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INTERNATIONAL DEVELOPMENT ASSOCIATION
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A PROPOSED CREDIT
IN THE AMOUNT OF SDR 1.80 MILLION (US$2.30 MILLION EQUIVALENT)

ON A PROPOSED CREDIT
IN THE AMOUNT OF SDR 22.60 MILLION (US$30.00 MILLION EQUIVALENT)
FROM SCALE-UP WINDOW-SHORTER MATURITY LOAN

AND

ON A PROPOSED CREDIT
IN THE AMOUNT OF SDR 7.60 MILLION (US$10.00 MILLION EQUIVALENT)
AND
ON A PROPOSED GRANT
IN THE AMOUNT OF SDR 7.60 MILLION (US$10.00 MILLION EQUIVALENT)
FROM THE WINDOW FOR HOST COMMUNITIES AND REFUGEES

TO THE ISLAMIC REPUBLIC OF MAURITANIA

FOR A HEALTH SYSTEM SUPPORT PROJECT (INAYA ELARGI)
AS PHASE ONE OF THE MULTI-PHASE PROGRAMMATIC APPROACH
ADVANCING UNIVERSAL HEALTH COVERAGE PROGRAM FOR HUMAN CAPITAL IN MAURITANIA
WITH AN OVERALL FINANCING ENVELOPE OF US$174.03 MILLION EQUIVALENT
FEBRUARY 28, 2024

Health, Nutrition and Population Global Practice
Western and Central Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2024)

Currency Unit =	Mauritanian Ouguiya (MRU)
MRU 40.68 =	US$1
US$1 =	SDR 0.7519

FISCAL YEAR
January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

CBO	Community-Based Organization
CERC	Contingent Emergency Response Component
CHW	Community Health Worker
CNAM	*Caisse Nationale d'Assurance Maladie* (National Health Insurance Account)
CNASS	*Caisse Nationale de Solidarité Santé* (National Health Solidarity Fund)
CPF	Country Partnership Framework
CSO	Civil Society Organization
DAF	*Direction des Affaires Administratives et Financières* (Financial Affairs Directorate)
DALY	Disability-Adjusted Life Year
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
E&S	Environmental and Social
EmONC	Emergency Obstetric and Newborn Care
ESS	Environmental and Social Standards
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
IEC	Information, Education and Communication
INAYA	Health System Support Project
IPF	Investment Project Financing
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MPA	Multiphase Programmatic Approach
NCD	Noncommunicable Disease
NCHS	National Community Health Strategy
NDC	Nationally Determined Contribution
NGO	Nongovernmental Organization
NHDP	National Health Development Plan
NPV	Net Present Value
PBA	Performance-Based Allocation
PBB	Program-Based Budgeting
PBF	Performance-Based Financing
PDO	Project Development Objective
PFM	Public Financial Management
PforR	Program for Results
PHC	Primary Health Care
PIU	Project Implementation Unit
PPR	Prevention, Preparedness, and Response
PPSD	Project Procurement Strategy Document
PrDO	Program Development Objective

REDISSE	Regional Disease Surveillance Systems Enhancement
RMNCAH-N	Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavioral Change Communication
SCAPP	*Stratégie Nationale de Croissance Accelerée et de Prosperité Partagée* (National Strategy for Accelerated Growth and Shared Prosperity)
SDG	Sustainable Development Goal
STEP	Systematic Tracking of Exchanges in Procurement
SUW-SML	Scale-Up Window Shorter Maturity Loan
SWEDD	Sahel Women's Empowerment and Demographic Dividend
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHR	Window for Host Communities and Refugees

TABLE OF CONTENTS

DATASHEET i

I. STRATEGIC CONTEXT 1

A. Country Context 1

B. Sectoral and Institutional Context 2

C. Relevance to Higher Level Objectives 5

D. Multiphase Programmatic Approach 6

II. PROJECT DESCRIPTION 12

A. Project Development Objective 12

B. Project Components 12

C. Project Beneficiaries 16

D. Rationale for World Bank Involvement and Role of Partners 17

E. Lessons Learned 17

III. IMPLEMENTATION ARRANGEMENTS 18

A. Institutional and Implementation Arrangements 18

B. Results Monitoring and Evaluation Arrangements 19

C. Sustainability 19

IV. PROJECT APPRAISAL SUMMARY 20

A. Technical, Economic and Financial Analysis 20

B. Fiduciary 21

C. Legal Operational Policies 22

D. Environmental and Social 22

E. Climate Vulnerability and Resilience 23

V. GRIEVANCE REDRESS SERVICES 24

VI. KEY RISKS 24

VII. RESULTS FRAMEWORK AND MONITORING 26

ANNEX 1: Implementation Arrangements and Support Plan 36

ANNEX 2: Trends in Maternal and Child Mortality Rates 43

ANNEX 3: Selection of the Target Regions in Phase 1 44

ANNEX 4: Climate Action and Contribution to Adaptation and Mitigation 46

ANNEX 5: Synergies with the Existing World Bank-Supported Health Sector Projects 49

ANNEX 6: Summary of Support from Development Partners 50

DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
Mauritania	Mauritania Health System Support Project		
Operation ID	Financing Instrument	Environmental and Social Risk Classification	
P179558	Investment Project Financing (IPF)	Moderate	

Financing & Implementation Modalities

[✓] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[✓] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternative Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date	Expected Program Closing Date
21-Mar-2024	30-Jun-2029	31-Dec-2033
Bank/IFC Collaboration		
No		

MPA Program Development Objective

PrDO is to reduce maternal and neonatal mortality, and stunting among children under five years of age and to enhance national health system capacities for pandemic preparedness.

MPA FINANCING DATA (US$, Millions)

MPA Program Financing Envelope	174.03

Components

Component Name	Cost (US$)
Improve quality and increase use of RMNCAH-N services	55,000,000.00
Strengthen health systems	15,030,000.00
Project management, monitoring and evaluation	4,000,000.00
Contingent Emergency Response Component	0.00

Organizations

Borrower:	Islamic Republic of Mauritania
Implementing Agency:	Ministry of Health

MPA FINANCING DETAILS (US$, Millions)

MPA Financing Envelope:	174.03
of which Bank Financing (IBRD):	0.00
of which Bank Financing (IDA):	122.30
of which Other Financing sources:	51.73

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)? No

Is this project Private Capital Enabling (PCE)? No

SUMMARY

Total Operation Cost	**74.03**
Total Financing	**74.03**
of which IBRD/IDA	**52.30**

Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Development Association (IDA)	52.30
IDA Credit	12.30
IDA Grant	10.00
IDA Shorter Maturity Loan (SML)	30.00

Non-World Bank Group Financing

Counterpart Funding	6.73
Borrower/Recipient	6.73
Trust Funds	15.00
Global Financing Facility	15.00

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
Scale-Up Window (SUW)	0.00	0.00	30.00	0.00	30.00
National Performance-Based Allocations (PBA)	2.30	0.00	0.00	0.00	2.30
Window for Host Communities and Refugees (WHR)	10.00	10.00	0.00	0.00	20.00
Total	**12.30**	**10.00**	**30.00**	**0.00**	**52.30**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2024	2025	2026	2027	2028	2029
Annual	2.30	14.70	14.79	13.14	13.43	8.94
Cumulative	2.30	17.00	31.79	44.93	58.36	67.30

PRACTICE AREA(S)

Practice Area (Lead)
Health, Nutrition & Population

Contributing Practice Areas

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Moderate
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	Substantial
10. Overall	Substantial
Overall MPA Program Risk	Substantial

POLICY COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

ENVIRONMENTAL AND SOCIAL

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
ESS 8: Cultural Heritage	Not Currently Relevant
ESS 9: Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

LEGAL

Legal Covenants

Sections and Description

Schedule 2 Section I.A.3 (a) and (b). The Recipient shall, not later than one (1) month after the Effective Date, establish a Project Implementation Unit (PIU) in the MoH for the purpose of coordinating and supervising the implementation of the Project, with composition, attribution and resources acceptable to the Association, including the following key staff or consultants: (i) a project coordinator; (ii) a deputy coordinator; (iii) a financial management specialist; (iv) two accountants; (v) a procurement specialist; (vi) an internal auditor; (vii) a monitoring and evaluation specialist; (viii) an E&S specialist; and (ix) a social assistant, each selected and appointed or recruited on the basis of terms of reference, qualifications and experience acceptable to the Association.
Schedule 2 Section I.A.4 (a). The Recipient shall, not later than three (3) months after the Effective Date, establish or cause to be established in each of the regions where activities under Part 1.1 of the Project will be implemented, a Verification Mechanism, and take or cause to be taken all measures needed if any to ensure that the Verification Mechanism is operational.
Schedule 2 Section I.A.4 (b). The Recipient shall ensure that a memorandum of understanding in form and substance acceptable to the Association is entered into no later than six (6) months after the Effective Date, between the General Inspectorate of MoH and the PIU, for the purpose of, among other things, the provision of counter-verification services of the results achieved under results-based financing arrangements for the implementation of Part 1.1 of the Project.
Schedule 2 Section I.A.5 (a). The Recipient shall, not later than three (3) months after the Effective Date, establish or cause to be established in each of the regions where activities under Part 1.1 of the Project will be implemented, in each case through a legal instrument in form and substance acceptable to the Association, an arrangement between the Region's decentralized authorities and the regional office of its MoH, for the purpose of cooperating for the implementation of the Project in such region.
Schedule 2 Section I. B. 1. The Recipient shall, not later than one (1) month after the Effective Date, develop, in a manner acceptable to the Association, a series of manuals for the implementation of the Project, which shall include a PBF Manual and a Manual of Administrative, Financial, Accounting and Disbursement Procedures.
Schedule 2 Section I. C. 1 and 3. The Recipient shall, not later than one (1) month after the Effective Date for the Fiscal Year in which this Agreement shall become effective, and November 30 of each subsequent Fiscal Year, consolidate and furnish to the Association for the Association's no objection, a consolidated annual program of activities proposed for implementation under the Project during the following Fiscal Year, together with a proposed budget which shall include the funds from the Financing, the IDA Grant, the GFF Grant, the financing to be provided by the Recipient, as well as any other funds which may become available for the implementation of the Project, and finalize its annual work plan and budget in a manner which takes into account comments from the Association not later than one (1) month later.
Schedule 2 Section I. F. Without limitation to Section 5.03 of the General Conditions, the Recipient shall make available to the Project a minimum amount of financing equivalent to six million and seven hundred thirty thousand Dollars (US$6,730,000), to be disbursed throughout the period of implementation of the Project, in the manner agreed in the Annual Work Plans and Budgets and in accordance with the PIM.
Per the ESCP, an SEA/SH action plan will be prepared no later than three months after Project's Effective Date and shall thereafter be implemented throughout project implementation.

Conditions

Type	Citation	Description	Financing Source
Effectiveness	Article V 4.01 (b)	Effectiveness of the Financing Agreement for the IDA Grant.	Trust Funds

Disbursement	Section III. B. 1. (b) of Schedule 2	No withdrawal shall be made under Category (1), for PBF-related Eligible Expenditures until: (i) the PBF Manual has been adopted; and (b) the Verification Mechanism has been established.	IBRD/IDA, Trust Funds
Disbursement	Section III. B. 1. (c) of Schedule 2	No withdrawal shall be made under Category (4) in the FA for the IDA Credit, Category (3) in the FA for the IDA Grant, for Emergency Eligible Expenditures until: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred which has been agreed by the Association; (ii) the Recipient has adopted the CERC Manual and Emergency Action Plan, in form and substance acceptable to the Association; and (iii) the Recipient has ensured that all Environmental and Social Standards instruments required for said activities have been prepared and disclosed, and that any actions which are required to be taken under said instruments have been implemented.	IBRD/IDA
Effectiveness	Article V, 5.01	The Association is satisfied that the Recipient has an adequate refugee protection framework.	IBRD/IDA
Effectiveness	Article IV, 4.01 (a)	The execution and delivery of GFF Agreement on behalf of the Recipient have been duly authorized	Trust Funds

		or ratified by all necessary governmental action.	

I. STRATEGIC CONTEXT

A. Country Context

1. **Mauritania faces economic, social, and environmental challenges that increase its vulnerability to risks.** The country is a vast and arid West African nation with a population of approximately 5 million people, making it one of the world's least densely populated countries. Despite the impact of the COVID-19 pandemic, Mauritania's economy rebounded in 2022, driven by strong extractive production and exceptional output in the primary sector. The economy is projected to decelerate due to a normalization of gold production and a decline in fishing output. Inflation decreased after the 2022 peak in food prices.[1] In the medium term, growth is subject to volatility due to the country's reliance on the extractive sector. Economic disparity and the spillover effects of the security crisis in Mali pose important social challenges. In addition, Mauritania is prone to natural disasters, posing significant risks to the population and negatively affecting social service delivery. These disasters can result in displacement, food insecurity, and the spread of water-borne diseases.

2. **Poverty and inequity persist with large geographic disparities.** The poverty rate declined only slightly from 30.9 percent in 2014 to 28.2 percent in 2019 due to commodity price fluctuations, contributing to a status quo in human capital development. Disparities between urban and rural areas doubled, with the rural poverty rate reaching 41.2 percent in 2019.[2] Disparities by income level remain significant, with the richest quintile consuming five times as much as the poorest. Over the same period, rapid population growth resulted in an increase in the number of poor individuals by 140,000, predominantly in rural areas.[3] Furthermore, the pandemic reversed the progress made in poverty reduction. Extreme poverty increased from 5.4 in 2019 percent to 6.1 percent of the population in 2020, and overall poverty rose from 28.2 percent in 2019 to 33.6 percent in 2021.[4]

3. **In Mauritania, a child's productivity potential is limited due to insufficient health and education, reaching only 38 percent, below the averages for Sub-Saharan Africa (40 percent) and lower-middle-income countries (48 percent).** Around 4 percent of children in Mauritania do not survive to age five, and over 25 percent are stunted and at risk of lifelong cognitive and physical limitations. A child who starts school at four years can expect to complete 7.7 years of school by his/her 18th birthday but only 4.2 learning-adjusted years of schooling.[5] The situation is more complex for women and girls, who have limited access to education, resulting in lower literacy rates that subsequently affect their health. The lack of maternal education affects child health and nutrition and impedes women's autonomy in decision-making, especially concerning their reproductive health.

