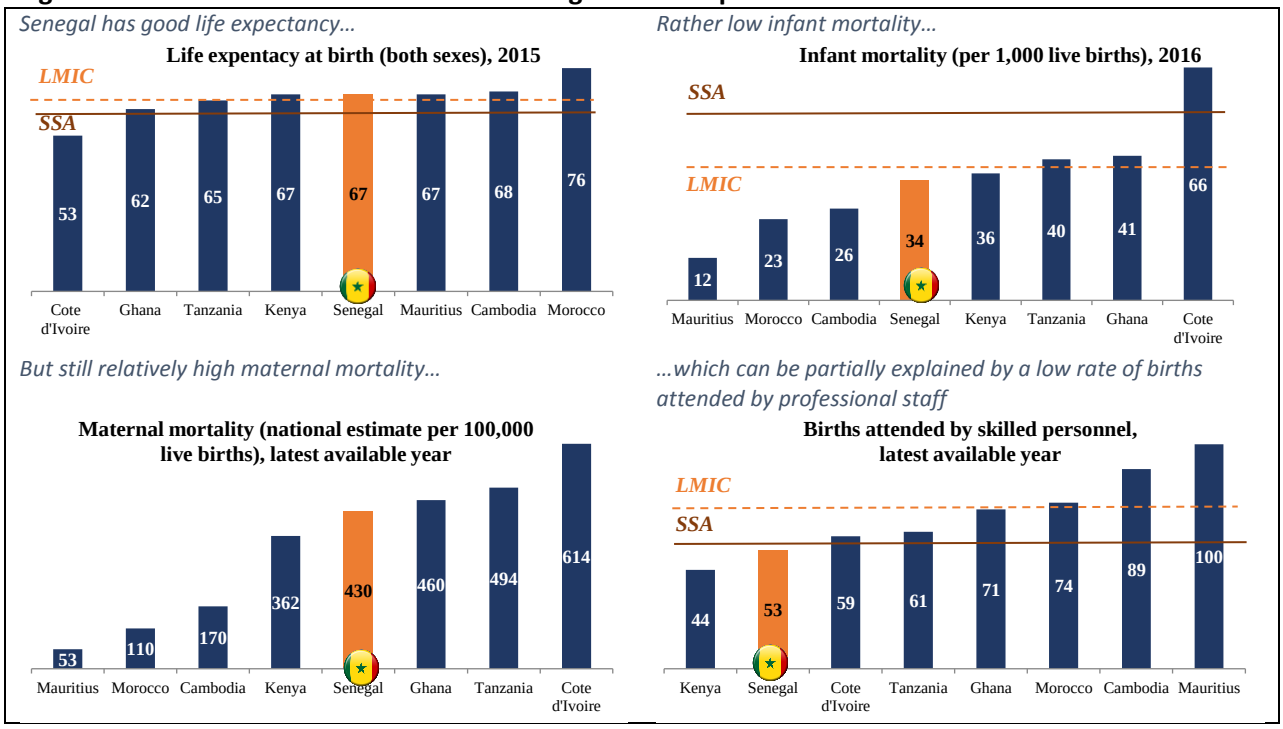
C. Sectoral and Institutional Context

6. While Senegal has seen substantial progress in infant mortality over the last decade, more needs to be done to accelerate reductions in stunting and neonatal mortality. The country has made tremendous strides in diminishing infant and under five mortality rates, which respectively decreased from 61 to 33 and 121 to 54 deaths per 1000 live births from 2005 to 2015. Such progresses is the result of better access to malaria treatment and prevention and enhanced vaccine

coverage (which increased from 59% in 2004 to 74% in 2015). Yet, nutrition progress is mixed: While Senegal has one of the lowest stunting rates in Africa (i.e., 17 percent in 2016), the prevalence of underweight children only decreased from 14.2% in 2005 to 12.6% in 2014 (DHS, 2005; 2014). Furthermore, the neonatal mortality rate has seen only a small decline, compared to the under-five and infant mortality rates, from 35 deaths per 1000 in 2005 to 21 in 2016, (DHS). Neonatal conditions are the leading cause of death for children under five (45%), followed by pneumonia (12%) and Diarrhea (9%).

7. Improvements in maternal health are modest, despite marked improvements in modern contraceptive prevalence. The maternal mortality ratio (MMR), while still high, has steadily declined, from 540 deaths per 100,000 live births in 1990 to 315 in 2015 (WHO, 2015). Thanks to a high-performing national program on family planning, the modern contraception rate increased from 10% in 2010 (2005 DHS) to 23% in 2016 (2016 DHS), which has certainly contributed to diminish the maternal mortality ratio. Despite a rapid progress in FP availability, the fertility rate has remained stable over the last decade (4.7 in 2016 and 4.9 in 2006) and particularly high among women from the lowest wealth quintile (7.1). Malnutrition is also a major risk factor in maternal mortality with over a fifth of all maternal deaths associated with undernutrition, particularly iron deficient anemia. Additionally, the rate of births assisted by trained personnel remains low at 59% (DHS 2016) and has improved only slightly since 2012 (51%). Skilled birth attendance also varies significantly across socio-economic gradients: 45% in rural areas versus 82% in urban areas, with skilled birth attendance at only 30% of births among women from lowest wealth quintile.

Figure 2.3: Selected Health Indicators of Senegal and Comparator Countries



Source: World Development Indicators, Senegal Strategic Country Diagnostic

8. Chronic malnutrition or stunting (i.e. children being too short for their age) has fallen from a rate of more than 30 percent before 2000 to approximately 17 percent in 2016, thus making Senegal the top performers in this area across continental SSA. Notwithstanding the progress, today Senegal is still classified as a low Human Development Country,

ranking 162nd out of 188 countries in the 2016 Human Development Index.[2] More than half of its population does not have access to sanitation services and maternal health care still lags, with almost one fifth of infants born with low birth weight[3], which jeopardizes critical early childhood development prospects. Moreover, critical disparities exist between various groups of population. In particular, rural access to electricity or sanitation is only a fraction of that in Dakar (a third and a half, respectively), and 40 percent of rural households live in precarious dwellings, while this percentage is well below 10 percent in urban areas.

9. Adolescent health service coverage remains weak. 16% of adolescents between 15 and 19 years of age have already begun engaging in sexual activity. Indeed, health services do not specifically target this age group and less than 2% of adolescents have access to modern contraception. Investing in adolescents is at the heart of the potential for demographic dividend. Youth represent almost one third of the Senegalese population (31.5% of the population is between 10-24) and 38% of adolescent girls are married before the age of 18 (DHS 2015).