4. **Given the reliance on climate-sensitive sectors such as agriculture, fisheries, mining, and livestock, climate change significantly affects human and animal health in Mauritania.** With three-quarters of the country being desert or semi-desert, Mauritania is one of the countries most affected by drought. This limits access to clean water and sanitation, leading to an increase in hygiene-related diseases. Individuals in flood-prone areas are at a heightened risk of water-borne and vector-borne diseases. Health risks stemming from exposure to climate hazards include migration and population displacement. To effectively address the impacts of climate change, it is crucial to build resilient health systems and

[1] Mauritania Macropoverty Outlook and Economic Update.
[2] *Enquête Permanente sur les Conditions de Vie en Mauritanie* 2019–2020.
[3] World Bank. 2022. Mauritania Poverty Assessment. Washington, DC: World Bank.
[4] World Bank. 2022. Performance and Learning Review of the Country Partnership Framework (CPF) for the Islamic Republic of Mauritania for the Period of 2018–2023. Report No. 170469-MR. Washington, DC: World Bank.
[5] World Bank. 2022. *Human Capital Country Brief – October 2022. Mauritania.* Washington, DC: World Bank. https://thedocs.worldbank.org/en/doc/7c9b64c34a8833378194a026ebe4e247-0140022022/related/HCI-AM22-MRT.pdf.

communities, strengthen disaster preparedness and prevention capacities, and develop effective emergency response strategies.

5. **Mauritania currently hosts more than 100,000 refugees, mainly from Mali.**[6] The deterioration of security conditions in northern Mali have resulted in a refugee crisis, with a growing number of people fleeing the violence and instability. This increase in refugees places additional strain on the already limited resources in the southeastern provinces of Mauritania, which have been hosting a large population of refugees since 2012.[7] Nonetheless, the Government remains committed to supporting and integrating refugees. In July 2023, it proposed a Strategy on Refugees and Host Communities, outlining a roadmap for the integration of refugees into its national systems. The United Nations High Commissioner for Refugees (UNHCR) considers the country's refugee protection framework to be adequate.[8] Further, as of now, there is no agreement on voluntary repatriation for any nationalities.

B. Sectoral and Institutional Context

6. **Mauritania falls behind the national targets for reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes.** With a maternal mortality ratio of 424 per 100,000 live births, the country surpasses the lower-middle-income country average (253 per 100,000 live births) and ranks as the 14th worst in Sub-Saharan Africa.[9] Without accelerated progress, meeting the 2030 target seems unlikely. Maternal mortality is especially high among women ages 15 to 19, who account for 27 percent of maternal deaths. Neonatal mortality is 22 per 1,000 live births, accounting for 44 percent of deaths in children under five (see historical trend in Figure 2.1 in Annex 2). Most of these deaths are from preventable and treatable complications. Only 70.4 percent of births are attended nationwide by skilled health professionals. The prevalence is higher in urban areas at 95.7 percent, decreasing to 53.3 percent in rural areas. Social norms and limited accessibility result in nearly 50 percent of births occurring at home. Ensuring the continuity of obstetric care is a major challenge. More than half of children under five do not receive treatment for diarrhea. Nearly 7 percent of children do not receive any vaccinations,[10] putting them at risk of diseases such as polio and measles, which strains health resources. Approximately 23 percent of under-five deaths occur in households with 'zero dose children'.[11] These situations are especially acute in border areas with Mali (see Annex 3).

7. **Despite having a youthful population, adolescent health outcomes are poor.** The total fertility rate rose from 4.7 children per woman in 2001 to 5.2 in 2021, reaching 6.4 in rural areas. Notably, the adolescent fertility rate has increased, with over one-quarter of young women in rural areas beginning childbearing before the age of 19. Early marriages are common, with the median age of first marriage being 17. Family planning services are primarily available to married people, yet one-third of married women have unmet need for family planning. Only 13 percent of married women use modern contraceptives. This unmet family planning need is more pronounced among rural, poorer, and less educated women. The frequent stockouts of family planning products at public health facilities force many to seek contraceptives privately, which are more expensive. Health information and services for adolescents and youth are lacking.

[6] UNHCR. 2023. Dashboard Mauritania – Refugees and Asylum Seekers (September 2023). https://data.unhcr.org/en/documents/details/104011.
[7] The M'bera refugees camp was established in 2012 in the Hodh Chargui region and hosted 70,000 refugees before the recent inflow.
[8] Mauritania has been eligible for the IDA Regional Sub-Window for Refugees and Host Communities since November 2018; the most recent UNHCR assessment of the country's protection framework for refugees is from July 2023.
[9] WHO (World Health Organization), UNICEF (United Nations Children's Fund), UNFPA (United Nations Population Fund), World Bank Group, and United Nations Department of Economic and Social Affairs Population Division. 2023. Trends in Maternal Mortality 2000 to 2020: Estimate by Geneva: WHO.
[10] Mauritania Demographic and Health Survey (DHS) 2019–2021.
[11] Global Alliance for Vaccines and Immunization. 2023. "Mauritania Zero Dose Analysis (Presentation)."

8. **Mauritania's poor health outcomes stem from barriers in access, availability, and quality of services, especially in rural areas.** Over 20 percent of the rural population lacks access to a health facility within a 5 km radius, particularly in the south and east of the country.[12] In addition to an already inequitable distribution of health workers, there is a recurring issue of low retention rates among competent staff and high absenteeism. The underrepresentation of women and youth in higher-skilled positions further strains health services in deprived areas.[13] Many health facilities are in poor condition, often do not follow clinical guidelines, and do not provide people-centered care. Only one-third of health facilities have access to electricity, and two-thirds have access to clean water. Availability of and maintenance standards for essential equipment are subpar, and lab testing capability is alarmingly low. Fewer than 35 percent have proper infectious waste disposal capability.[14] Perceived unsatisfactory patient experiences and low-quality care deter individuals from seeking timely health services.[15] Furthermore, only 12 percent of last-mile service delivery points have all necessary tracing drugs. Stock-out rates at service delivery points are as high as 50 percent for contraceptives and other essential reproductive health materials.[16] Despite the existence of a relatively solid structure under the pharmaceutical policy, including the Central Medical Procurement Agency and the National Laboratory to Control Quality of Medicines, good-quality medicines are often unavailable and unaffordable. Moreover, Mauritania's health-related data are not fully digitalized, and its Health Management Information System (HMIS) is fragmented.

9. **Mauritania faces the double burden of malnutrition and a rise in noncommunicable diseases (NCDs).** One-quarter of children under five are stunted, and the nation contends with pervasive food insecurity and a lack of dietary diversity. Acute undernutrition persists at around 10 percent, with a notable increase in 2022 due to multiple crises (see the historical trend in Figure 2.2 in Annex 2).[17] Anemia affects three-quarters of children ages 6 to 59 months and half of women ages 15 to 49. Inadequate breastfeeding and poor infant and young child feeding practices, coupled with factors such as poor sanitation, contribute to the intergenerational malnutrition cycle, especially in the first 1,000 days of life. In Mauritania, annual economic loss associated with chronic malnutrition is estimated at US$759 million—approximately 7.6 percent of the gross domestic product (GDP).[18] NCDs account for 37 percent of deaths.[19] Obesity is prevalent. One-quarter of women ages 15 to 49 are obese and another one-quarter are overweight, leading to complications during pregnancy that increase risks for both mother and child health.

10. **The COVID-19 pandemic has hampered access to health services and highlighted the importance of preparedness.** In response to the pandemic, the Government is implementing measures to prevent and enhance preparedness for future public health emergencies. However, the 2022 floods revealed a need for continuous coordination and collaboration among various ministries and development agencies for emergency prevention, preparedness, and response (PPR). In addition to the proposed Multiphase Programmatic Approach (MPA), the World Bank-supported Mauritania Fiscal Management and Resilience Stand-alone Development Policy Financing (P179263) aims to strengthen the country's resilience to climate change and disaster risks. Moreover, the Decentralization and Productive Intermediate Cities Support Project - Moudoun (P169332) finances waste management and sanitation interventions in urban areas.

[12] MoH (Ministry of Health) Mauritania. Health Facilities Coverage 2022.
[13] MoH Mauritania. 2021. Human Resources for Health Development Plan 2022–2026.
[14] Service Availability and Readiness Assessment (SARA) 2018.
[15] UNICEF Mauritania. 2015. Etude de faisabilité pour la mise en place d'un mécanisme d'incitation à l'utilisation des services de santé par les populations pauvres et vulnérables (Financement basée sur les résultats) - Volet demande de services (Feasibility study for the implementation of an incentive mechanism for the use of health services by poor and vulnerable populations (results-based financing) - Demand for services component).
[16] SARA 2018.
[17] MoH Mauritania, Agence Nationale de la Statistique, de l'Analyse et de la Démographie, and UNICEF. 2022. Rapport de l'enquête nutritionnelle SMART (Nutrition SMART Survey Report).
[18] World Food Programme. Mauritania. https://www.wfp.org/countries/mauritania.
[19] WHO. 2018. NCD Country Profiles: Mauritania. https://cdn.who.int/media/docs/default-source/country-profiles/ncds/mrt_en.pdf?sfvrsn=68b09b9_36&download=true.

Box 1: Strengthening Pandemic Prevention, Preparedness, and Response in Mauritania

The COVID-19 pandemic has hampered access to health services. The fear of infection led to a reduction in availability and utilization of community-based health services, and hospitals faced overwhelming numbers of patients due to an acute increase in cases. The World Bank was at the forefront of Mauritania's response to the COVID-19 pandemic through financing under the Regional Disease Surveillance Systems Enhancement (REDISSE) Project Phase III (P161163) and the Strategic Preparedness and Response Project (COVID-19 Project, P173837). The Government promptly addressed the pandemic and intensified COVID-19 vaccination efforts while strengthening the national capacity for PPR. These efforts resulted in a relatively low case fatality rate of 1.56 percent[20] and positioned Mauritania among the top countries in West Africa for COVID-19 vaccination rates in early 2022. It is noteworthy that the REDISSE Project played a pivotal role in operationalizing the 'One Health' platform in Mauritania, covering human, animal, and environmental health. This platform enabled the Government to swiftly respond to recurring episodes of hemorrhagic fevers in both cattle and humans.

The proposed MPA further supports the development and institutionalization of an emergency response mechanism while strengthening primary health care (PHC) systems to provide extensive financial risk protection for vulnerable households from acute shocks. Given the number of crises Mauritania faces, the establishment of resilient health systems is imperative. Between 1980 and 2020, an average of 920,000 people were affected by each drought and 27,722 people were affected by each flood. Preliminary results from the 2023 resilience assessment of the health sector show that a significant portion of roads and approximately 11 percent of health facilities are directly exposed to flood hazards. These vulnerabilities impede access to health services, disrupt supply chains, and compromise the operational capacity of health facilities, elevating the risk of disease outbreaks. The MPA, in conjunction with support from other development partners, will aid the Government in continuing to operationalize cross-sectoral One Health platforms and reinforcing the disaster risk reduction coordination mechanism. This approach will allow for better preparation and response to health and climate shocks, integrating an early warning system and digital solutions. The MPA will also provide flexible financing for emergency responses through a contingent emergency response component (CERC). Resilient health systems not only expand effective service coverage but also protect vulnerable populations from the disruption of essential health and nutrition services.

11. **The country is at a critical juncture in health financing reforms.** The Ministry of Health (MoH) has outlined four primary strategic pillars for health financing: (a) ensuring mobilization of financial resources for Universal Health Coverage (UHC) by 2030; (b) strengthening financial protection through resource pooling; (c) enhancing resource allocation in health and adopting more strategic purchasing; and (d) strengthening foundational functions in the health financing system. However, Mauritania faces significant challenges in health financing. The current health expenditure per capita (US$59 in 2020) is lower than the average of countries with a similar income level (US$123.8) and falls below the WHO's recommendation (US$96). In 2020, the Government's contribution to health expenditures was only 1.3 percent of its GDP. Households bear a significant burden, covering 46.6 percent of health expenditures in 2020, with minimal insurance accounting for only two percent of health expenditures. There are significant allocative and technical inefficiencies in the budget, particularly for PHC. Two-thirds of the health budget is allocated to NCD treatment, while allocations for maternal health (12.2 percent) and nutrition (0.2 percent) are alarmingly low.[21] To improve budget efficiency and targeting, the World Bank is supporting the MoH in transitioning toward program-based budgeting (PBB), aligning with the three-year cycle of the Medium-Term Expenditure Framework.

12. **Mauritania is facing limitations in pooling financial resources for UHC, leaving 71 percent of the population without adequate financial protection against health care costs.** There are multiple and fragmented risk-pooling arrangements in the health sector. The Caisse Nationale d'Assurance Maladie (National Health Insurance Account, CNAM) was established in 2007 as a mandatory national health insurance scheme for formal sector employees, covering approximately 15 percent of the population. The Caisse Nationale de Solidarité Santé (National Health Solidarity Fund, CNASS) was introduced in 2022 as a voluntary health insurance scheme for informal sector workers and indigents, with

[20] MoH Mauritania. COVID-19 Epidemiologic Situation Report. (February 21, 2024).
[21] WHO. Global Health Expenditure Database. https://apps.who.int/nha/database/country_profile/Index/en.

the goal of covering 70 percent of the population by 2027. The Programme Prioritaire Elargi du Président (President's Flagship Expanded Program) 2020–2023 facilitated the enrollment of the 100,000 poorest households in CNAM. Additionally, there are numerous targeted free healthcare programs for priority diseases (such as human immunodeficiency virus (HIV), malaria, and maternal health); however, financing for these programs is uncertain and often relies on donor support.

13. **The inflow of refugees exerts significant pressure on the already fragile national health and nutrition systems, as the country grapples with an increased demand for health and nutrition services.** The Government's Strategy on Refugees and Host Communities of July 2023 aims to provide refugees with similar access to health and nutrition services as Mauritanians. In addition to the humanitarian aid provided by Médecins Sans Frontières since 2012, the Health System Support Project (P156165, INAYA Project) has played a crucial role in health service delivery for refugees in M'bera, a refugee camp. Furthermore, the project contributed to the establishment of a public hospital in Bassikounou in 2023, the largest border town (with Mali) in the country. The transition of service delivery from humanitarian nongovernmental organizations (NGOs) to the MoH was facilitated by performance-based financing (PBF) and conditional cash transfers. Continuing and increasing such support is crucial, especially with the ongoing increase in population and cattle movement from Mali to Mauritania. This is essential to maintain the quality of health services for both refugees and host communities to prevent and contain disease outbreaks.

C. Relevance to Higher Level Objectives

14. **The proposed program is consistent with the Performance and Learning Review (Report No. 170469-MR) of the Country Partnership Framework (CPF) for FY 2018–2023 for Mauritania (Report No. 125012-MR, June 13, 2018).[22]** It aims to contribute to Priority Policy Area 2, focusing on building human capital for inclusive growth and Objective 2.4, targeting increased access to maternal and child health services. The proposed program is designed to ensure the protection of the target population. This will be achieved through decentralized financing and effective delivery of health services. In alignment with other sectoral supports, the proposed program will consolidate and scale up the World Bank's investments to support the Government's initiatives in the early years and human capital development across the life cycle. This is also aligned with the World Bank's Africa Human Capital Plan.