10. Furthermore, significant geographical iniquities exist in maternal, reproductive and child health, as illustrated in the figures below:

[2] United Nations Development Program (2016). Human Development Report 2016. Briefing Note on Senegal. Available at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/es/SEN.pdf
[3] 18.6 percent in 2011, according to the World Development Indicators

Figure 1: Fertility (number of children per woman)

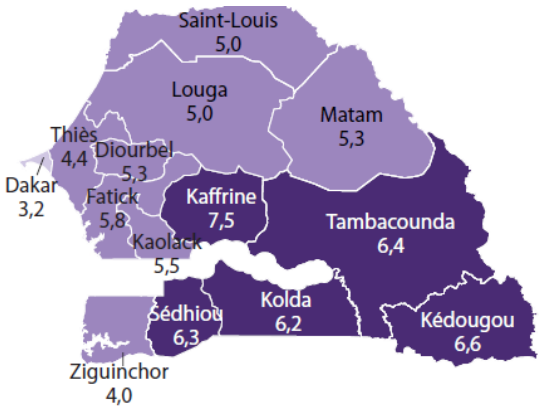


Figure 2: Assisted deliveries

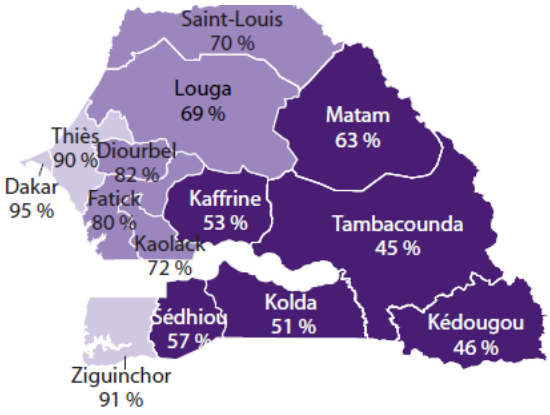


Figure 3: Children 12-23 months fully immunized

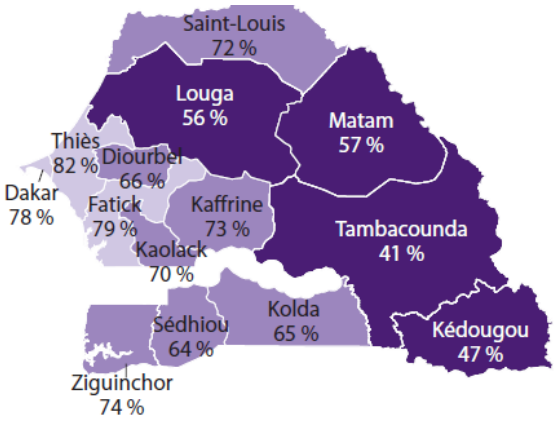
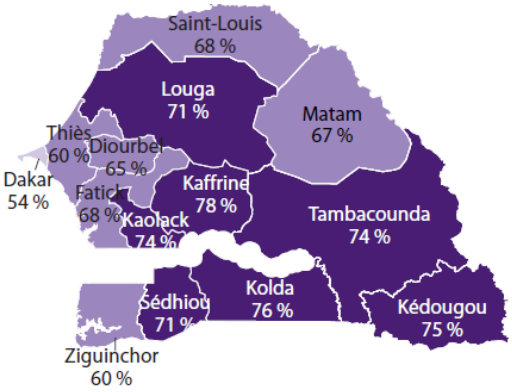


Figure 4: Children 6-59 months with anemia



Source : Demographic and Health surveys data 2015-2016

Senegal reforms towards Universal Health Coverage

11. The Government of Senegal launched its ambitious Universal Health Insurance program ("Couverture Maladie Universelle or CMU) in 2013 and created an autonomous Agency (under the Ministry of Health and Social Action) to manage this program in January 2015 (Agency for Universal Health Insurance- *Agence pour la Couverture Maladie Universelle* ACMU). Most of the program features had been designed (and sometimes piloted) between 2009 and 2012. But the major boost came in 2012 when the President (Macky Sall) made the launch of the UHC a formal commitment during his political campaign. The objective of the UHC is to cover 75 percent of the population by the end of 2021, and the ultimate goal remains the coverage of the entire Senegalese population. ACMU intends to provide coverage to members of the informal sector, including the most vulnerable. To do so, it relies on a well-developed network of CBHI (at least one per municipality), the central level is the ultimate payer, guaranteeing a high level of risk pooling. In addition, enrolment is either partly or fully subsidized. Annex 1 provides details on the design of the CMU in Senegal.

The ACMU (Universal Health Insurance agency) is subsidizing the poor through the management of the free health care policies. Free care policies have been implemented targeting specific groups to increase access to care: free delivery care for pregnant women (2005), free health services for the elderly (*Plan Sésame*, 2006) and free services at primary level for under five years old children in 2013. However, these free health care programs have some limitations. Benefit packages

are limited, and there are frequent issues of availability of drugs, delays of reimbursements to health facilities leading to their limited effectiveness in some regions (for example for the Plan Sésame). **Overall, as a result of the introduction of CMU, Senegal has demonstrated significant increase of financial health protection coverage (including all schemes) of the population from 20% in 2010 to 47% in 2017,** and the coverage rate by CBHIs has increased over the same period from 4 percent in 2010, 12 percent in 2014 to 17 percent in 2017.

12. But critical challenges for the Universal Health Program need to be addressed for impact and sustainability of the approach: (i) the scheme is currently voluntary and to ensure that health insurance coverage can be increased (and with the issue of a weak quality of care in public health facilities) it is crucial to develop strategies to have a large pooling of resources and limit adverse selection, including a potential move towards more mandatory approaches and (ii) the different mechanisms of care coverage for the population, especially the most vulnerable groups, need to be better integrated to ensure greater efficiency and sustainability of the Universal Health Coverage program.

13. Using Public Private Partnership to achieve UHC by making essential inputs available at facility is critical but challenges remain. Through the National Supply Pharmacy, Senegal is adopting the "last mile" model as part of supply chain reforms, which should be self-sustaining by June 2018. This approach focuses on improving distribution to "last mile" health facilities through the Informed Push Model, which relies on third-party private logistics providers to deliver contraceptives directly to health facilities, based on practices adapted from the commercial sector. In only three years, the model was scaled nationwide, dramatically reducing stock-outs to less than 2% of all public facilities. This model is now extending beyond contraceptives to include more than 100 essential medicines but is facing financial sustainability that the government is not able to cover in the next year

14. Fostering data quality and use through Digital health to reach UHC. Senegal has developed a National Digital Health Strategy 2018-2023, also aligned with the orientations of the Digital Senegal Plan 2025 and the Emerging Senegal Plan (PSE). The vision is to use the digital tool for a more efficient health system. By 2023, the objective is to contribute substantially to the universal health coverage and to ensure decision-making by stakeholders based on quality and secure information. Areas of focus of the digital health strategy are to: i) promote access to quality care through e-health solution; ii) promote the prevention and management of health risks through a wider dissemination of digitized health information through digitalization of the CMU; (iii) strengthen the performance of health personnel through the optimal use of ICTs in day-to-day work; iv) improve health governance through the availability of quality and secure information at all levels of the health system. To strengthen its health information system, the Ministry of Health launched the deployment of the District Health Information Software 2 (DHIS2), a platform for reporting and analyzing health and social data that is already operational at hospitals, health centers and health posts levels. Additionally, the Universal Health Insurance Agency is setting up an integrated management information system for Universal Health Coverage.