15. **The proposed program is consistent with the National Health Policy—Vision 2030, the National Health Development Plan (NHDP) 2021–2030, and the 2023 Mauritania Strategy on Refugees and Host Communities.** In these policy documents, the Government outlines its vision for achieving UHC, ensuring that all individuals in the Mauritanian population, including refugees, have access to quality essential health and nutrition services and are protected against financial risks associated with illnesses without any forms of exclusion or discrimination, fostering the full participation of the population. The program is also aligned with the Stratégie Nationale de Croissance Accelerée et de Prosperité Partagée (National Strategy for Accelerated Growth and Shared Prosperity, SCAPP) 2016–2030 and other relevant national policies and plans in the health sector, in line with Sustainable Development Goal (SDG) 3: ensuring healthy lives and promoting well-being for all at all ages. The proposed program is designed to facilitate key reforms aimed at improving health sector governance and contribute to the six strategic pillars of the national health strategy: (a) health; (b) resilience of vulnerable groups; (c) political governance, social cohesion, peace, and security; (d) capturing of the demographic dividend; (e) promotion of women's civic participation and fight against gender-based violence (GBV); and (f) local development and decentralization.

[22] The proposed operation corresponds to the additional financing proposed in the PLR (Report No. 170469-MR) and it is included in the new CPF (P505242) under preparation.

16. **The proposed program will scale up interventions, building on the lessons learned from the World Bank-supported INAYA Project.** It aimed to improve equitable access to quality health services, expand the use of PBF and other strategic purchasing mechanisms nationwide, and protect vulnerable populations including refugees and host communities. Therefore, the proposed MPA qualifies for the Window for Host Communities and Refugees (WHR). Mauritania's ongoing commitment to integrate refugee health into the national health systems not only fulfills the IDA20 policy commitments, but also explicitly underscores its strategic direction toward collaborative and inclusive health systems. The RMNCAH-N Investment Case, supported by the Global Financing Facility (GFF), prioritizes integrated high-impact interventions for RMNCAH-N. Furthermore, the digitalization of health information aligns with the National HMIS Strategy 2023–2026, which aims to reach the fourth phase of the Global Digital Health Index by 2030.

17. **The proposed program will help the Government fulfill its Nationally Determined Contribution (NDC) to achieve net-zero emissions by 2050 under the Paris Agreement, and contribute to climate change adaptation and mitigation, which is consistent with Mauritania's climate change strategies and the World Bank Climate Change Action Plan 2021–2025** (see Annex 4). According to the Country Climate and Development Report for the G5 Sahel Region, the total estimated investment required for climate adaptation and mitigation by 2030 is US$44.88 billion.[23] In the NDC submitted to the United Nations Framework Convention on Climate Change in 2021, the health sector is identified as a vulnerable sector to be prioritized to receive climate finance to ensure the sector's climate adaptation. Mauritania has incorporated measures for health sector climate change adaptation in the NHDP 2021–2030. Key adaptation investment priorities include establishing a program to address diseases with common risk factors related to climate change and strengthening the disease surveillance system, including the early warning system. The proposed program is designed to address the identified main bottlenecks and investment priorities for the health sector, which will help reduce the population's vulnerability and improve the health sector's resilience to climate change.

D. Multiphase Programmatic Approach

18. **An MPA is proposed at this critical juncture to meet long-term health-related SDGs and the national goal of achieving UHC.** It will enable the implementation of the long-term national vision of improving access to and the quality of PHC, while supporting the core foundations for strengthening health systems.

(i) Rationale for using MPA

19. **An MPA will facilitate adaptive, innovative, and continuous engagement to achieve the Government's ambitious goals of UHC, requiring an extended implementation timeframe that extends three years beyond the SDGs.** Mauritania has developed a sustainable health financing strategy to align various financing schemes, targeting incremental enrollment of public health facilities in the PBF program by 2030. The INAYA Project demonstrates the protection of indigent people and refugees through the delivery of health and nutrition services. Digital interventions in health are an emerging opportunity to overcome structural problems and leverage disruptive technologies. Transforming social and gender norms for adolescent health requires a considerable amount of time, building on ongoing initiatives within the World Bank-supported Sahel Women's Empowerment and Demographic Dividend (SWEDD) Project (P150080) (see Annex 5). The long-term nature of the MPA ensures effective implementation and multistakeholder engagement, leaving no one behind in the pursuit of UHC.

20. **An MPA allows for flexibility in transitioning from project-specific interventions to institutionalization through sector reforms.** It includes advocacy for national financial resource mobilization and political and technical leadership from the Government. In fact, the Government has committed to making the PBF program a national program by

[23] World Bank Group. 2022. *Country Climate and Development Report G5 Sahel Region.* Washington, DC: World Bank Group.

increasing its co-financing from US$3.50 million equivalent under the INAYA Project to US$6.73 million equivalent for Phase 1 of the MPA. The phased rollout of PBF will help overcome technical complexities, enabling the PBF program to evolve into a fully government-funded national program. Furthermore, the World Bank has conducted analytical work to assess the health sector public financial management (PFM) system and identify enabling conditions for integrating PBF into the PFM system. A stand-alone approach, such as investment project financing (IPF) or Program for Results (PforR), would not be as effective as an MPA in implementing crucial health financing reforms in Mauritania. Moreover, an adaptive approach is required for coverage expansion, service delivery remodeling, and updated institutional arrangements for financing and regulations when implementing other health reforms.

21. **Implementation of an MPA also enhances the Government's stewardship of the health systems, contributing to its resilience against foreseeable acute shocks.** A stand-alone IPF or series of projects poses potential risks due to its stop-and-go approach, which could undermine gains made with prior investments. Using an MPA can reduce service delivery disruptions and facilitate transformative health reforms by minimizing the need for frequent restructurings or additional financing. Adopting an MPA can facilitate the continuity of service delivery and achievement of program objectives over multiple phases, with sustained commitments from stakeholders.

22. **The MPA will serve as a platform for tracking and analyzing the long-term health impacts at the Program Development Objective (PrDO) level.** This can enable more focused policy and technical discussions and inform decisions to ensure alignment of investments with the sector's strategic direction. A different approach may lack a long-term perspective, hindering effective monitoring of health outcome progress and potentially leaving gaps in improving service and health outcomes. The proposed MPA will allow for multiple phases to align with national goals, ensuring a comprehensive and well-planned results chain. The World Bank will help convene multisectoral partners and the private sector and support coordination and alignment of common long-term national goals.

23. **Finally, an MPA facilitates continuous learning, innovation, and timely program adaptation.** Integrating research into implementation, through process and impact evaluations, will facilitate iterative improvements and adaptations to enhance operational effectiveness. The successful adoption and institutionalization of the program can serve as an inspiration for additional health sector reforms, expanding knowledge and informing necessary changes. This will enable policy makers to optimize and improve the benefits of the program.

(ii) Program Results Chain

24. **The proposed MPA will address the limitations and gaps highlighted in the preceding context sections.** The program results chain is presented in Figure 1. It is anticipated that the interactions and collaborations among the expected outputs will enhance service outcomes, particularly at the PHC level (Subcomponent 1.1); promote positive behavioral outcomes to strengthen community resilience (Subcomponent 1.2); and contribute to overall system-level improvements (Component 2). The proposed MPA will also address cross-cutting challenges such as changes in gender norms, climate change mitigation and adaptation, and community engagement.

25. **The underlying assumption for program implementation is that the Government will mobilize domestic resources and maintain its strong, multisectoral commitments to health sector reforms, protecting vulnerable populations, including refugees, and increasing national capacity for PPR.** The proposed MPA will consolidate the existing mechanisms created and/or supported by other World Bank initiatives. This will ensure financial protection for vulnerable populations against health expenditures and address multiple threats from spillover effects associated with insecurity in the Sahel, climate change, and other public health emergencies.

Figure 1. Program Results Chain

Level			
Impacts	Improved human capital outcomes		Progress towards Universal Health Coverage (UHC)
Outcomes	Maternal and neonatal mortality rates and under-five child stunting reduced		National health system capacities for pandemic preparedness enhanced
Intermediate Results	• Preventable deaths and morbidities relate to pregnancy and childhood reduced • Early and unintended pregnancy reduced • Child nutrition optimized • Resilience of communities and health systems increased		• Sustainable health financing with domestic resource mobilization and efficient utilization • RMNCAH-N service delivery for refugees integrated into the national health systems • Disease prevention, early detection and timely and effective case management improved
Outputs	• RMNCAH-N service delivery ensured with better health facility management • Disruption of RMNCAH-N service delivery minimized at the onset of disease outbreaks and other hazards or crises • Quality of RMNCAH-N services improved • Utilization of RMNCAH-N services more equitably increased	• Access to quality RMNCAH-N services increased • Competency and skills of health workers to provide people-centered care improved • Appropriateness of services and community participation and ownership improved • People's knowledge, attitudes and practices related to health and nutrition improved	• Vulnerable populations protected from financial burdens due to health expenditures • Health facilities enhanced with hazard resilience • Continuum of obstetric care improved • Evidence-based and timely decision making improved • National capacities for PPP and DRM strengthened
Activities	**Subcomponent 1.1: Improve quality and increase use of RMNCAH-N services** • Scale up PBF with decentralized financing and autonomy to health facilities • Scale up community PBF • Verification and counter-verification of PBF results • Conduct client satisfaction surveys	**Subcomponent 1.2: Increase equity in use of RMNCAH-N services** • Expand community-driven RMNCAH-N interventions with CHWs (task shifting) and outreach activities • Strengthen the integration of CHW service package on the ground • Intensify SBCC for demand creation • Training of health workers and CHWs in community and adolescent health • Expand community and school health platforms and youth networks for better access to health information and services	**Component 2 : Strengthen health systems** • Organize a coordination platform for UHC • Integrate the strategic purchasing mechanism • Support the PBB reforms • Capitalize health information systems • Upgrade hub facilities for EmONC to the national standards with climate resilient designs • Strengthen national PPR and DRM capacities
Binding constraints	• Inadequate and inequitable access to and quality of RMNCAH-N services • Absence of people-centered care • High absenteeism and attrition of health workers	• Certain societal and gender norms not in favor of seeking care • Limited knowledge of health information and available health services • Financial vulnerability of populations	• Technical and allocative inefficiency • Low service readiness of health service provision (HR, infrastructure, equipment, norms and regulations etc.) • Vulnerable to climate changes
Problems	Persistently unsatisfactory maternal and neonatal health outcomes and child nutritional status		

(iii) Program Development Objective with Key Program DO Indicators

26. **In alignment with the Government's objectives of human capital development and UHC, the proposed PrDO is to reduce maternal and neonatal mortality and stunting among children under five years of age and to enhance national health system capacities for pandemic preparedness.** The proposed program is designed to save the lives of mothers and newborns and facilitate community-driven, system-wide approaches to improve the nutritional status of children in the face of threats of food insecurity and economic downturns. Given the increasing climate variability, regional insecurity, and the country's vulnerability to their impacts, minimizing disruption of essential health and nutrition service delivery with resilience

is essential to avoid adverse effects from acute shocks on the achieved health outcomes. Ultimately, the improved health systems will advance UHC, leading to improved human capital outcomes and realizing benefits from demographic dividends.

27. **There are four key program indicators.** Progress on these indicators will be monitored and reported through population surveys and program-specific household and health facility surveys.

Table 1. Key Program Indicators

Indicators	Baseline	Endline (2033)
Maternal mortality rate (per 100,000 live births)	424 (2021)	200
Neonatal mortality rate (per 1,000 live births)	22 (2021)	12
Prevalence of stunting in under-five children	25.1 (2022)	15
Functional One Health platforms (5-point Likert scale)	3 (2023)	5

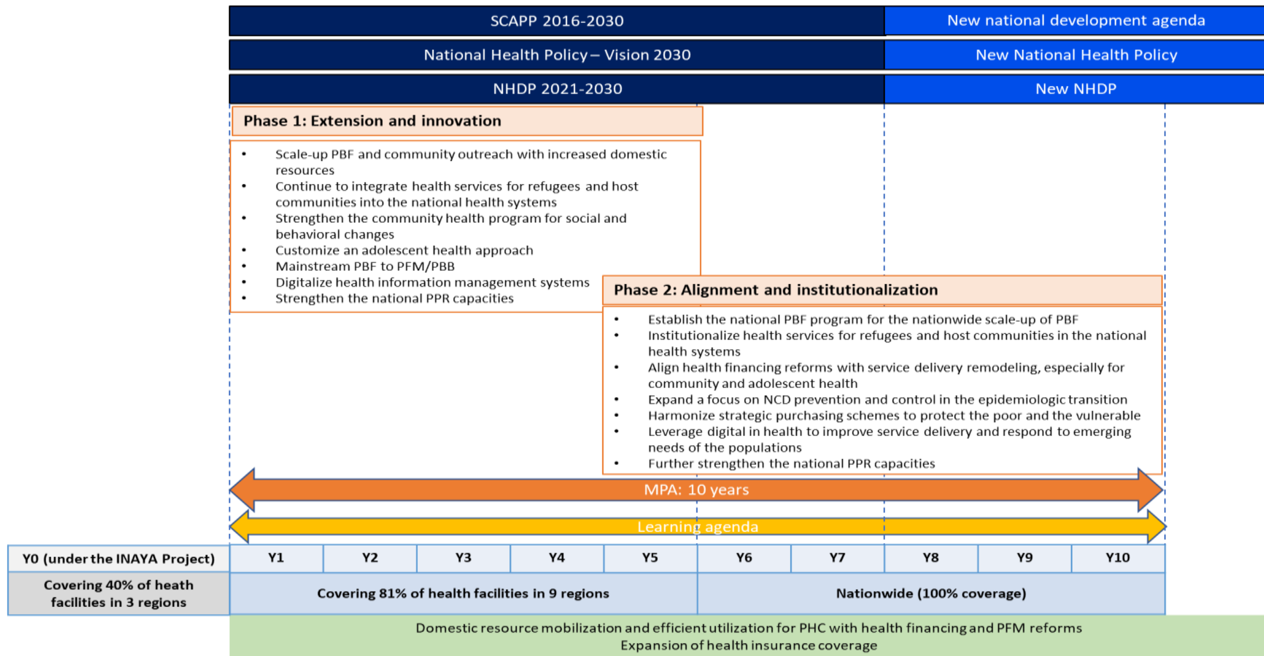
(iv) Program Framework

28. **Phase 1 of the MPA will span five years, while Phase 2 will extend for six years, with a one-year overlap, resulting in a total program duration of 10 years and a budget of US$174.03 million** (see Figure 2). The simultaneous implementation of the two phases will enhance project management efficiency. Preparation for Phase 2 will commence during the fourth year of Phase 1 to ensure a smooth transition and avoid any gaps between the phases.

29. **Phase 1: Extension and innovation (US$74.03 million equivalent, starting from FY2024).** Phase 1 will expand the interventions supported under ongoing World Bank-supported projects (see Annex 5) and introduce innovations. It aims to strengthen PHC systems to reach vulnerable populations, particularly in the hardest-to-reach areas. The PBF program will extend coverage to nine rural regions to improve access, quality, and utilization of essential RMNCAH-N services. Details about the selection methodologies for the target regions are provided in Annex 3. The PBB reform and its incorporation of PBF will strategically align the sector budget with priorities and health outcomes. Moreover, Phase 1 will support innovative remodeling of community-driven and adolescent-led service delivery platforms. By utilizing existing structures and disruptive technologies, the goal is to create demand and implement community-driven preventive and promotive care, which will eventually increase the resilience and ownership of project beneficiaries. Phase 1 will support the digitalization of HMIS for informed and timely decision-making to improve technical and allocative efficiencies. The national PPR capacity will be strengthened based on lessons learned from public health emergency responses and key findings from the resilience assessment of health systems.

30. **Phase 2: Alignment and institutionalization (US$100.00 million equivalent, starting from FY2027).** Phase 2 will support the alignment of health financing reforms with improved service delivery outcomes, ensuring their integration as sustainable national programs. In Phase 2, the program is designed to expand PBF coverage nationwide and mainstream people-centered quality of care through community- and adolescent-driven interventions. The program will carefully examine evolving trends in disease burden, support the integration of preventive and promotional care for NCDs into PHC, and advocate for evidence-based budget allocation and efficient execution. Phase 2 will leverage digital technologies in health to enhance operational effectiveness, improve efficiency, and maximize the digital dividend. National PPR capacity will be further strengthened to build the resilience of health systems. Improved service delivery, behavioral outcomes, and system outcomes are expected to contribute to achievement of the PrDO, thereby supporting the attainment of UHC and enhancing human capital outcomes.

Figure 2. Mauritania's MPA Operational Framework



(v) Learning Agenda

31. **The MPA will leverage its flexibility and adaptive mechanism to adjust technical designs through iterative application of learning and feedback from various stakeholders.** The country is currently undergoing important health sector reforms, which will require continuous review, evaluation, and adaptative operationalization in diverse contexts within the country. The MPA will establish a routine review mechanism, including semiannual reviews of progress on health insurance coverage and an annual progress review of PBF and community health programs. Specifically, the new target regions will gain valuable insights through knowledge exchange facilitated by exchange visits and joint review meetings with the three intervention regions of the INAYA Project. The extent to which the PBF and community health programs have been adapted will be assessed within the specific contexts of the target regions. Lessons learned will provide valuable insights for health sector and public financial reforms, facilitate the integration of PBF into these reforms, and support alignment with service delivery remodeling efforts.

32. **The program will design and conduct a process evaluation during Phase 1 to draw lessons learned and incorporate best practices into Phase 2.** The program will finance household surveys and program-specific household and health facility surveys to measure progress on the PrDO. Further, it will conduct implementation research and process evaluation to test and adapt implementation strategies and program designs to respond to community and adolescent health needs in a timely manner. The program will leverage innovative and transformative technologies in implementing these methodologies and strengthening the HMIS to enable data-driven, evidence-based decision-making and facilitate timely adjustments by the Government.

Table 2. An Illustration of the Program Framework

	Operation ID	Sequential or Simultaneous	Phase's Proposed Development Objective*	IPF or PforR	Estimated IBRD Amount (US$, millions)	Estimated IDA Amount (US$, millions)	Estimated Other Amount (US$, millions)	Estimated Approval Date	Estimated Environmental & Social Risk Rating
1	P179558	—	Increase the accessibility, quality, and use of RMNCAH-N services in the selected regions, and in case of an Eligible Crisis or Emergency, to respond promptly and effectively to it	IPF	0.00	52.30	21.73 (15.00 from GFF grant) and 6.73 from the Government contribution)	March 21, 2024	Moderate
2		Simultaneous	Institutionalize innovations and ensure financial protection of vulnerable populations	IPF[a]	0.00	70.00	30.00	2027	Moderate
Total					0.00	122.30	51.73		
Board Approved Financing Envelope							174.03		

Note: a. Final decision on the financing instrument will be taken at a later stage.

II. PROJECT DESCRIPTION

A. Project Development Objective

(i) PDO Statement

33. Project Development Objective (PDO) is to improve the accessibility, quality, and use of reproductive, maternal, neonatal, child, and adolescent health and nutrition services in the selected regions, and in case of an Eligible Crisis or Emergency, to respond promptly and effectively to it.

(ii) PDO Level Indicators

34. **The PDO level indicators are as follows:**

(a) Deliveries in a health facility, disaggregated for women below 19 years of age and refugee women ages 15 to 49 (percentage).

(b) New users of modern contraceptives among women ages 15 to 49, disaggregated for refugee women ages 15 to 49 (number).

(c) Exclusive breastfeeding of children younger than five months (percentage)

(d) Average quality score for health facilities (percentage)

(e) Individuals who needed clinical care in the past 12 months but did not seek it because of financial constraints (percentage).

B. Project Components

35. **The proposed project comprises four components designed to increase use of quality RMNCAH-N services in the selected regions.**

Component 1: Improve quality and increase use of RMNCAH-N services (total US$55.00 million equivalent: US$7.00 million equivalent from WHR grant, US$8.00 million equivalent from WHR credit, US$21.00 million equivalent from SUW-SML credit, US$13.00 million from GFF grant, and US$6.00 million equivalent from the Government)

Subcomponent 1.1: Improve delivery of quality RMNCAH-N services using PBF (total US$45.00 million equivalent: US$7.00 million equivalent from WHR grant, US$8.00 million equivalent from WHR credit, US$19.00 million equivalent from SUW-SML credit, US$5.00 million from GFF grant, and US$6.00 million equivalent from the Government)

36. **This subcomponent will support improvement in the quality of RMNCAH-N service delivery and establish financial frameworks aligned with the national vision to pool financial resources for UHC.** Building on good practices under the INAYA Project, the subcomponent will prioritize the delivery of quality health and nutrition services to refugees and their host communities, with a focus on the M'Bera refugee camp, where 77.5 percent of refugees reside.[24] Public health facilities in the target regions will receive PBF payments based on the delivery of predetermined packages of RMNCAH-N services, ensuring both the quantity and quality of service provision. One key quantitative indicator under the

[24] UNHCR. 2023. "Dashboard Mauritania – Refugees and asylum seekers (September 2023)." https://data.unhcr.org/en/documents/details/104011.

PBF is institutional delivery, which should contribute to changing gender and social norms, departing from a tradition of home delivery. The share of health workers' bonuses in the PBF payments will not exceed 40 percent. The remaining funds will be allocated to pre-agreed activities outlined in health facility business plans. The quality checklist for PBF includes assessing the availability of essential medicines and commodities and evaluating whether the health facilities have the autonomy to procure from accredited wholesalers, in addition to the support provided by the Government (additional details of the PBF procedures are articulated in the PBF manual).

37. **The community component of the PBF will be strengthened to promote the use of RMNCAH-N services in alignment with the revised package of the community health program and ensure increased equity through geographical outreach and inclusion of the target populations.** The program will engage community actors such as health workers, volunteers, local leaders, civil society organizations (CSOs), community-based organizations (CBOs), and traditional birth attendants to raise awareness of the importance of seeking care, ensuring timely referrals, and following up with patients to complete or maintain necessary home-based care. The community-based PBF will help reduce geographic and financial barriers to accessing RMNCAH-N services, identified as major reasons for delays in seeking care.[25] The PBF program will be expanded to include incentives to reach adolescents.

38. **The MoH and regional health teams will verify reported results and outcomes,** while the General Inspectorate of Health, with enhanced capacity under the INAYA Project, will conduct counter-verification to ensure reliable and consistent data. In cases where phantom patients are identified or overreporting is found, PBF payments to health facilities will be deducted in subsequent payments.

39. **Local health committees will conduct semiannual client satisfaction surveys to evaluate the perceived quality of service delivery and user satisfaction.** The results will be periodically reviewed for adjustments, and the data will be automatically generated through the PBF database. This measure will provide a solid feedback mechanism from communities and other stakeholders to enable fine-tuning of project design and implementation strategies.

Subcomponent 1.2: Increase equity in use of RMNCAH-N services (total US$10.00 million equivalent: US$2.00 million equivalent from SUW-SML credit and US$8.00 million from GFF grant)

40. **This subcomponent will support community-driven RMNCAH-N interventions, focusing on outreach to the poorest and most-marginalized populations, including refugees and their host communities.** Building on the INAYA Project's community health implementation, this subcomponent will facilitate routine visits by frontline health workers, community health workers (CHWs), and mobile teams, who target adolescents, refugees, and other vulnerable populations, who are often the hardest to reach, to increase access to essential health and nutrition services. Additionally, this subcomponent will support community-based training programs on disaster prevention and preparedness, the promotion of climate-resilient practices for maternal and child health, and the encouragement of community participation in decision-making related to RMNCAH-N services. The subcomponent will also explore task shifting (redistributing tasks among health teams) for effective service delivery to target populations, especially in prevention, early detection, and timely case management for malnourished children and pregnant and breastfeeding women. This subcomponent will also support cascaded monitoring and supportive supervision for health workers at the PHC level, aiming to improve quality and enhance information management for evidence-based decision-making at all levels. Furthermore, technical assistance

[25] MoH and UNICEF Mauritania. 2015. Etude de faisabilité pour la mise en place d'un mécanisme d'incitation à l'utilisation des services de santé par les populations pauvres et vulnérables (Financement Basé sur les Résultats). Volet demande de services (Feasibility study for the implementation of an incentive mechanism for the use of health services by poor and vulnerable populations (results-based financing) - Demand for services component).

will be provided to design a CHW program specifically for urban and semi-urban areas, to be implemented in Phase 2 of the MPA.

41. **The subcomponent will also support intensified social and behavioral change communication (SBCC) activities to prevent early and unintended pregnancies, promote birth spacing and the use of modern contraceptives, encourage breastfeeding, promote dietary diversity, and conduct basic screening for NCDs, including early detection and community-based treatment for child malnutrition.** It will disseminate information about the program to increase project beneficiaries' understanding of their right to health services, the importance of seeking timely care, and existing financial protection measures through community platforms and engagement of community leaders and peer support groups for women. It will support the development and use of information, education and communication (IEC) materials in local languages, using local media such as community radios. Technical assistance will be provided for the design, testing, and promotion of these materials. To further optimize coverage and use of RMNCAH-N services, the results of this subcomponent will be used to inform policy makers for equitable and efficient resource allocation to PHC, especially preventive and promotive care.

42. **This subcomponent will facilitate better accessibility, quality, and utilization of health services for adolescents at the PHC level in target regions.** It will support training health providers in adolescent-friendly and culturally sensitive services, including counseling on sexual and reproductive health, HIV and human papillomavirus (HPV) prevention, and family planning. Refresher training will be provided for health workers and GBV survivors in case management and psychosocial support. Pregnant adolescents will receive community-based health and nutrition services, including prenatal nutrition counseling and postpartum family planning, without financial burdens. The project will collaborate with relevant ministries and youth networks to establish and support youth associations. Training materials for peer educators and youth ambassadors will be updated in consultation with the youth to address their needs effectively. The learning agenda will support the design and adaptation of services to better reach adolescents.

43. **Finally. the subcomponent aims to enhance the availability of sexual and reproductive health services, information, and nutrition for adolescents by expanding school health platforms.** It will support the expansion of health services within schools. It will build on multisectoral interventions from the SWEDD Project and implement health education and life skills training, menstrual health and hygiene management, and empowerment programs for girls (see Annex 5). The project will help schools reach in- and out-of-school youth and address important topics on adolescent health, changing behaviors, and norms of adolescents. In addition to school-based platforms, outreach programs will be implemented to specifically target out-of-school youth through community-based initiatives; mobile PHC facilities for preventive, promotive, and curative care; or partnerships with local youth organizations. By utilizing a combination of school-based platforms and targeted outreach efforts, the project will ensure that both in-school and out-of-school youth have access to vital information and services related to adolescent health.

Component 2: Strengthen health systems (total US$15.03 million equivalent: US$3.00 million equivalent from WHR grant, US$2.00 million equivalent from WHR credit, US$5.00 million equivalent from SUW-SML credit, US$2.30 million equivalent from Performance-Based Allocation [PBA], US$2.00 million from GFF grant, and US$0.73 million equivalent from the Government)

Subcomponent 2.1: Operationalize health sector reforms (total US$7.00 million equivalent: US$3.00 million equivalent from WHR grant, US$2.00 million equivalent from SUW-SML credit, US$2.00 million from GFF grant)

44. **This subcomponent will enhance cross-sectoral and multistakeholder coordination and establish regulatory frameworks to improve the efficiency and effectiveness of health systems toward achieving UHC.** This subcomponent will assess the PFM system and provide support to the Technical Committee for the PBB. The regulatory framework will

be revised to align with the PBB, and a comprehensive system for budget allocation, execution, and monitoring will be developed with a data-driven budget allocation formula. This subcomponent will facilitate the integration of a strategic purchasing mechanism in the health sector, in coordination with the CNAM and CNASS to optimize resource distribution, including for the improved health service and insurance coverages for refugees and other vulnerable populations. Additionally, an institutionalized approach will be adopted to develop national health accounts, providing a clearer understanding of financial flows, and enabling targeted interventions where necessary. This subcomponent will also foster collaboration between the Ministry of Finance and the MoH to explore progressive taxation systems, including a possibility of sugar sweetened beverage taxes, and other financial mechanisms, ensuring long-term sustainability.

45. **The subcomponent will provide technical assistance to develop strategies for human resources for health, with a focus on achieving better gender balance, and operationalize more equitable distribution of health workers in the target regions.** It will also contribute to improving references and counter-references, as well as improving the supply chain and logistics for essential medicines and strategic commodities, including their last-mile distribution, especially in the most deprived areas, including host communities of refugees.

46. **Finally, the subcomponent will support data-driven decision-making by digitalizing the HMIS.** It will support digital solutions in collaboration with other partners to improve data collection, sharing, and analysis, particularly for climate-sensitive diseases. This includes strengthening the HMIS and logistics management system, integrating private sector data into District Health Information Software 2 (DHIS2), implementing a human resource information system, and digitizing community health information systems, ensuring that real-time data flows into the DHIS2. Where applicable, it will strengthen links with the civil registration and vital statistics system. These efforts will reduce fragmentation and support timely and evidence-based decision-making. The digital in health solutions will help optimize financing, resource allocation, and improve service delivery efficiency and effectiveness in both public and private sectors.