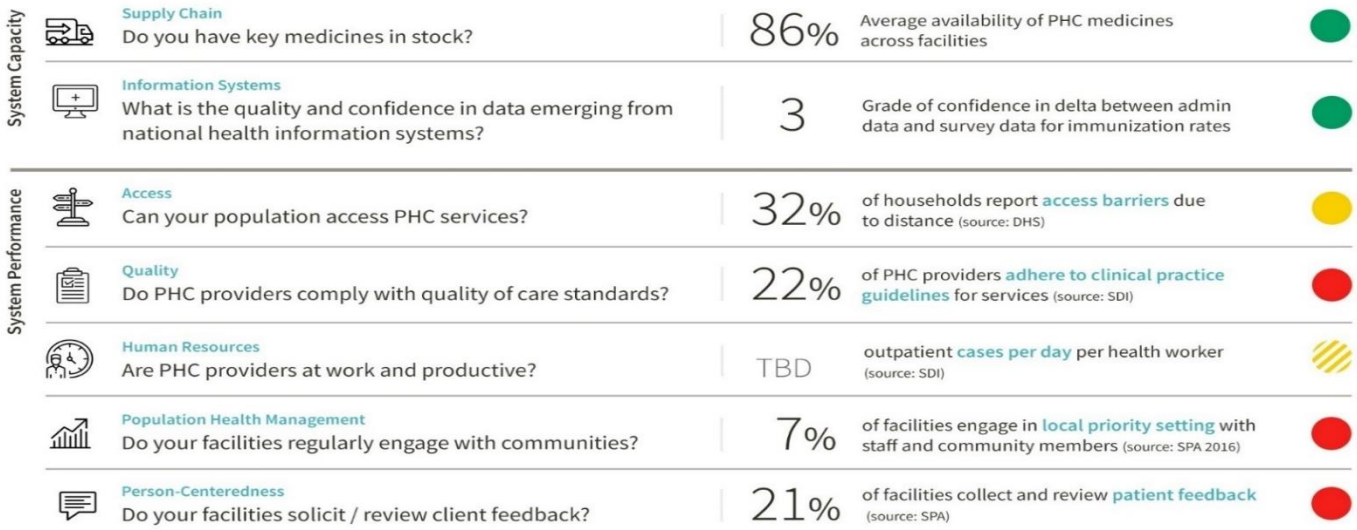
15. While Senegal's civil registry system is strong, bottlenecks remain that impede on the implementation of an efficient and accountable system that registers all civil facts and that is not well connected to the health management information system. Overall, Senegal has 587 civil registry establishments (*Centre d'état Civil – CEC*) in its territory (CNEC – Centre National d'états Civils). These establishments are key to help consolidate national statistics and to obtain qualitative data on health care, since registry of civil status, including birth, death, and weddings, allow to get a better overview of demographic indicators. In 2016, ANSD estimated that one third of all children under five are not registered at birth in Senegal, and thus remain inexistent for the government. Furthermore, only 30,8% of all deaths are declared in Senegal, with a higher rate in Dakar (82,8%) compared to the rest of the regions (Ex : Sédhiou : 9,2%, Kaffrine : 8,1%).

16. Finally, the Ministry of Health has developed a Health Financing Strategy to reach UHC with four strategic directions: (i) improve the availability of quality health services; (ii) extend financial protection against health-related risks; (iii) strengthen high-impact multi-sectoral interventions; and (iv) increase resource mobilization to reach UHC. **The HFS was finalized in 2017 and was followed by a high-level forum chaired by the President on health financing in November 2017**.

But major health system constraints to achieve UHC and trigger the Demographic Dividend remain

17. A health system bottleneck analysis[4] conducted in 2017 showed that clinical quality, financial access and cultural acceptability are the top three barriers to effective coverage of the Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) package. Further studies show that the following obstacles are limiting the accessibility to quality health services: (i) the density of health centers is low, reducing their geographical accessibility and capacity for outreach activities; (ii) qualified health workers prefer to work in urban areas, especially Dakar; (iii) the performance of health workers is weak, and (iv) health facilities have limited funding for ensuring the availability of drugs and supplies. At the national level, care competence, organization, and management are the dimensions of the quality of care with the worst performance. Health facilities are performing particularly poorly on child visits, followed by family planning and antenatal care (Primary Health Care Performance Initiative, 2017). Financial access is also an issue: 65% of total health expenditures for PHC services are paid by households. Furthermore, issues with cultural acceptance negatively impacts key priority interventions including FP, ANC, assisted deliveries and emergency obstetric and neonatal care (EONC). The figure below summarizes key primary health care performance indicators.

Figure 5: Snapshot of primary health care performance in Senegal (PHCPI, 2018)



18. Despite the great strides Senegal has made to improve its overall primary health care (PHC) system, potential benefits remain largely dependent on having sufficient numbers of competent human resources that are geographically well distributed to deliver PHC services. In 2018, the PHCPI's performance index for Senegal remained quite low regarding its workforce and inputs (36,2%), below the Sub-Saharan average (41,5%). This situation is due essentially to three factors:

[4] Conducted by the Global Financing Facility for Every Woman Every Child Platform with support from the Primary Health Care Performance Initiative.

insufficient number of students admitted for health training in universities; lack of adequate management of the hiring process for civil servants; insufficient incentives given to retain personal and foster a better distribution of human resources. In addition, the low level of competence of health care workers remained one of the top three hurdles identified to improve quality of care. Overall, only 22% of primary health care workers adhered to clinical practice guidelines for services (SDI 2010). As an illustration, only 7% of parents/caregivers are told their child's diagnosis (SPA 2016). **Some barriers also persist in terms of geographical accessibility of health services, notably in regions that remain marginalized due to distance from urban centers and lack of adequate transport infrastructure.** Overall, 68,5% of patients indicate that they had "no barrier due to distance". However, Senegal needs to maintain efforts to strengthen the foundations of the system, by consolidating infrastructure density and basic equipment. Indeed, there are clear disparities by region, with better coverage in Ziguinchor, Fatick, Saint-Louis, Dakar and Kedougou, while the regions of Diourbel, Kaffrine, Kolda and Louga remain the least covered (PNDS 2018).