Subcomponent 2.2: Ensure health facilities meet standards (total US$5.00 million equivalent: US$2.00 million equivalent from WHR credit, US$3.00 million equivalent from SUW-SML credit)

47. **This subcomponent will upgrade hub facilities from basic emergency obstetric and newborn care (EmONC) to comprehensive EmONC, based on World Bank-supported geospatial analysis.** All project-supported health facilities will be designed to be climate resilient, incorporating natural ventilation and water-efficient systems and promoting the use of reusable, eco-friendly medical supplies and equipment and alternative technologies such as autoclaves and microwaves to minimize waste and decrease the carbon footprint of health facilities while ensuring patient safety. Better water management and energy-efficient measures will reduce the need for medical treatment and minimize risks of infectious diseases among the population. The designs of health facilities and water, sanitation, and hygiene facilities within them will also consider the needs of people with disabilities and sociocultural and gender factors through participatory processes. The subcomponent will support these health facilities to develop their climate-sensitive emergency plans, conduct drills, and train their health workers. These efforts will enhance resilience to climate change and natural disasters and increase the PPR capacity of health systems to climate-related emergencies as well as to acute increase of demand for health and nutrition services in host communities with the inflow of refugees. Furthermore, building on investments made under the World Bank-supported projects (see Annex 5), the project will ensure that medical waste management and cold chain systems are in place in all the health facilities in the target regions.

Subcomponent 2.3: Increase national capacity for pandemic prevention, preparedness, and response (PPR) (total US$3.03 million equivalent: US$2.30 million equivalent from PBA, and US$0.73 million equivalent from the Government)

48. **This subcomponent is designed to increase national PPR capacity.** Building on the investments made under the REDISSE and COVID-19 Projects, the subcomponent will strengthen the existing One Health coordination platform and

cross-sectoral disaster risk reduction committee. Based on the results of the resilience assessment in the health sector, supported by the COVID-19 Project, the subcomponent will explore the possibility of establishing a network of disaster referral facilities in the target regions to enhance early warning and detection systems and to safeguard the continuity of health service delivery for vulnerable populations during crises.

Component 3: Project management, monitoring and evaluation (M&E) (total US$4.00 million equivalent: US$4.00 million equivalent from SUW-SML credit)

49. **This component will finance operating costs, consultancy services, and some equipment for the National PBF Unit and the Project Implementation Unit (PIU).** It will also provide support for the Direction des Affaires Administratives et Financières (Financial Affairs Directorate, DAF), particularly at the subnational level. This will ensure compliance with World Bank fiduciary requirements, increase financial management capacity, and finance periodic monitoring and supportive supervision by the National PBF Unit and the PIU for quality improvement and assurance. The component will finance data view tools to facilitate data-driven decision-making and timely adjustments as needed. It will also support the implementation of developed standards and creation of supportive mechanisms for integrated monitoring, supportive supervision and evaluation, and evidence-based decision-making, as these are critical elements in strengthening health systems. This component will help the MoH integrate an ethical and values-based approach into project management, fiduciary tasks, M&E, and other logistics support for project implementation. Applicable World Bank policies, staff rules, and other accountability frameworks will be articulated in relevant documents during project preparation and implementation to promote transparency, mitigate potential conflicts of interest, and guide collaboration and decision-making. Periodic assessments, studies, and surveys will be conducted to identify and address relevant project-related risks through the development of appropriate mitigation measures. Additionally, these assessments will identify implementation gaps and assess the project's impacts. Based on findings from these studies, the PIU will develop and implement targeted solutions to effectively address the identified challenges and ensure the intended project outcomes.

Component 4: Contingent Emergency Response Component (CERC) (US$0)

50. **A CERC is included in the project in accordance with IPF Policy**, paragraphs 12 and 13, for Situations of Urgent Need of Assistance and Capacity Constraints. This will allow for rapid reallocation of credit/grant uncommitted funds in the event of an eligible emergency, as defined in OP 8.00.[26] A CERC Manual will guide the activation and implementation of the CERC, and an Emergency Action Plan will be prepared to confirm activities and financing for a specific event. WHR funds reallocated to the CERC will only be used to benefit refugees and host communities.

C. Project Beneficiaries

51. **The project will target women of reproductive age, adolescents and youth, and children under the age of five, including refugees, in the nine targeted regions.** It is estimated that 2.5 million or 66.9 percent of women of reproductive age, children, adolescents, and youth, and 81 percent of health facilities will be direct beneficiaries of the project. In addition, over 70,000 refugees will benefit directly from the project's interventions. They will receive specific assistance tailored to their needs for better health and well-being. The general public in the nine target regions (Hodh Chargui, Hodh Gharbi, Guidimagha, Assaba, Gorgol, Brakna, Trarza, Adrar, and Tagant), who constitute 62.4 percent of Mauritania's total population, will be indirect beneficiaries. The selection criteria and characteristics of the target regions are described in Annex 3.

[26] An eligible emergency is defined as an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact associated with natural or man-made crises or disasters. Such events include a disease outbreak.

D. Rationale for World Bank Involvement and Role of Partners

52. **The Government has demonstrated strong political commitment to results-driven interventions and increasing equity and has established a goal in the NHDP of achieving UHC by 2030.** The World Bank-supported INAYA Project highlighted the success of the results-based approach, especially in providing essential health services to vulnerable populations with equity, effectiveness, and autonomy. Recognizing the success of this partnership with a US$3.50 million contribution from the Government, the Government requested the World Bank on October 31, 2022, to expand the PBF, transitioning to a broader 10-year program that will cover comprehensive interventions aligned with other strategic initiatives of the health sector. The World Bank's involvement is pivotal in driving expansion and institutionalization of the PBF program and other strategic purchasing mechanisms, as well as in strengthening community-based interventions sensitive to age, sex, and socioeconomic status to ensure the protection of vulnerable populations. The digitalization of HMIS, in alignment with the National HMIS Strategy 2023–2026, will further support the country's ambition to improve health outcomes.

53. **There is substantial momentum among development partners to capitalize on the opportunity that the World Bank and GFF have presented to reestablish an effective health sector coordination mechanism.** The GFF Trust Fund links catalytic resources to World Bank financing, and the project will benefit from a US$15.00 million grant in Phase 1. The GFF helps low- and lower-middle-income countries address RMNCAH-N and strengthen financing and health systems for UHC. It also helps government-led, multistakeholder platforms in developing and implementing national prioritized health plans (Investment Case) to mobilize sustainable financing for health and nutrition. The GFF assists countries to focus on data, equity, and domestic resources for health services. By helping coordinate partners, the proposed program will complement service delivery efforts that are supported by other development partners (see Annex 6). The proposed program will continue its close collaboration with UNHCR to support refugees and host communities. The World Bank and GFF aim to reduce fragmentation and enhance development effectiveness by aligning resources with government priorities in close coordination with other development partners.

E. Lessons Learned

54. **The INAYA Project has increased the use of essential health and nutrition services in its target regions since 2019 through participatory planning; transparent financial incentives; and a robust, accountable M&E system.** Decentralized financing under the INAYA Project increases health providers' ability to improve their working environment for better service delivery. The proposed program will adopt this approach to expand PBF interventions.

55. **The INAYA Project has improved the quality of care through facility-based assessments, customized quality improvement plans, and regular supportive supervision and mentoring, using the comprehensive PBF quality checklist and scorecards.** These efforts resulted in a significant increase in the average quality score of the health facilities supported by the INAYA Project, rising from 14 percent in 2019 to 52 percent in 2022. However, challenges still exist in terms of the availability of competent health workers, essential medicines and commodities, and sufficient financial management capacity at the health facility level. To ensure the institutionalization of quality enhancement, the proposed program will adopt a more systematic approach. This will include facility-based assessments; the development of facility-specific quality improvement plans, and their implementation through counseling and mentoring; and integrated monitoring and supportive supervision. These measures are crucial in achieving sustained improvements in the quality of care and increasing overall satisfaction among the population.

56. **Community participation remains limited.** While the INAYA Project has implemented citizen engagement mechanisms through health committees and community surveys in its target regions that have improved communication and participatory decision-making, overall community participation has been limited. At the health facility or community

level, little attention has been paid to the three major causes of childhood illness: diarrhea, malaria, and acute respiratory infection. The increasing number of unvaccinated children remains a concern. The proposed program will work with community-based groups to implement low-cost, high-impact, community-driven health and nutrition interventions in rural areas.

57. **Refugees and host communities have benefited from health services under the INAYA Project with support from the IDA Refugees Sub-window.** The INAYA Project successfully integrated refugees into national health systems and attentively addressed emerging needs of host communities, ensuring equitable access to health services through mechanisms such as PBF and conditional cash transfers. The INAYA Project also fostered a strong partnership with UNHCR to improve service quality and accessibility and ensure the continuity and sustainability of service delivery in volatile situations. These lessons underscore the need for continuous support to improve access to and the quality of health services for both refugees and host communities.

58. **The complexity of implementation arrangements hinders project implementation.** The INAYA Project involves actors outside the health sector, such as Taazour for conditional cash transfer, but this has resulted in delayed or inadequate project implementation and cost overruns. The proposed program will simplify implementation and obtain multisectoral stakeholder buy-in at the design stage to ensure effective program implementation, ownership, and sustainability.

59. **The PBF program alone may not be enough to address complex health system challenges.** Improving health outcomes requires not only financial incentives, but also a strong health workforce, adequate infrastructure, access to essential medicines and equipment, and demand for care. Implementing PBF alongside other interventions can create a comprehensive approach to improving health systems and health outcomes. The proposed program will strive to achieve synergies with interventions from other World Bank-supported projects, fostering coordination and collaboration with other development partners.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

60. **The project will build upon existing coordination mechanisms under the INAYA Project at the national and subnational levels and use institutional mechanisms set up for REDISSE, SWEDD, and COVID-19 operations.** Institutional arrangements for Phase 1 include the following (see additional details in Annex 1):

(a) **A Steering Committee** will oversee project implementation, provide strategic guidance, and ensure stakeholder communication and collaboration. It will approve annual work plans and budgets, monitor implementation progress, and guide corrective measures if needed. Chaired by the Secretary General of the MoH, the committee members include the project coordinator; the two Director-Generals and directors of the MoH; the General Inspectorate of Health; a representative from the Ministry of Interior and Decentralization; and a representative from the Ministry of Economy and Sustainable Development, the Ministry of Finance, the CNAM, and the CNASS.

(b) **A Technical Committee** will provide technical support at all implementation levels to inform decisions of the Steering Committee. The Technical Committee will be chaired by the project coordinator. Other committee members include the directors of the MoH; the deputy coordinator of the project; the Regional Health Directorate (rotational); the financial management officer of the PIU; and representatives from the Ministry

of Youth and the Ministry of Environment, the WHO, UNICEF, UNFPA, and the CSO Network. Furthermore, the Technical Committee has the flexibility to include other stakeholders when necessary.

(c) **A PIU** will be responsible for day-to-day project coordination and M&E. The DAF will handle project administration, procurement, financial management, and disbursement. A project coordinator, a deputy project coordinator, and an M&E specialist have been appointed by the Secretary General of the MoH. The PIU will hire: (i) a financial management specialist; (ii) two accountants; (iii) a procurement specialist; (iv) an internal auditor; (v) an environmental and social (E&S) specialist; and (vi) a social assistant, within one month after the effectiveness. Additional staff will be hired as needed to enhance project management capacity.

61. **The PIU has prepared a Project Implementation Manual that covers all aspects of project implementation.** This will guide all government implementation agencies comply with World Bank policies and procedures that the Ministry of Finance has established for financial arrangements and flows.

B. Results Monitoring and Evaluation Arrangements

62. **Results monitoring.** The Project Technical Committee, National PBF Unit, and PIU will monitor activities and progress at the central level, while the regional and departmental health teams will monitor activities and progress at the subnational level. The PIU will consolidate technical and financial reports from implementation partners. Additionally, the quarterly and annual progress reports will provide comprehensive information on project activities, key indicators, beneficiaries, fiduciary matters, and E&S safeguards. All project monitoring data will be uploaded to the national DHIS2 and the PBF portal for public disclosure.[27] Data collected through the project will be protected under the national law on data protection, which is compliant with international standards.

63. **M&E arrangements.** The PIU will furnish the World Bank with data and information necessary to complete a semiannual Implementation Status and Results Report and a midterm review. The quality of care and community satisfaction will be monitored and evaluated through a client satisfaction survey. Regular forums will be organized to gather citizen feedback and address grievances. The MoH and the World Bank will periodically review and evaluate the progress and processes of project implementation and results to refine the implementation strategies and make timely course correction. Capacity strengthening of the institutions involved in M&E functions will be supported as needed.

64. **The verification and counter-verification of PBF**. The Regional Verification Team will carry out quantitative verification of performance of the contracted health facilities as per the pre-determined package under the PBF scheme. Each target region will have its verification team. The General Inspectorate of Health will conduct counter verification annually. To ensure the independence and accuracy of the PBF verification, an international agency specializing in PBF will be commissioned to verify counter-verification results at least twice during the five-year project implementation.

C. Sustainability

65. **Long-term financial sustainability is a critical factor in maintaining project gains and improving health systems.** The Government, building on experience from the INAYA Project, has integrated the PBF strategy into the SCAPP 2016–2030 and the NHDP 2021–2030. It has also financially contributed to PBF implementation in the three target regions under the INAYA Project. In Phase 1 of the proposed program, the Government committed to contributing US$6.73 million equivalent. In Phase 2, the Government is expected to take ownership and establish a framework for the strategic

[27] MoH Mauritania. Le Financement Basé sur la Performance dans le Secteur de la Santé en Mauritanie (Performance-Based Financing in the health sector in Mauritania). http://www.portailpbf.gov.mr.

purchasing of essential health and nutrition services. The increased government funding highlights its dedication to executing reforms with a focus on lasting gains. Embedding the PBF scheme into the Government's budget as part of the PBB reform will promote sustainability. Developing local capacity will empower local personnel to sustain gains achieved through the program. Additionally, engaging policy makers and health sector leaders from the planning and implementation stages of the MPA will reinforce the Government's commitment to sustaining gains and improving the quality of health services and health outcomes.

66. **The health sector in Mauritania employs coordination platforms and establishes the national compact to facilitate collaboration between the MoH and development partners in achieving targets outlined in the NHDP.** The proposed program will ensure synergies and coordination with other development partners to align efforts, share information, and collaborate toward the shared goal of UHC.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

67. **Phase 1 of the proposed program (the project) is considered economically viable after an assessment determined that the transition risks to a low-carbon development pathway are low.** The primary objective of the project is to increase the use of evidence-based RMNCAH-N services in the target regions. The economic analysis estimated the impact of the interventions on the health and nutritional status of women and children, expressed in net present value (NPV), using standard methods to justify its economic feasibility. Project costs were compared with benefits, and measures such as the internal rate of return and benefit-cost ratio were calculated to assess the project's economic feasibility. The project's economic returns were estimated in terms of NPV and return on investment using a cost-benefit analysis with Mauritania-specific data and best available evidence.

68. **The project is projected to gain 6,518 quality-adjusted life years from 2024 to 2028 on RMNCAH-N outcomes, using the List tool.** The project is also expected to prevent more than 20, cases of chronic malnutrition in children under five and more than 3,897 and 17,215 cases of anemia in pregnant women and women of reproductive age, respectively.

69. **The cost per life saved under this program is estimated at US$13,808, and the cost per disability-adjusted life year (DALY) saved is US$229.** It is important to note that a DALY is a measure of overall disease burden, combining years of healthy life lost due to premature death and years lived with disability. The cost per DALY saved in this program is considerably below the annual per capita GDP. The project is considered economically viable, with an NPV of US$205.10 million and a price-to-earnings ratio of 3.3, indicating that, for every dollar invested, the project will yield an economic return of US$3.30. Even with discount rates higher than 5 percent, specifically 10 percent and 15 percent, the NPV remains positive. The NPV is estimated at US$160.8 million with a benefit-cost ratio of 2.8 for the 10 percent discount rate, and US$93 million with a benefit-cost ratio of 2 for the 15 percent discount rate. Additionally, the project's economic viability is supported by an assessment that concluded that the risks associated with transitioning to a low-carbon development pathway are considered low.

70. **Alignment with the Paris Agreement.** The project is aligned with the goals of the Paris Agreement and consistent with the country's NDC (see Climate Vulnerability and Resilience section for additional details).

(a) **Assessment and reduction of adaptation risks.** The NDC includes commitments to developing climate-resilient infrastructure. The project will support the development of standards for climate-resilient infrastructure and ensure compliance during the rehabilitation or refurbishment of health facilities. Specifically, climate change

risks will be managed and mitigated through targeted adaptation measures such as the provision of solar power, natural ventilation, and rainwater and graywater management for health facilities. Climate-sensitive contingency measures will be built into health facility plans, using health and nutrition data for effective monitoring and early detection. The project will support the pre-positioning of medical supplies and training of health workers and beneficiaries in climate-sensitive disease prevention and control. These adaptation design considerations will limit exposure to the low level of residual risk.

(b) **Assessment and reduction of mitigation risks.** The project design will have little to no impact on greenhouse gas (GHG) emissions and poses a low risk to preventing the Government's transition to low-carbon development. It will encourage the use of lower-carbon alternatives and practices and will implement climate-related risk reduction measures, such as medical waste management, climate-resilient and energy-efficient upgrades for health facilities, and the adoption of digital solutions, all of which are universally aligned. Building on investments made under the INAYA, REDISSE, and COVID-19 Projects, the project will further strengthen the medical waste management system in the target regions. Additionally, it will enhance energy efficiency during the upgrading of targeted health facilities. The designs of these facilities will not hinder the transition to lower-carbon alternatives. Instead, it will finance solar panels to power health facilities, aligning with the country's goal of increasing renewable energy generation. The project will also leverage digital solutions to strengthen the early warning system, which will be linked with climate information services to enhance PPR to public health emergencies. Thus, mitigation risks are Low.

B. Fiduciary

(i) Financial Management

71. **In line with the guidelines in the Financial Management Manual for World Bank IPF Operations, which became effective on March 1, 2010, and were last revised on February 10, 2017, a financial management assessment was conducted within the MoH.** It was agreed that the DAF will perform financial management functions for the proposed project through arrangements established under the INAYA Project. The financial management assessment revealed that the proposed implementing agency has a commendable track record in executing World Bank-supported projects: the INAYA Project has a qualified, experienced financial management team comprising one financial management specialist, one accountant, and one internal auditor, all well-versed in World Bank procedures; proper books of accounts and supporting documents have been maintained for all expenditures; the PIU is equipped with multi-project accounting software capable of easily accommodating the project's accounts; and an adequate internal control system and budget preparation and monitoring tools are in place. Therefore, the INAYA Project's financial management performance is rated Satisfactory following the recent supervision mission.

72. **The financial management assessment concluded that the existing financial management arrangements are adequate, but the overall financial management risk is considered Substantial.** To mitigate this risk to a level acceptable to the World Bank, agreed-upon actions must be implemented. The DAF is responsible for overseeing the implementation of these actions. Upon successful implementation of the financial management action plan described in Annex 1, the residual financial management risk is expected to be **Moderate**.

73. **Retroactive financing for a maximum amount of SDR 7.60 million equivalent (US$10.00 million equivalent: US$2.00 million equivalent from WHR grant, US$3.00 million from GFF grant, and US$5.00 million equivalent from SUW-SML credit) or 20.0 percent, 20.0 percent, and 16.7 percent of the total funding of the respective funding resources, is allocated for the proposed project.** Eligible activities may include: (a) PBF subsidy payments and (b) operational costs related to the rollout of the PBF subsidy payments, such as verifications and counter-verifications, and other needs. The

eligible expenditures made on or after January 1, 2024, and before the signing of the Grant and Financing Agreements are proposed for this retroactive financing. The procurement and E&S safeguard procedures followed by the Recipient will be consistent with World Bank Procurement Regulations and E&S safeguards framework. This financing will ensure continuity of services provided under the current INAYA Project between its closure and effectiveness of the proposed program.

(ii) Procurement

74. **Procurement activities under the project will adhere to World Bank Procurement Regulations for IPF Borrowers:** Procurement in IPF, Goods, Works, Non-Consulting, and Consulting Services, dated September 2023; Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, revised as of July 1, 2016; and provisions stipulated in the Legal Agreements.

75. **The procurement assessment** confirmed that the MoH has relevant experience with World Bank procurement procedures. Additionally, the project will retain experienced staff from the INAYA Project's PIU and hire additional staff as required. Consequently, the overall risk of implementation in procurement, after mitigation, is **Moderate** (see details in Annex 1). Risk mitigation measures include: (a) hiring a procurement specialist and a procurement assistant within one month after effectiveness; and (b) developing the project’s procurement procedures manual.

76. **The Project Procurement Strategy Document (PPSD) and the Procurement Plan for the initial 18 months have been prepared and approved by the World Bank.** The PPSD provides the framework and guidelines for determining the selection methods in the procurement process. The Procurement Plan will be available in the project’s database and on the World Bank’s external website. The project team will update it annually or as required to reflect project implementation needs and increases in institutional capacity. The project will use the Systematic Tracking of Exchanges in Procurement (STEP) tool to prepare, clarify, and update its Procurement Plan to ensure implementation.

C. Legal Operational Policies

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

D. Environmental and Social

77. **The overall project E&S risk is Moderate.** Potential E&S risks include generation of biomedical waste, occupational health and safety related to work conditions, and possible discrimination against population subgroups. The Environmental and Social Management Framework (ESMF) of the INAYA Project has been updated in line with the World Bank Environmental and Social Framework and was disclosed on December 27, 2023. The Stakeholder Engagement Plan, the Labor Management Procedures, and the Biomedical Waste Management Plan have been prepared and disclosed on February 8, 2024. The project will intensify social mobilization efforts, employ SBCC, and strengthen community-driven interventions. These measures will contribute to transforming gender and cultural norms and empowering women and girls to make informed decisions about their health.

78. **The Government will engage citizens and CSOs, including youth associations, through dialogue platforms provided by the World Bank and GFF**. These platforms facilitate open and inclusive discussions, allowing citizens to voice

their opinions, concerns, and suggestions. This demonstrates the Government's commitment to inclusivity and participatory decision-making. Health committees in target regions will collaborate with community members to develop business plans and conduct client satisfaction surveys, ensuring citizen engagement and promoting ownership and empowerment. The feedback gathered through community satisfaction surveys and dialogue with the youth associations, CSOs and CBOs will directly inform improvements and calibrations to project implementation.

79. **The project will address gender gaps in access to health information and services.** Mauritania's gender inequality index was 0.63, ranking 161 out of 191 countries in 2021/22.[28] Women in Mauritania, especially adolescent girls, face intergenerational inequity in accessing health services. Limited access to people-centered and/or adolescent-friendly health services hinders or delays the seeking of reproductive and maternal health services. Consequently, these gender gaps exacerbate risks of early or undesired pregnancy and unsafe abortion. These gender gaps will be narrowed through tailored SBCC activities and citizen engagement under the project to enable the target populations to make informed decisions and transform social and gender norms related to seeking necessary care. IEC materials, including visual aids, will accompany interpersonal communication in local languages, sensitive to group compositions of each IEC session. In addition to transforming health workers' attitudes and practices without judgement and discrimination, the project will proactively reach out to adolescents in communities, using their preferred communication channels. The project will also strengthen advocacy for the prevention, early detection, and treatment of GBV to all stakeholders and provide quality health services to GBV survivors. Three key indicators will be tracked to monitor the disproportionate effects on women's health, disaggregated for girls below 19 years of age: proportion of deliveries in a health facility, number of pregnant women who attended at least four prenatal care visits with a qualified health worker, and number of mothers with newborns who attended at least two postnatal care visits with a qualified health worker.

E. Climate Vulnerability and Resilience

80. **The project has been screened for long- and short-term disaster risks and found to be highly vulnerable to climate-related hazards, particularly extreme precipitation and flooding.** Climate risks to project activities are currently rated as high and are expected to remain high in the future due to extreme temperature, extreme precipitation and flooding, and drought. Mauritania is vulnerable to extreme temperatures, droughts, and a projected temperature increase of 2.5°C between 2040 and 2059 under a high-emission scenario (Representative Concentration Pathway 8.5). This scenario also predicts an additional 35.4 hot days per year. By 2050, the annual GDP could be 3.4 percent to 7.2 percent lower, which would increase poverty.[29] The region is also highly exposed to extreme precipitation and flooding.

81. **Mauritania is highly vulnerable to and is in the process of improving preparedness for the impacts of climate change, ranking 143 out of 182 on the Notre Dame Global Adaptation Initiative.[30]** Drought, heat waves, and severe flooding make access to clean water and sanitation a major challenge, contributing to the prevalence of diarrhea and other climate-sensitive diseases among adults and children due to poor hygiene. Additionally, these factors have serious implications for crop production, affecting productivity and life expectancy, especially among elderly adults, children, and other vulnerable groups. The supply chain for medications and other health commodities can also be disrupted, which can increase the prevalence of climate-sensitive diseases due to shortages of essential medicines and supplies. The floods in 2022 resulted in a notable increase in acute child malnutrition, with rates rising from 11.2 percent in 2019 to 13.6

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[28] United Nations Development Programme. Human Development Reports. Gender Inequality Index. https://hdr.undp.org/data-center/thematic-composite-indices/gender-inequality-index#/indicies/GII.
[29] World Bank Group. 2022. *Country Climate and Development Report G5 Sahel Region*. Washington, DC: World Bank Group.
[30] University of Notre Dame. 2023. Notre Dame Global Adaptation Initiative Country Index - Mauritania. https://gain-new.crc.nd.edu/country/mauritania.

percent.[31] Despite these challenges, the risk to project activities and outcomes is categorized as Moderate because several adaptation measures will be adopted. Some mitigation measures have also been integrated, which will reduce the impact of the project's activities on the environment and the country's GHG emissions. Refer to Annex 4 for additional details.

V. GRIEVANCE REDRESS SERVICES

82. **Grievance Redress.** Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's Grievance Redress Service (GRS), visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, visit https://accountability.worldbank.org.

VI. KEY RISKS

83. **The overall risk rating for the MPA is Substantial.** Over the next decade, the MPA will face risks related to climate hazards, disease outbreaks, and geopolitical uncertainties in the Sahel. The project will help increase the resilience of the health systems and communities, with a specific emphasis on strengthening PHC systems. Additionally, the project will incorporate a CERC to reduce these residual risks to the health and well-being of the target populations. This CERC will also facilitate swift response to unforeseen challenges.

84. **The overall risk rating for the project in Phase 1 is Substantial.** Key risks and their ratings are as follows:

85. **Political and governance risks are rated Substantial.** The influence of political elites and governance shortcomings pose a considerable risk to the success of the project. The upcoming Presidential Elections in 2024 introduce additional risks related to political shifts in leadership and changes in political priorities. To mitigate these risks, the project will continue to provide technical and financial assistance to strengthen support for the MoH as a permanent institution to systematically engage and coordinate multiple agencies to foster health systems strengthening and PPR. Additionally, fragility in neighboring countries, particularly in Mali, increases the risk of spillover effects such as an increase in refugees and internal displacement. These factors could strain the national capacity for health service delivery and affect the health budget. However, Mauritania has an explicit policy to contain the risk of radicalization and support both refugees and host communities. Aligned with this refugee-friendly policy, the MPA emphasizes the integration of refugee health services into national health systems; pays particular attention to the vulnerability of host communities; and is designed to be inclusive, leaving no one behind in the pursuit of advancing UHC and human capital. This strategy may increase the population's confidence in public policies and sustain the achieved health outcomes.

[31] MoH Mauritania, Agence Nationale de la Statistique, de l'Analyse et de la Démographie, and UNICEF. 2022. *Rapport de l'Enquête Nutritionnelle SMART* (Nutrition SMART Survey Report).

86. **Macroeconomic risk is rated Substantial.** The country's economy has faced significant challenges due to the impact of the COVID-19 pandemic and its associated inflation. While the project does not directly engage in risk mitigation measures to address exchange rate and monetary policies, it will support more efficient utilization of the health budget and facilitate the PBB reform within the health sector. The project has secured a commitment of US$6.73 million equivalent as government contribution, which is a significant increase from the US$3.50 million equivalent allocated under the INAYA Project. The project will actively engage in policy and technical dialogues to ensure its commitments to transitioning toward sustainable financing for health, ultimately aiming to achieve UHC with improved RMNCAH-N outcomes.

87. **The risk of technical design is rated Substantial.** The MPA contains a broad range of interventions, including strategic purchasing integration, PBF expansion, innovative approaches for community and adolescent health, PPR, and health systems strengthening, using digital solutions. Given the interconnected nature of these interventions and their significance in improving targeted health outcomes, the project will intensify efforts in institutional capacity building, robust monitoring and supervision, evaluation and learning, and effective citizen engagement to mitigate residual risks. The project will also strengthen the verification mechanism to detect and address any overreporting of PBF results. Adhering to an ethical framework will prioritize transparency, accountability, and equity, building trust and ensuring responsible outcomes.