19. Health financing and financial accessibility to health services. Total annual health expenditure in Senegal is approximately 4% of GDP (GHED, 2015). The share of domestic general government expenditure as percent of general government expenditure dropped from 4% to 8% from 2005 to 2015 (GHED). This is a large reduction in the prioritization of health. In 2014, the GGHE/GGE ratio was below the median of L-LMICs of 9.7%. Private spending on health are mostly supported by out-of-pockets (OOP) payments from households. According to Health accounts, out-of-pocket-payments represent 44% percent of current health expenditure in in 2014 and 2015, down from 45% in 2015 (GHED), which however still hints at a low level of financial protection of Senegalese citizens again health-related financial risks. The latest analysis report of catastrophic health expenditure and their impact on impoverishment and use of services in Senegal in 2005 & 2011 (MoH, WHO and ANSD, *Agence Nationale de Statistiques Démographiques*, 2013, using poverty surveys) found that the proportion of out-of-pocket expenditure in the total household expenditures was higher for the poor. Furthermore, healthcare issues are strongly contributing to poverty and to gender inequalities, with health-related shocks being the most frequent shocks faced by households in Senegal. An analysis of the latest poverty assessment (Echevin, 2012) has found that the most frequent shock experienced by households was related to the death, illness or injury of a revenue-earning household member (16.5 percent of households). This factor was even higher for the poorest households, as 18.2 percent of the poorest households had experienced such a health-related shock. This suggests that health-related shocks are a major contributor to vulnerability and poverty incidence in Senegal. Additionally, important gender inequalities persist in accessing basic services and productive inputs and considering that women are the main care givers in the households, health shocks have a direct, significant impact of their ability to accumulate human capital and engage in productive activities.

20. Efficiency of the available resources is also an issue. A Public Expenditure Review (PER) conducted in 2011 raised pending efficiency concerns:

- Insufficient allocation of funds to primary care and preventative services: Senegal spends half on preventive care (15%) than on curative care (30%);
- Limited capacity of domestic resource mobilization at regional level: "*collectivites locales*" health expenditure represents 1.37% of THE;
- Low technical efficiency in the hospital sector;
- Overall, very little is known about health facility productivity[5];

[5] The 2016 DEA study of 17 hospitals examined hospital efficiency but did not identify correlates of low or high productivity

- Limited donor coordination: While external funds represented 21% of THE in 2014, donor coordination mechanisms are limited and aid at the regional level is fragmented. On one hand, donors complement each other by supporting different regions, on the other hand this contributes to fragmentation, with several systems being used, increasing transaction costs and inefficiencies. Furthermore, only 45% of participating Development Partners have communicated their resources for the next 3 years to the MOH (IHP+, 2016 scorecard).

21. Decentralization. Senegal has undergone successive waves of decentralization in recent years, with local authorities now responsible for the management of public health facilities. In practice, many local stakeholders have limited engagement with health system management; the failure by some local authorities to release all funds allocated to health facilities under their supervision is a particularly significant challenge.

22. Thus, the health system does not provide an equitable access to quality health services. This is due to the inequity in allocation of resources between regions but also for rural and vulnerable areas. The results of the 2013 national health accounts show that the Southeast regions (with the highest child mortality rates in the country) are receiving fewer resources, and an important part of the financing for Reproductive, Maternal, Neonatal, Child and Adolescent Health services (RMNACH) is concentrated in a Dakar, Thiès and Kaolack triangle, regions with the lowest maternal and child mortality rates.

23. As part of the Global Financing Facility for Every Women Every Child (GFF), Senegal is engaged in prioritizing interventions and regions of focus to improve equity and maternal and child health outcomes, using the available resources. The GFF is a global partnership which supports the improvement of the health and well-being of women, children, and adolescents. The objective is to strengthen the dialogue among key stakeholders under the leadership of governments and supporting the identification of a clear set of priority results that all partners commit their resources to achieving: (i) getting more results from existing resources and increasing the total volume of financing from four sources (Domestic government resources, Financing from IDA, Aligned external financing, and Private sector resources) and (ii) strengthening systems to track progress, learn, and course-correct.

24. Through the GFF process, Senegal has developed an RMNCAH Investment Case (IC) based on a thorough analysis of the system bottlenecks and evidence-based interventions, strengthened coordination with its financial and technical partners and built a strong consensus on the priorities the country should focus on to significantly improve maternal, child and adolescent health outcomes. A GFF platform was created (building on the existing RMNACH group) with representatives from key Ministries (health, finance, interior, education), partners, civil societies organizations and private sector. The GFF Platform delivered an RMNCAH Investment Case in 2018 (validated technically in March 2018). Partners and the government are engaged and have a better understanding where the gaps are and where to re-align.

The GFF Investment Case focus on the following five key priority areas: 1) Provision of a high-impact RMNCAH package; 2) Enhanced financial access to and socio-cultural acceptability of the RMNCAH package through demand side financing; 3) Improved adolescent health through multi-sectoral approaches; 4) Strengthened supply of healthcare services by scaling up high-impact human resources and supply chain interventions to address low RMNCAH service coverage; and 5) Strengthening health system governance. **The IC took an equity lens by focusing on the regions with the weakest health and socio-economic indicators.** The Senegal IC targets five priority regions based on a composite index comprised of the following indicators: poverty rate, neonatal mortality, under-five mortality, assisted delivery, contraceptive prevalence, proportion of adolescents with active sexual life and ANC coverage. The regions in the south of the country, e.g., Sedhiou,

Kolda, Tambacounda, Kedougou and Kaffrine have the lowest index. Increasing quality and accessibility of adolescent, maternal and child health services will support Senegal in its efforts to reap the benefits of the demographic dividend. The IC is aligned with the Domestic Resources Mobilization agenda of the Health Financing Strategy (HFS) and its related HFS workplan.

Current Health Portfolio and complementarity with other sectors

25. The Bank supports the Government to strengthen the health system and reaching Universal Health Coverage through lending operations an analytical work. The proposed Project will build on lessons learnt from current Health and Nutrition Financing Project (to close in June 2019, ***details on links between current and proposed operations in Annex 2***) and be complementary to other operations.

- **The Senegal Health and Nutrition Financing Project (PFSN *Projet Financement de la Santé et de la Nutrition*)** is a five years US$ 40.8 million project slated to close on June 30th, 2019. The objective of the Project is to increase the utilization and quality of maternal, neonatal and child health and nutritional services, especially among the poorest households in targeted areas of Senegal. The Project contributes to support Senegal in reaching UHC, by improving financial accessibility for health and protection for the poorest (through the extension of community-based health insurance, a community nutrition program and maternal vouchers) and improving the quality of care (through Results-Based Financing scheme).

- **The REDISSE Project is a US$ 30 million regional and multi-sectoral Project**, effective since December 2016. It supports Senegal to address systemic weaknesses within animal and human health systems that hinder effective disease surveillance and response. Its specific objective is to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in West Africa, and in the event of an eligible crisis or emergency, to provide immediate and effective response to said eligible crisis or emergency.

- **An Advisory Services and Analytics task "Support to Universal Health Coverage and pandemic preparedness"(P164017) provides support for Senegal's, UHC agenda** by (i) monitoring Senegal's progress reaching Universal Health Coverage and health-related Sustainable Development Goals and (ii) strengthening pandemic emergency response capacities, especially coordination. This US$ 1 million Bank-executed ASA is funded by the PHRD Trust Fund.

- Additionally, the bank-executed GFF Trust Fund supports analytical work on adolescent health, health financing and efficiency, health system performance at the primary level, human resources for health and health information system.

- The Primary Health Care Performance Initiative is a bank-executed Trust Fund supporting the government of Senegal on international performance comparisons and analytics, access to global knowledge and best practices related to performance improvement, and multi-country learning for the primary health care system.

26. The proposed operation will also complement interventions of the Early Years, Education and Social Protection Projects and interventions from other health partners in Senegal.

27. Catalytic role and complementarities with other partners in the GFF approach: As previously highlighted, the proposed project is aligned with the priorities identified in the GFF investment case. The IDA/TF GFF financing is also a way to catalyze the mobilization of additional public and private resources to fill funding gaps identified in priority regions and interventions to achieve RMNACH targets (a resource mapping and costing exercise for these priorities is being undertaken). Through the GFF, the national platform (including representatives of Ministry of Health, Ministry of Finance, partners, civil society, private sector) will facilitate transparency, dialogue and synergies of interventions, identify unfunded priority interventions and avoid duplication. Thus, the World Bank with its expertise is playing a convening role in the different UHC areas.

D. Relationship to CPF

28. Through strengthening health system performance, quality of care and improving financial protection, the proposed project will directly address some of the binding constraints identified in the SCD, especially the inequality of social public policies and expenditures. As indicated in the SCD, lagging outcomes in child, maternal and reproductive health undermine Senegal's ability to build a strong and inclusive human capital base for its long-term development.

29. Building on the SCD, the interventions under the project remain consistent with, and aligned to, the emerging framework of the Country Partnership Framework (FY19-FY23) (currently under development), which focuses on: (i) Building up Human Capital throughout the life cycle, (ii) optimizing social development and (iii) creating an ecosystem for innovation. More particularly, under the first focus area related to building human capital throughout the life cycle, this project will support the Bank approach on providing universal access to healthcare, increasing resilience among the poorest households (through health insurance and financial protection) and reducing dependency ratio to leverage the demographic dividend (by improving access to quality health care, especially reproductive health and family planning and nutrition services).

30. 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.

E. Proposed Project Development Objective(s)

The Project Development Objective is to increase utilization and improve the quality of health services in priority regions with a particular focus on reproductive, maternal, adolescent and child health and nutrition services.

F. Key Results

31. The proposed PDO indicators are the following:

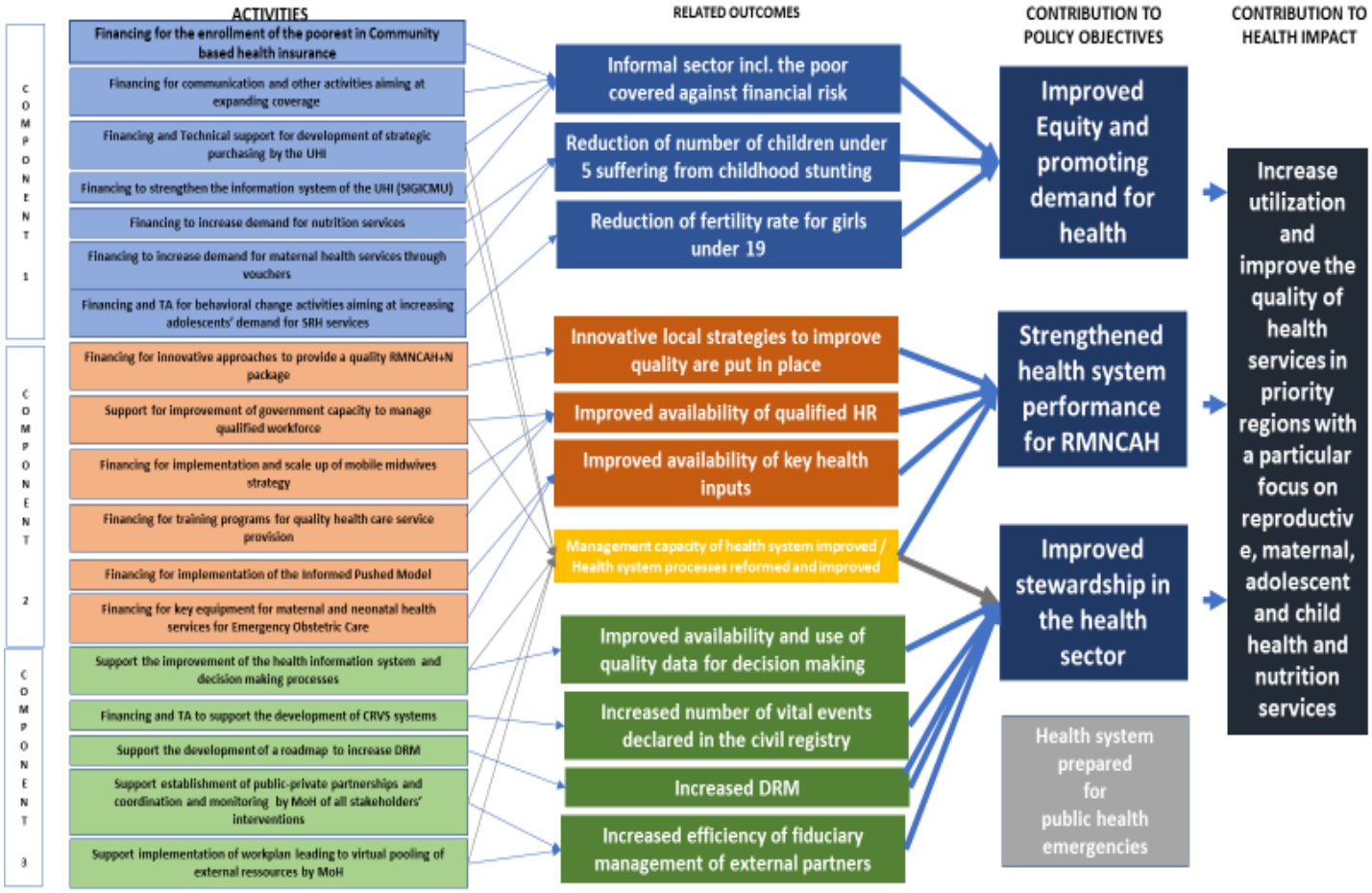
1. Utilization of curative services by insured/uninsured people;
2. Percentage of Births (deliveries) attended by skilled health personnel ;
3. Fertility rate of teenage girls aged 15-19 (percentage);
4. Percentage of children under 5 suffering from childhood stunting;
5. Incidence of catastrophic health expenditures for the poorest wealth quintile

32. The key results including intermediate outcome indicators will be refined during project preparation. A detailed description of how PDO and intermediate indicators will be used to measure progress in achieving the project's development objectives, will be provided in the Project Appraisal Document (PAD).