88. **Risks associated with institutional capacity for implementation and sustainability are rated Substantial.** Although the MoH and the PIU have gained substantial experience in project management and M&E through their involvement in World Bank-supported projects, the project’s ambitious technical and geographical scopes present a challenge. To mitigate these risks, the project will leverage the existing structures of the MoH and the INAYA Project. The MoH will maintain the adviser to the minister as the project coordinator and retain core PIU staff from the INAYA Project. Further, the project will proactively collaborate with the Ministry of Finance to advance health financing reforms in conjunction with other development partners. To mitigate sustainability risks amid a strained macroeconomy and inequitable access to health services, the project will extend PBF to broader geographical areas. This approach would improve working conditions for health workers, support the MoH to develop innovative solutions for the equitable deployment and retention of health workers, and protect vulnerable populations from financial burdens when seeking care in the target rural areas.

VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
Increase the accessibility, quality, and use of RMNCAH-N services in the selected regions					
Deliveries in a health facility (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
53.4	60.00	65.00	70.00	75.00	80.00
➢Deliveries in a health facility among refugee women (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
50	60	65	70	75	80
➢Deliveries in a health facility by women below 19 years of age (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	37	40	44	48	54
New users of modern contraceptives among women ages 15 to 49 (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
61,656	62,564	130,195	204,141	285,435	376,121
➢New users of modern contraceptives among refugee women ages 15 to 49 (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
870	879	1,766	2,662	3,567	4,481
Exclusive breastfeeding of children younger than five months (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
27.20	30.00	35.00	40.00	45.00	50.00
Average quality score for health facilities (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	29.00	33.00	40.00	50.00	60.00
Individuals who needed clinical care in the past 12 months but did not seek it because of financial constraints (Percentage)					
Apr/2021	Dec/2026				Dec/2028
60	45				30

Intermediate Indicators by Components

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
Improve quality and increase use of RMNCAH-N services					
People who have received essential health, nutrition, and population (HNP) services (Number) CRI					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1800000.00	3600000.00	5400000.00	7200000.00	9000000.00
➢Number of women and children who have received basic nutrition services (Number) CRI					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	49500	100000	152000	205500	260500
➢Number of deliveries attended by skilled health personnel (Number) CRI					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	57962.00	120223.00	187949.00	262148.00	344999.00
➢People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (Number) CRI					
0.00	900000.00	1800000.00	2700000.00	3600000.00	4500000.00
➢Number of children immunized (Number) CRI					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	75263.00	154754.00	238983.00	329694.00	427211.00
Pregnant women who attended at least four prenatal care visits with a qualified health worker (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
32,978.00	35,878.00	75,011.00	119,012.00	168,127.00	223,513.00
➢Pregnant refugee women who attended at least four prenatal care visits with a qualified health worker (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
622.00	625.00	1,253.00	1,885.00	2,519.00	3,157.00
➢Pregnant women younger than 19 who attended at least four prenatal care visits with a qualified health worker (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	510.00	1,204.00	2,268.00	3,532.00	4,824.00
Mothers with newborns who attended at least two postnatal care visits with a qualified health worker (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
30,894	36,343.00	74,893.00	116,157.00	160,767.00	209,390.00
➢Refugee mothers with newborns who attended at least two postnatal care visits with a qualified health worker (Number)					
Dec/2022	Dec/2024	Dec/2026	Dec/2025	Dec/2027	Dec/2028
998	1,003	2,011	3,024	4,042	5,065

➢Mothers younger than 19 with newborns who attended at least two postnatal care visits with a qualified health worker (Number)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	1,121.00	2,858.00	4,986.00	7,153.00	9,367.00
Health facilities with no stock-out of essential medicines during the last three months (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	40.00	45.00	50.00	55.00	60.00
Average health facility quality-of-care score for the minimum package activity (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	29.00	33.00	40.00	50.00	60.00
Average community satisfaction score (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	50.00	60.00	65.00	70.00	70.00
Strengthen health systems					
PHC facilities meeting minimum human resources for health standards (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
30	35	40	45	50	55
Health facilities designed, rehabilitated, and maintained according to climate-resilient standards, ensuring continuity of service during extreme weather events and climate-related disasters (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	10	20	30	40	50
People who have benefitted from strengthened capacity to prevent, detect, and respond to health emergencies (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	30	40	50	60	70
Climate and disaster risk management scorecard for health system (Percentage)					
Oct/2023	Dec/2025	Dec/2027			Dec/2028
0	5	15			20
Identified emergency obstetric and newborn care facilities met national standards (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	30	40	50	60	70
Interoperable, interconnected, electronic real-time disease surveillance reporting systems (Number)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
3	3	3	4	4	5
Project management, monitoring and evaluation					
Public health facilities under PBF contracts (Percentage)					

Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
40	50.00	60.00	70.00	80.00	80
Public health facilities submitting timely monthly reports at the department (Moughataa) level in the three preceding months (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	80.00	85.00	90.00	95.00	95.00
Complaints recorded during implementation and delivery of project benefits addressed (Percentage)					
Dec/2023	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0.00	80.00	85.00	85.00	90.00	90.00
Catchment communities with a functional health committee (Percentage)					
Dec/2022	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
33.00	80.00	90.00	100.00	100.00	100.00
Contingent Emergency Response Component					

Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

Increase the accessibility, quality, and use of RMNCAH-N services in the selected regions	
Deliveries in a health facility (Percentage)	
Description	Numerator: Number of deliveries in a health facility in target regions Denominator: Number of livebirths in target regions (estimate)
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Deliveries in a health facility among refugee women (Percentage)	
Description	Numerator: Number of deliveries in a health facility among refugee women in target regions Demoniminator: Number of deliveries among refugee women in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data, quarterly progress reports
Responsibility for Data Collection	MoH
Deliveries in a health facility by women below 19 years of age (Percentage)	
Description	Numerator: Number of deliveries in a health facility among women younger than 19 in target regions Denominator: Number of deliveries among women younger than 19 in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
New users of modern contraceptives among women ages 15 to 49 (Number)	
Description	Number of new users of modern contraceptives among women ages 15–49 in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
New users of modern contraceptives among refugee women ages 15 to 49 (Number)	
Description	Number of new users of modern contraceptives among refugee women ages 15–49 in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Exclusive breastfeeding of children younger than five months (Percentage)	
Description	Percentage of infants younger than six months who are fed exclusively with breast milk for the first six months in target regions
Frequency	Annually
Data source	SMART surveys

Methodology for Data Collection	Review of SMART survey data
Responsibility for Data Collection	MoH
Average quality score for health facilities (Percentage)	
Description	Average score for health facilities on the basis of a quality of care assessment checklist, including appropriate materials, documentation and qualified staff for quality RMNCAH-N and acute malnutrition management as part of the PBF program
Frequency	Annually
Data source	PBF quality scores and annual progress reports
Methodology for Data Collection	Review of PBF quality scores and annual progress reports
Responsibility for Data Collection	MoH
Individuals who needed clinical care in the past 12 months but did not seek it because of financial constraints (Percentage)	
Description	Numerator: Number of people who needed clinical care in the past 12 months but did not seek it due to financial constraints in target regions Denominator: Number of people who needed clinical care in the past 12 months in target regions
Frequency	Every two years
Data source	DHS, *Enquête Permanente sur les Conditions de Vie en Mauritanie*, program-specific survey
Methodology for Data Collection	Review of DHS, Enquête Permanente sur les Conditions de Vie en Mauritanie, or program-specific survey data
Responsibility for Data Collection	MoH

Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Improve quality and increase use of RMNCAH-N services	
People who have received essential health, nutrition, and population (HNP) services (Number) CRI	
Description	Number of people who have received outpatient services at a PHC facility (Health center and Health Post) in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Number of women and children who have received basic nutrition services (Number) CRI	
Description	Number of pregnant women who have received folic acid and micronutrient supplements during prenatal visits and children ages 6 to 59 months who have received vitamin A in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Number of deliveries attended by skilled health personnel (Number) CRI	
Description	Number of women who delivered with the assistance of a skilled health service provider[a] in a health facility or at home in target regions
Frequency	Every six months

Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (Number) CRI	
Description	Number of women who have received outpatient services at a PHC facility (Health center and Health Post) in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Number of children immunized (Number) CRI	
Description	Number of children ages 12 to 23 months fully vaccinated (completion of measles and rubella 2) in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Pregnant women who attended at least four prenatal care visits with a qualified health worker (Number)	
Description	Number of pregnant women ages 15 to 49 who attended at least four prenatal care visits with a qualified health service provider[a] in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Pregnant refugee women who attended at least four prenatal care visits with a qualified health worker (Number)	
Description	Number of pregnant refugee women ages 15 to 49 who attended at least four prenatal care visits with a qualified health service provider[a] in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF dat, and quarterly progress reports
Responsibility for Data Collection	MoH
Pregnant women younger than 19 who attended at least four prenatal care visits with a qualified health worker (Number)	
Description	Number of pregnant women younger than 19 who attended at least four prenatal care visits with a qualified health service provider[a] in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Mothers with newborns who attended at least two postnatal care visits with a qualified health worker (Number)	
Description	Number of mothers with newborns who attended at least two postnatal care visits with a qualified health service provider[a]
Frequency	Every six months

Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Refugee mothers with newborns who attended at least two postnatal care visits with a qualified health worker (Number)	
Description	Number of refugee mothers with newborns who attended at least two postnatal care visits with a qualified health service provider[a]
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Mothers younger than 19 with newborns who attended at least two postnatal care visits with a qualified health worker (Number)	
Description	Number of mothers younger than 19 with newborns who attended at least two postnatal care visits with a qualified health service provider[a]
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Health facilities with no stock-out of essential medicines during the last three months (Percentage)	
Description	Numerator: Health facilities under PBF contracts in target regions with no stock-out of essential medicines in the preceding three months Denominator: Total number of health facilities under PBF contracts in target regions
Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Average health facility quality-of-care score for the minimum package activity (Percentage)	
Description	Average structural score of health facilities for the minimum package activity quality of care in target regions
Frequency	Annually
Data source	PBF quality score, annual progress reports
Methodology for Data Collection	Review of PBF quality score and annual progress reports
Responsibility for Data Collection	MoH
Average community satisfaction score (Percentage)	
Description	Average quality-of-care satisfaction score from the community survey in target regions
Frequency	Every six months
Data source	Community satisfaction surveys, quarterly progress reports
Methodology for Data Collection	Review of community satisfaction survey data and quarterly progress reports
Responsibility for Data Collection	MoH
Strengthen health systems	
PHC facilities meeting minimum human resources for health standards (Percentage)	
Description	Numerator: Number of public PHC facilities in target regions meeting human resources for health standards Denominator: Total number of public PHC facilities in target regions

Frequency	Every six months
Data source	HMIS, PBF data portal, quarterly progress reports
Methodology for Data Collection	Review of HMIS and PBF data and quarterly progress reports
Responsibility for Data Collection	MoH
Health facilities designed, rehabilitated, and maintained according to climate-resilient standards, ensuring continuity of service during extreme weather events and climate-related disasters (Percentage)	
Description	Numerator: Number of health facilities under PBF contracts in target regions affected by climate-related events without disruption of health and nutrition service delivery Denominator: Total number of health facilities under PBF contracts in target regions affected by climate-related events
Frequency	Annually
Data source	Quarterly and annual progress reports
Methodology for Data Collection	Review of quarterly and annual progress reports
Responsibility for Data Collection	MoH
People who have benefitted from strengthened capacity to prevent, detect, and respond to health emergencies (Percentage)	
Description	Numerator: Number of actors involved in the surveillance who have obtained satisfactory score (more than 80%) during a formative supervision Denominator: Number of actors involved in the surveillance who were supervised
Frequency	Annually
Data source	Quarterly and annual progress reports
Methodology for Data Collection	Review of quarterly and annual progress reports
Responsibility for Data Collection	MoH
Climate and disaster risk management scorecard for health system (Percentage)	
Description	Numerator: Number of climate and disaster risk management indicators with green color that are associated with positive outcomes or low risk Denominator: 85 indicators
Frequency	Every two years
Data source	Climate and disaster risk management assessments
Methodology for Data Collection	Review of climate and disaster risk management assessment report
Responsibility for Data Collection	MoH
Identified emergency obstetric and newborn care facilities met national standards (Percentage)	
Description	Numerator: Number of identified emergency obstetric and newborn care facilities that met national standards in target regions Denominator: Number of identified emergency obstetric and newborn care facilities in target regions
Frequency	Annually
Data source	PBF quality score, annual progress reports
Methodology for Data Collection	Review of PBF quality score and annual progress reports
Responsibility for Data Collection	MoH
Interoperable, interconnected, electronic real-time disease surveillance reporting systems (Number)	
Description	Number as joint external evaluation score: 1 = no capacity (no system), 2 = limited capacity (country is developing a system), 3 = developed capacity (country has developed a system but is unable to share data in real-time), 4 = demonstrated capacity (country has a system, but the Government does not fully sustain it), 5 = sustainable capacity (country has and sustains a system and shares data with stakeholders)

Frequency	Annually
Data source	Joint external evaluation and World Organization for Animal Health Performance of Veterinary Services expert report
Methodology for Data Collection	Review of joint external evaluation and World Organization for Animal Health Performance of Veterinary Services expert report
Responsibility for Data Collection	MoH
Project management and monitoring and evaluation	
Public health facilities under PBF contracts (Percentage)	
Description	Numerator: Number of public health facilities under PBF contracts in target regions Denominator: Total number of public health facilities in target regions
Frequency	Every six months
Data source	Quarterly and annual progress reports
Methodology for Data Collection	Review of quarterly and annual progress reports
Responsibility for Data Collection	MoH
Public health facilities submitting timely monthly reports at the department (Moughataa) level in the three preceding months (Percentage)	
Description	Numerator: Public health facilities in target regions that submitted timely, complete monthly reports through the health information management system Denominator: Total number of public health facilities in target regions Timeliness: Reports submitted between 1st and 10th of following month Completeness: Relevant information about facility complete
Frequency	Every six months
Data source	HMIS and quarterly progress reports
Methodology for Data Collection	Review of HMIS data and quarterly progress reports
Responsibility for Data Collection	MoH
Complaints recorded during implementation and delivery of project benefits addressed (Percentage)	
Description	Numerator: Number of complaints submitted and addressed Denominator: Number of complaints recorded
Frequency	Every six months
Data source	Community satisfacton surveys, quarterly progress reports
Methodology for Data Collection	Review of HMIS data and quarterly progress reports
Responsibility for Data Collection	MoH
Catchment communities with a functional health committee (Percentage)	
Description	Numerator: Number of catchment communities in the target regions with an operational health committee Denominator: Total number of catchment communities in the target regions
Frequency	Every six months
Data source	Quarterly and annual progress reports
Methodology for Data Collection	Review of quarterly and annual progress reports
Responsibility for Data Collection	MoH
Contingent Emergency Response Component	

a. Qualified health service providers include medical doctors, nurses, and midwives educated and trained in skills needed to manage normal (uncomplicated) pregnancies, childbirth, and immediate postnatal care and in identification, management, and referral of complications in women and newborns. This excludes traditional birth attendants, whether they are trained or not.