Possible Intermediary Indicators:

- Percentage of pregnant women having 4 antenatal care visits (at standard quality)
- Percentage of children age 0 to 23 that were born at least 24 months after the preceding birth
- Coverage rate of post-natal consultations
- Percentage of newborns who benefited from an immediate care package at birth
- Percentage of children age 0 to 6 month exclusively breastfed
- Percentage of birth registered in the civil records
- Percentage of households impoverished because of OOP
- Health facilities reporting health management data on time
- Number of operational SIGICMU models
- People who have received essential health, nutrition and population services (Corporate Indicator) – Female (RMS requirement)
- Number of mobile midwives providing services in the priority regions
- Government Health expenditure per capita in real terms (without external on-budget funding)
- Ratio of government health expenditures to total government expenditures
- Number of people from the informal sector covered by a universal health insurance scheme;

Figure 6: Results Chain



G. Concept

1. Description

33. The proposed Project is aligned with the priority interventions identified in the GFF investment case to improve maternal, child and adolescent health and will be focused on the five priority regions defined through an in-depth prioritization exercise: Kédougou, Kolda, Kaffrine, Tambacounda and Sédhiou. The project intends to achieve its objective through interventions at the community, primary, and central level that are organized into three complementary components: 1) Improving equity and promoting demand for health; 2) strengthening health system performance for RMNACH; 3) Improving stewardship in the health sector. A fourth component for this project consists of a Contingency Emergency Response Component (CERC) which will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis. Table 1 below provides an overview of the financing proposed for each component/sub-component:

Table 1: Overview of components and financing by component in USD million

Project Components	Project cost
1. Improving equity and promoting demand for health	**20**
1.1 Supporting Universal Health Insurance for the poorest	11
1.2 Supporting community-based interventions for adolescents and mothers	9
2. Strengthening health system performance for RMNACH	**13**
2.1 Supporting decentralized innovations for quality improvement	5
2.2 Scaling up human resource initiatives to improve the provision of maternal and neonatal services	3
2.3 Supporting the availability of key health inputs	5
3. Improving stewardship in the health sector	**7**
3.1Health information system and CRVS	3.5
3.2: Support to health financing reforms	1
3.3: Supporting partnership and coordination for GFF implementation	2.5
4. CERC	**0**
Total Project Cost	**40**

Component 1: Improving equity and promoting demand for health (US$ 20 million)

This first component will specifically address accessibility to high impact health services (at community and primary health care levels) for the most vulnerable: the poorest, women and adolescents.

Sub-component 1.1: Supporting Universal Health Insurance for the poorest (US$ 11 million)

34. The objectives of this sub-component are to support the Government implementing the Universal Health Insurance Coverage scheme and developing strategic purchasing mechanisms to strengthen its impact and sustainability. Under this sub-component, the following activities will be financed: (i) contribute to finance the enrollment of the poorest (as identified in the Unified Registry) in Community-Based Health Insurance; (ii) support communication and other initiatives to expand the coverage and (iii) support the development of strategic purchasing by the Universal Health Insurance, for instance through the integration of policies focused on providing free access to health care services for specific population groups (especially for under-five children) into health insurance, strengthening the information system of the Universal Health Insurance (SIGICMU- *Système d'Information de Gestion Intégré de la CMU*) and building capacities for informed-decisions to manage the health insurance (control, equalization, costs, etc..).

35. Support enrollment of the poorest in CBHIs. Senegal's poorest families—300,000 households, or about 20 percent of the population—benefit from the *Programme National de Bourses de Sécurité familliales* (PNBSF), which is implemented by the *Délégation Générale à la Protection Sociale au Sénégal* (DGPSN) and provides support to families to invest in the development of their young children, including through cash transfers, social promotion/information sessions. Enrollment of these families in CBHIs is supposed to be fully subsidized by the state budget. The Project will financially contribute to the enrollment of the poorest.

36. Support expanding CBHIs coverage. With a voluntary scheme, it is crucial to develop strategies to have a large pooling of resources and limit adverse selection, thus ensuring that health insurance coverage is wide. Communication strategies at national and community levels will be funded by the Project. The voluntary nature of enrolment being a well-known factor of mid-term slowdown in the enrolment rate of CBHI, the Project may also provide technical assistance to facilitate the shift to a more mandatory approach should this policy option be considered by the government.

37. Strategic Purchasing by Universal Health Insurance. As defined by WHO, "Strategic purchasing means active, evidence-based engagement in defining the service-mix and volume, and selecting the provider-mix to maximize societal objectives. Improving the strategic purchasing of health services is central to improving health system performance and making progress towards universal health coverage". The Project will hence provide technical assistance for the alignment and improvement of existing benefit packages and purchasing mechanisms, to render promised services effective and in the longer run, incentivize health providers for greater efficiency. In the same spirit, technical assistance may be provided to investigate the positive impact of the introduction of new purchasing mechanisms (such as capitation). For the ACMU to purchase health care services strategically, it requires adequate information and the capacity to use it to inform decision-making. Thus, the Project will continue supporting the development and functionality of the SIGICMU (its design already supported by the current health operation), training for ACMU staff, as well as the financing of the integration of the free delivery of health care services modality or under-five children into the health insurance scheme. The ACMU is monitoring the progress of the implementation of the UHC policy, collecting and analyzing data on functionality of CBHIs throughout Senegal, number of CBHIs members (including PNBSF and CEC beneficiaries), and beneficiaries of the different free access to health care initiatives. The Agency is already working on setting up a computerized system for the integrated management of the different health insurance schemes, SIGICMU. The UHC data warehouse-data mining will receive data from CBHIs, private health insurers, public sector and IPMs. The idea is to integrate the data related to universal health coverage into the new biometric identity card (multi-application) which must be available in 2018 (first cards issued). The final goal is for this information system, beyond its administrative function, to become an evidence-based decision-making tool for the ACMU managers, and beyond, all decision-makers of the sector.

Sub-component 1.2: Supporting community-based interventions for adolescents and mothers, using the nutrition platform (US$ 9 million)

38. Under this sub-component, the Project will support the community-based interventions of the CLM and build on it to promote demand for adolescent and maternal health services. The objective of this sub-component is to enhance demand for nutrition services and for behavioral change for nutrition, adolescent and maternal health services, to improve nutrition and health for children and pregnant women. Senegal has made great progress in addressing chronic malnutrition (stunting), which is now the lowest in continental Sub-Saharan Africa at 17 percent (down from 34.4 percent in 1992), and expected to fall to or below 10 percent by 2025. Such progress was achieved largely due to the effective community-based approach of the *Cellule de Lutte contre la Malnutrition* (CLM). The CLM program success rests on its

mainstreaming nutrition across sectors; decentralization of program delivery; and use of a community-based approach. The program currently intervenes in 400 communes (municipalities) and aims to expand to all 571 and reach full coverage of nutrition services in all children under five, as well as to intensify services for those mothers and children in the first 1,000 days in the communes where it currently intervenes.

39. This sub-component will support the CLM (*Cellule de Lutte contre la Malnutrition*) to carry on the demand-side activities of the current nutrition program in Senegal in the five targeted regions. As currently done, local NGOs (called *"Agences d'Exécution Communautaire" - AEC)* are contracted by the CLM to implement the different community-based nutrition services. One "AEC" is covering approximately one health district. AECs work closely with local councils to implement the package of nutrition services and activities at the community level. Three kinds of activities would be implemented: (i) growth promotion and monitoring for children between 0 and 24 months in communities; (ii) Behavioral Change Communication (BCC) activities; and (iii) detection and community care of malnutrition.

40. Additionally, this sub-component will support interventions to boost demand for maternal health services by supporting households to overcome barriers (including financial and gender-related barriers) they could face to access maternal health care. This sub-component will expand the maternal health vouchers pilot intervention that is currently implemented under the Health and Nutrition Financing Project and identified in the GFF Investment Case as successful to increase demand for maternal services. Two services are incentivized through these vouchers: (i) four antenatal care (ANC) visits by poor pregnant women; and (ii) assisted deliveries at the health center level.

41. Using the successful community platform, this subcomponent will build on current adolescent health interventions, with a special focus on sexual and reproductive health care (ASRH). Building on the successes achieved by partners that are engaged in this area, this component will contribute to finance the demand for family planning through mass media, community mobilization and messages targeted for women, but also increase the participation of men and young people in reproductive health services. The project will scale-up several successful demand-side adolescent health interventions, such as (but not limited to) the following: adolescent health related messages by SMS and other digital community communication strategies to foster behavior change towards adolescent health; engagement with religious leaders or local policy champions in Family Planning in the five priority regions; improvement of existing health services linked to adolescent health such as Counseling Centers (Centre Conseil Adolescent) managed by the Ministry for the Youth; support the integration of ASRH locally by creating mobile strategies. Approaches such as *Ecole des Maris* (School for Husbands), which have been successfully implemented in Niger and have been tested via pilots in Senegal (districts of Makacolibantang et Koumpentoum) could be developed in the five regions. Ecole des Maris aims at including men and boys in the delivery of sexual and reproductive health care, by fostering sociocultural acceptability and behavior change through an inclusive process. Furthermore, the project will scale up the Informed Pushed Model in Senegal (Yeksi naa) improving the availability and quality of Family Planning consumables (under component 2).

42. Special focus will be given to ASRH, with the aim to reduce teenage pregnancies in Senegal using behavioral economics. As such, the team is currently working with the Mind, Behavior, and Development Unit (eMBeD) of the World Bank to define the most appropriate interventions to decrease early pregnancies among adolescents, especially in rural areas. A pilot will be implemented, and it will assess cost-effectiveness of the intervention as well as potential for scale-up. Currently the team has pre-identified three behaviors and possible strategies as a starting point for this subcomponent initiative: (i) adolescents girls go seek information and/or counseling on reproductive health by working

on their aspiration, self-esteem, and life plan; (ii) marriages in rural areas are delayed, by sensitizing parents on the detrimental impact of early weddings and pregnancies using religious, medical and economic facts; (iii) adolescent health counselors provide a more objective and better quality service to teenagers by improving healthcare quality.

43. Interventions under this sub-component will be complementary (geographically) to the interventions supported by the Early Years Project under preparation, but above all benefit from the interventions developed under this Project.

Component 2: Strengthening health system performance for RMNACH (US$ 13 million)

This component will support key interventions to overcome bottlenecks identified as major constraints for health system performance and effective delivery of RMNACH services in the five targeted regions.

Sub-component 2.1: Supporting decentralized innovations for quality improvement (US$ 5 million)

44. To improve the clinical quality of healthcare services and innovations at the community and primary level, it is proposed to set up **an innovation fund which will stimulate innovation and learning for a quality RMNCAH+N package delivered in the poorest regions** targeted by the Project. The proposal will include a process to adjudicate resources based on innovative proposals developed by healthcare facilities. The objective is to provide funds at the lower level of the health system and empower local authorities, health workers and communities to develop appropriate strategies to improve the clinical quality of RMNACH services.

45. The proposals selected and funded by the Project will be made publicly available, especially for local communities which would play a key role in monitoring the implementation of the proposal and related improvements in the quality of services. As part of the development of the proposals, local communities would be involved in the process, thus strengthening accountability of health services providers towards their patients. Technical support will be provided for the development of the proposals (by local NGOs), and proposals will be reviewed by a committee at the national level (for example the Quality Commission, which includes representatives of patients, health workers unions, partners). Implementation of the proposals will be reviewed every six months, especially on achievement of specific targets, to benefit from another tranche of funds. This innovative fund will potentially use DLIs.

46. To develop a positive benchmarking and emulation dynamic, experience and successes will be documented and shared on an annual basis. An accreditation mechanism could also be set up as part of this initiative. Details on the modalities and implementation arrangements of this innovation fund will be developed during Project Preparation.

Sub-component 2.2: Scaling up human resource initiatives to improve the provision of maternal and neonatal services (US$ 3 million)

47. This subcomponent will include activities related to supporting the Government in better managing a qualified workforce of health care providers and building cost-effective solutions for adequate human resources distribution. The project will strengthen the Healthcare Map Strategy (Carte Sanitaire 2017-2021) and help overcome the gaps it underlines regarding availability of qualified healthcare providers in the 5 priority regions. Furthermore, the project will involve the private sector within this subcomponent, by promoting increased partnership between the Ministry of Health and the private sector, regarding recruitment and distribution of unemployed midwives and health care workers.

48. Specifically, to improve the availability of qualified human resources, this subcomponent will finance (i) the implementation and scaling-up of the strategy for mobile midwives (*Strategie des Sages-Femmes itinérantes* or SAFI) and (ii) the training programs for quality health care services. The strategy is to increase the availability of qualified health workers at the health posts level. Certified midwives (called SAFIs) devote more of their working time to reach the most remote populations at community sites and public gathering places (weekly markets ....). The tasks of SAFI are to deliver quality curative, preventive and promotional services and plan outreach in collaboration with the community. The SAFI strategy has proven successful in the past in Senegal in the regions of Matam and Sedhiou to help increase the recruitment of midwives, but also their availability at the outpost level. Within this initiative, midwives are mobile and can thus connect with the populations that are the most remote, at a community level. Training programs will be coordinated with the Ministry of Health and its Department of Human Resources, to help improve current care competency levels, and insure that staff that are in the field have received adequate training and support.

Sub-component 2.3: Supporting the availability of key health inputs (US$ 5 million)

49. Under this sub-component, the Project will support the availability of key drugs, commodities and equipment for maternal and child health. Funding will support the strengthening of the supply chain to address one of the key health system bottlenecks which is low quality of health services. After a pilot approach funded by partners, the Government of Senegal chose the Informed Pushed Model as its national strategy for supply chain. The National Pharmacy Agency (PNA) is in the process of scaling up the push model approach. PNA transports supplies to the district level and contracts private operators for last mile delivery to provide medicines to health facilities. The PNA has done extensive financial analysis of the budget and cost recovery involved in scaling up IPM, and foresees that it will be self-sustaining after a transition period. The proposed Project will support the PNA to ensure the transition and the sustainability of the approach, for example in financing the private operators contracts in the priority regions.

50. Additionally, the Project will procure key equipment for maternal and neonatal health services (for Emergency Obstetric Care Services) that are essential to avoid maternal and neonatal deaths. Specific trainings to use this equipment will also be provided.

Component 3: Improving stewardship in the health sector (US$ 7 million)

Sub-component 3.1: Health information system and CRVS (US$ 3.5 million)

51. The dissemination and use of quality data for decision-making or advocacy purposes is a priority. Significant gaps are noted in the quality of RMNACH information. Timeliness, completeness and data quality remain a challenge for the information system through the DHIS2 platform. Under this subcomponent the Project will support the improvement of the health information system and decision-making process by ensuring a stronger data monitoring/ implementation support during the implementation of the IC with potentially the development of an integrated dashboard with different health information available.

52. Additionally, this sub-component will support the improvement of the CRVS system: Vital events occur for the most part in healthcare facilities. Nevertheless, some of these vital events (births and deaths) are not declared in the civil registry. In the context of Senegal, the integration of information and communication technologies into the management of civil status is crucial to record all vital events and generate statistics periodically. To this end, the following

interventions have been selected as priorities : Strengthening universal registration in civil status with i) capacity building of actors ii) increasing and strengthening civil status data management platforms iii) sensitization of all actors and the population on the importance of registration of civil status facts; (iv) establishment and scaling up of vital records offices at the level of health facilities, (v) census and regularization of the civil status of undeclared children, (vi) development of interoperability for health-civil registration information systems.

Sub-component 3.2: Support to health financing reforms (US$ 1 million)

53. Support to health financing reforms as part of the Health Financing Strategy adopted in June 2017. This sub-component will support the roadmap for increasing domestic resource mobilization, supporting the development of strategic purchasing approaches and evaluation of related pilot experience, and promoting efficiency gains in the sector. Thus, studies, trainings and dissemination will be funded. This project through this component will support analytical work that will help providing evidence to strengthen advocacy supporting health financing reforms.

Sub-component 3.3: Supporting partnership and coordination for GFF implementation (US$ 2.5 million)

54. One of the main obstacles to governance and leadership remains the lack of synergy among stakeholders due to an insufficient coordination of interventions. The GFF process is involving several stakeholders, including the Ministry of Health, other Ministries, local communities, civil society, the private sector, and technical and financial partners to develop the RMNACH Investment Case and Health Financing Strategy. During implementation, this partnership will be strengthened. To this end, the Project will contribute to support the Ministry of Health to enhance public- private partnership in the sector but also civil society organizations (members of the GFF platform) to play their role to monitor implementation of interventions. Indeed, the Senegalese civil society has put in place a governance mechanism to better structure its contribution to the GFF. Thus, it will implement the scorecard for monitoring commitments and accountability of stakeholders.

55. The objective of this subcomponent is also to ensure an effective and efficient technical and fiduciary management and implementation of the project. Moreover, it will also support **the implementation of a unique workplan leading to a virtual pooling of external resources by the Ministry of Health to support the funding of the RMNCAH+N package in the long-term.** Some donors (Global Fund, GAVI, USAID, World Bank) are already strengthening their partnership in support of a common workplan to build capacities of the fiduciary unit of the Ministry of Health (DAGE-*Direction de l'Administration et de la Gestion des Equipements*), at central and regional levels, to manage resources of external partners. This unique workplan aims at ensuring that high impact RMNCAH+N unfunded interventions get funded and implemented. It will also be an opportunity to support the Government to better track external resources for the sector, with developing an aid management information system.

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

56. The total project cost is US$40 million (IDA US$30 million and GFF TF US$10 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. DLI-based financing will be based on achieving a set of tracer indicators aimed at measuring performance against health system strengthening actions. These indicators as well as interventions link with DLIs will be further discussed during project preparation with the client.

SAFEGUARDS

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

The project will be implemented in five priority regions in South/East of Senegal: Sedhiou, Kolda, Kedougou, Tambacounda and Kaffrine. During the course of the project, some regions could be added in agreement with the Borrower, but that will not be known by project appraisal.

The project will focus on strengthening of regional capacities, in particular on supply and demand for health services and medical care. The project will not finance the construction of health centers or other physical structures (e.g. additions or expansion of existing structures).

B. Borrower's Institutional Capacity for Safeguard Policies

The Borrower prepared the Medical Waste Management Plan for the Health Financing and Nutrition Project and updated it for the REDISSE phase one. A dedicated unit at the Ministry of Health is in charge of following up on this plan.

C. Environmental and Social Safeguards Specialists on the Team

Fabienne Anne Claire Prost, Environmental Safeguards Specialist
Mamadou Moustapha Ndoye, Social Safeguards Specialist

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project triggers Safeguards Policy OP/BP 4.01 (Environmental Assessment) and is classified as category B project given the likely increase in biomedical waste due to improved coverage and quality of maternal and child health services across the regions. Since the exact nature and scope are not precisely known, an Environmental & Social Management Framework (ESMF) will be prepared and the Medical Waste Management Plan, prepared under the

		Regional Disease Surveillance Systems Enhancement (REDISSE - P154807) will be assessed and updated. The two documents will be consulted upon and disclosed before appraisal both in country and at the Bank website prior to appraisal. The implementation of a grievance redress mechanism will be put in place within the project to materialize citizen engagement. It will also address the concerns of communities and all stakeholders involved including civil society. These aspects must be supported by social communication about the objectives of the project, the targets as well as the mechanism put in place with the aim of raising the concerns and providing the appropriate responses. Such mechanisms should be accessible to communities, but also to other stakeholders and should be documented and monitored as part of the performance indicators. Support for a specialization in social inclusion is recommended.
Performance Standards for Private Sector Activities OP/BP 4.03	No	Non applicable
Natural Habitats OP/BP 4.04	No	The policy is not triggered as the project activities are not expected to overlap or cause adverse impacts on natural habitats.
Forests OP/BP 4.36	No	The policy is not triggered as the project activities are not expected to overlap or cause adverse impacts on forests or forestry activities.
Pest Management OP 4.09	No	This policy is not triggered as the project does not anticipate acquiring pesticides or equipment of pesticides application.
Physical Cultural Resources OP/BP 4.11	No	The scale and scope and location of subprojects makes it an unlikely possibility of chance finds of physical cultural resources in the identified project
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project areas, as defined by OP/BP 4.10.
Involuntary Resettlement OP/BP 4.12	No	The project activities will not involve land acquisition leading to the economic or physical displacement of project-affected people.
Safety of Dams OP/BP 4.37	No	The project interventions is not expected to require the construction of dams or impoundment structures, nor is it expected that they could cause impacts to existing structures as governed by this policy.
Projects on International Waterways OP/BP 7.50	No	The project interventions are not expected to cause any drainage or discharges to surface waters, nor

		entail any significant usage of surface water that would affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project interventions are not in any disputed areas. Therefore, this policy is not triggered.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Aug 30, 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

Environmental and Social Management Framework (ESMF) and Medical Waste Management Plan (MWMP) will be prepared and disclosed prior to the project appraisal. Project appraisal is planned in August 2018.

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APPROVAL

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