ANNEX 1: Implementation Arrangements and Support Plan

Implementation arrangements

1. **The proposed project (Phase 1 of the MPA) will use and strengthen the existing coordination mechanisms of the INAYA Project at the national and subnational levels, considering lessons learned from its implementation.** The project will establish the Steering Committee, the Technical Committee, the PBF units at the national and regional levels, and the PIU. The same institutional arrangements under the INAYA Project at the regional and operational levels will be established in the three regions and will be extended to the newly added six regions under the project. The regional verification teams will be responsible for conducting quantitative verification of health facility performance under the PBF program. Each region covered by the PBF program has its own audit team led by a coordinator. The Regional Council will be responsible for contract management with health facilities and health committees under the PBF program. In line with its mandate, the Regional Council acts as the body delegated by the MoH to purchase and validate PBF services for health facilities and health committees. Health committees will conduct community surveys to ensure that communities' voices are heard and adapted in project implementation. The General Health Inspectorate will conduct counter-verification of services provided under the PBF program. To ensure independent verification, an international agency specialized in PBF will be contracted to conduct counter-verifications at least twice during the project period. This will ensure the accuracy of the counter-verification by an unbiased entity.

Table 1.1. Summary of Responsibilities by Concerned Parties

Level	Element	Responsibility
National	Steering Committee	Oversight of project in alignment with the NHDP
	Working Group on the Refugee Strategy	Coordination on refugee strategy of the Government, including coordination with UNHCR
	Secretary General of the MoH	Project coordination and oversight
	National PBF Unit	Overall management of PBF implementation
	DAF	Fiduciary management of project
	Sectoral Unit in charge of the procurement process	Support procurement of project
	Public Hygiene Department	E&S safeguards of project
	MoH directorates[32]	Technical support for project implementation and capacity building, according to their respective missions
	UNHCR and UNICEF	Coordination to identify refugees and support to assess needs of refugees and technical coordination for project implementation
	Office of the Inspector General	Support to counter-verification activities
	Technical Working Group	Orientation of regional PBF implementation

[32] The project will coordinate with units in all the concerned directorates of the MoH responsible for health financing, refugees, nutrition and basic services, hospitals, planning and international cooperation, HMIS, public hygiene, RMNCAH-N, infrastructure, public health research, pharmaceuticals, and human resources for health throughout project implementation.

Level	Element	Responsibility
Regional	Regional Councils, the regional verification teams, Regional Health Directorates, and moughata'a, including the M'bera camp administration	Regulatory agencies involved in verification activities and decentralized coordination of PBF
	NGOs, CBOs, refugee groups, and other service providers	Community verification activities and support to implement the National Community Health Strategy (NCHS) and adolescent health activities
	Technical assistance providers	Support for project implementation, capacity building, and operations research activities
	Health facilities, including nongovernmental facilities in the M'bera camp	Provision of health and nutrition services (promotional, preventive, and curative) to refugees
	Community agents, including refugee groups	Implementation of community-level PBF activities for the NCHS

2. **It will be necessary to decentralize administrative processes and increase the capacity of regional health teams because the geographic target areas will be expanded, so a significant increase in transaction volume is anticipated.** The project will support regional coordination committees, councils, health teams, and verification teams in the target areas to increase their capacity to supervise and monitor the implementation of health programs, analyze data related to health services, and verify requests for payment from health facilities. Because the three pilot regions under the INAYA Project have gained significant experience in PBF implementation, their experts will train implementation partners in other regions to ensure smooth project implementation. The project will explore a feasible way of decentralizing financial management and supporting project management and financial management at subnational levels. The project will use the existing PBF portal for timely reporting and digital verification.

Financial Management

3. **In line with guidelines in the Financial Management Manual for World Bank IPF Operations, which became effective on March 1, 2010, and were last revised on February 10, 2017, a financial management assessment was conducted within the MoH.** The Government is implementing four World Bank-supported health projects: the INAYA Project (P156165, US$40.00 million), the SWEDD Project (P150080, US$75.00 million), the REDISSE Project (P161163, US$20.00 million), and the COVID-19 Project (P173837, US$40.20 million). It was agreed that the DAF will provide the financial management functions for the proposed project through arrangements established under the ongoing INAYA Project (P156165). The objectives of the financial management assessment were to determine whether the existing financial management arrangements are capable of correctly and completely recording all transactions and balances related to the project; facilitating the preparation of regular, accurate, reliable, and timely financial statements, safeguarding the project's assets; and ensuring compliance with acceptable auditing standards.

4. **The assessment revealed that the proposed implementing agency has a good track record in World Bank-supported project implementation.** The INAYA Project has a qualified, experienced financial management team of one financial management specialist, two accountants, and one internal auditor; proper books of accounts and supporting documents have been maintained for all expenditures; the PIU is equipped with multi-project accounting software that will be easily integrated into the project's accounts; and an adequate internal control system and budget preparation and monitoring tools are in place. Therefore, the INAYA Project's financial management performance was rated Satisfactory at its closure in December 2023. However, the project's financial management arrangements must be further strengthened to comply with the requirements under the World Bank policies and procedures for IPF operations.

5. **Project risk, before implementation of mitigation measures, is considered Substantial because of the following risks associated with project activities:** fraud and inaccurate reporting on the indicators that generate PBF payments, insufficient capacity of staff to handle a larger scale World Bank-supported project, and political interference with PBF payments that may result in ineligible expenditures. The conclusion of the financial management assessment is that the existing financial management arrangements are adequate. Subject to the implementation of the financial management action plan described in Table 1.2, the residual financial management risk is **Moderate**.

Table 1.2. Financial Management Action Plan

Action	Due by
Recruit two accountants with qualifications and experience satisfactory to the World Bank to strengthen the financial management team.	One month after effectiveness
Recruit an external auditor with terms of reference satisfactory to the World Bank.	Within six months after effectiveness
Sign a memorandum of understanding with the General Inspectorate of the MoH to act as independent verification agent for PBF payments.	Within six months after effectiveness

Financial Management and Disbursement Arrangements

6. The following are the financial management arrangements for the project.

Internal Control Arrangements

7. The administrative and financial procedures manual clearly describes the approval and authorization processes in accordance with the principle of segregation of duties.

Internal Auditing Arrangements

8. The MoH’s internal inspectorate is not yet able to conduct the internal audit of the project’s activities, so the current internal audit framework of the INAYA Project will be implemented, and an internal auditor will be recruited. In this context, the internal auditor for the INAYA Project will be evaluated, and if the results are satisfactory, the terms of reference will be revised to include internal audit activity under the new project.

Accounting Arrangements

9. The accounting standards in use in Mauritania for ongoing World Bank-supported projects will be applicable. The project accounts will be maintained on an accrual basis and supported with appropriate records and procedures to track commitments and safeguard assets. The DAF will prepare annual financial statements. The project's accounting system will be designed to record expenditures in such a way as to ensure that reports can be provided for each source of funding.

10. Accounting software will be installed to generate accurate financial reports and data.

Budgeting Arrangements

11. **Every year, the DAF will prepare a budget based on the agreed-upon annual work program and procurement plan.** The Program Steering Committee will adopt the budget before the beginning of every calendar year, and the DAF will monitor the execution of the budget quarterly. The budgeting process and monitoring will be clearly defined in the administrative and financial procedures manual. Annual draft budgets will be submitted for the World Bank’s ‘no

objection' before adoption and implementation no later than November 15 every year. The financial management team will prepare periodic reports of budget monitoring and variance analysis.

Financial Reporting Arrangements

12. **The DAF will prepare quarterly interim financial reports for the project in form and content satisfactory to the World Bank** and submit them to the World Bank within 45 days after the end of the quarter to which they relate. The DAF has prepared and agreed with the World Bank on the format of the interim financial reports during negotiations. The DAF will also prepare project financial statements in compliance with international accounting standards and World Bank requirements.

Auditing Arrangements

13. **The Financing Agreements will require submission of audited financial statements for the project to the IDA within six months after the end of each fiscal year.** The audit report should reflect all project activities. An external auditor with qualifications satisfactory to the World Bank will be appointed to audit the project financial statements annually (see Table 1.3).

Table 1.3. Audit Report Timeline

Audit Report	Entity	Due Date
Annual audited financial statements and Management Letter	DAF	June 30 N+1

14. **Results will be verified before payment is made.** In many cases, the responsibility for this verification is assigned to an independent entity. Further details regarding this verification process have been outlined in the PBF manual.

Disbursement Arrangements

15. **The following disbursement methods may be used under the project:** reimbursement, advance, direct payment, and special commitment, as specified in the Disbursement and Financial Information Letter. In accordance with the Disbursement Guidelines for IPF, dated February 2017, disbursements will be transaction based and withdrawal applications will be supported by a statement of expenditures. Retroactive financing for a maximum amount of SDR 7.60 million (US$10.00 million equivalent: US$2.00 million equivalent from WHR grant, US$3.00 million from GFF grant, and US$5.00 million equivalent from SUW-SML credit) or less than 20.0 percent of the total funding of the above grants, respectively, is allocated for the proposed project. Eligible activities may include: (a) PBF subsidy payments; and (b) operational costs related to the roll out of the PBF subsidy payments, such as verifications and counter-verifications, and other needs. The eligible expenditures made on or after January 1, 2024, and before the signing of the Grant Agreements are proposed for this retroactive financing.

16. **All replenishments or reimbursement applications will be documented using customized statements of expenditures for PBF payments and standard statements of expenditures for all other expenditures.** Detailed supporting documentation will be retained at the DAF for review by World Bank staff and auditors. The disbursement letter will provide details of the disbursement methods, required documentation, designated account ceiling, and minimum application size.

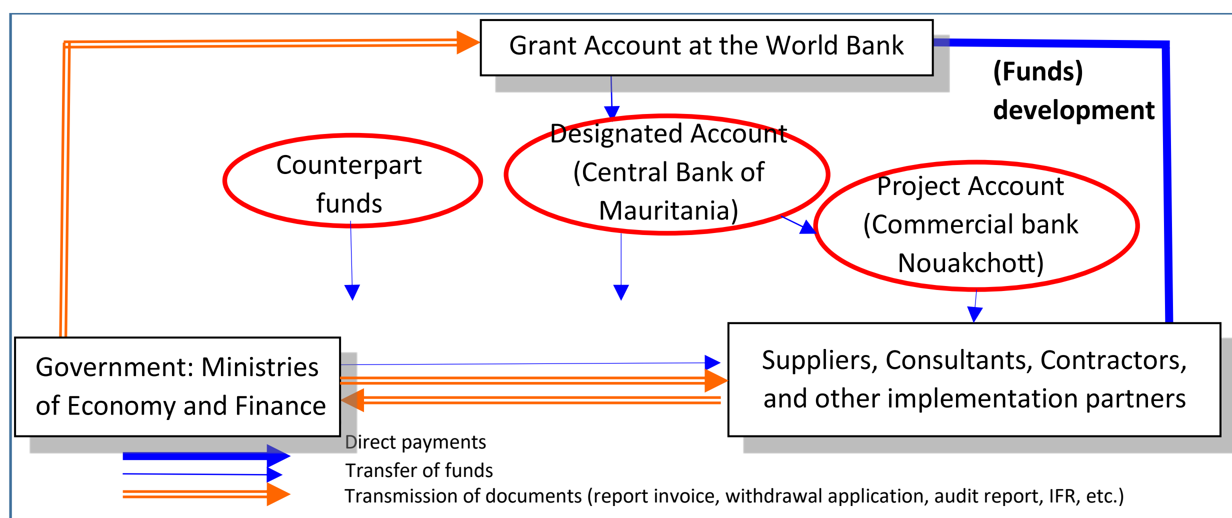
Banking Arrangements

17. **A Designated Account for the project will be opened at the Central Bank of Mauritania, and a project account will be opened at a commercial bank in Nouakchott on terms and conditions acceptable to the World Bank.** The Designated Account will be used for all eligible payments financed by the credit, as indicated in the specific terms and conditions of the Financing Agreements.

Flow of Funds Arrangements.

18. The flow of funds arrangements for the project are shown in Figure 1.1.

Figure 1.1. Flow of Funds Arrangements



Implementation Support Plan

19. Based on the outcome of the financial management risk assessment, the implementation support plan outlined in Table 1.4 is proposed. The objective of the implementation support plan is to ensure that the DAF maintains a satisfactory financial management system throughout the project's life.

Table 1.4. Implementation Support Plan

Financial Management Activities	Frequency
Desk reviews	
Interim financial report review	Quarterly
Internal audit report review of the program	Quarterly
External audit report review of the program	Annually
Review of other relevant information such as interim internal control systems reports	Continuous as they become available
On-site visits	
Review of overall operation of financial management system	Annual for implementation support mission

Financial Management Activities	Frequency
Monitoring of actions taken on issues highlighted in audit reports, auditors' Management Letters, internal audit, and other reports	As needed
Transaction reviews (if needed)	As needed
Capacity-building support	
Financial management training sessions	During implementation and as needed

20. **Conclusion of the financial management assessment.** Based on the assessment, the financial management arrangements of the DAF need to be strengthened to meet the requirements of the IPF policy and directive.

Procurement

21. The procurement assessment confirmed that the MoH is responsible for project preparation, and the MoH has relevant experience with World Bank procurement procedures. Additionally, the project will retain experienced staff from the INAYA Project's PIU and hire additional staff as needed to enhance project management capacity.

22. After the assessment, and given that the PIU will perform project procurement, the overall risk of implementation in procurement is **Moderate.** The mitigation measures to be taken are as follows:

(a) Recruit a qualified procurement specialist for the PIU to ensure quality control of procurement activities.

(b) Recruit a procurement assistant to assist the procurement specialist in managing and organizing procurement files within the procurement department and other relevant control structures and to archive the project procurement documents.

(c) Train the team in charge of project procurement within the PIU and within the ministry's Procurement Commission on the New Procurement Policy for World Bank-supported projects.

(d) Prepare an administrative and financial procedures and procurement manual for the project.

(e) Prepare a manual for execution and monitoring of project activities.

23. Procurement decisions subject to prior review by the World Bank, as stated in Appendix 1 to the Procurement and Consultant Guidelines, are detailed in Table 1.5:

Table 1.5. Summary of Procurement and Consultant Guidelines

Expenditure Category	Contract Value (US$, millions)	Procurement Method	Contract Subject to Prior Review
Works	≥25.0	International competitive bidding	All contracts
	<25.0	National competitive bidding	All contracts <10,000,000 are subject to post review
	<0.25	Shopping	n.a
Goods	≥10.0	International competitive bidding	All contracts
	<10.0	National competitive bidding	All contracts <2,000,000 are subject to post review
	<0.1	Shopping	n.a
Consultants (firms)	≥6.0	Quality cost-based selection; quality-based selection; least-cost selection; fixed budget selection; direct selection	All contracts

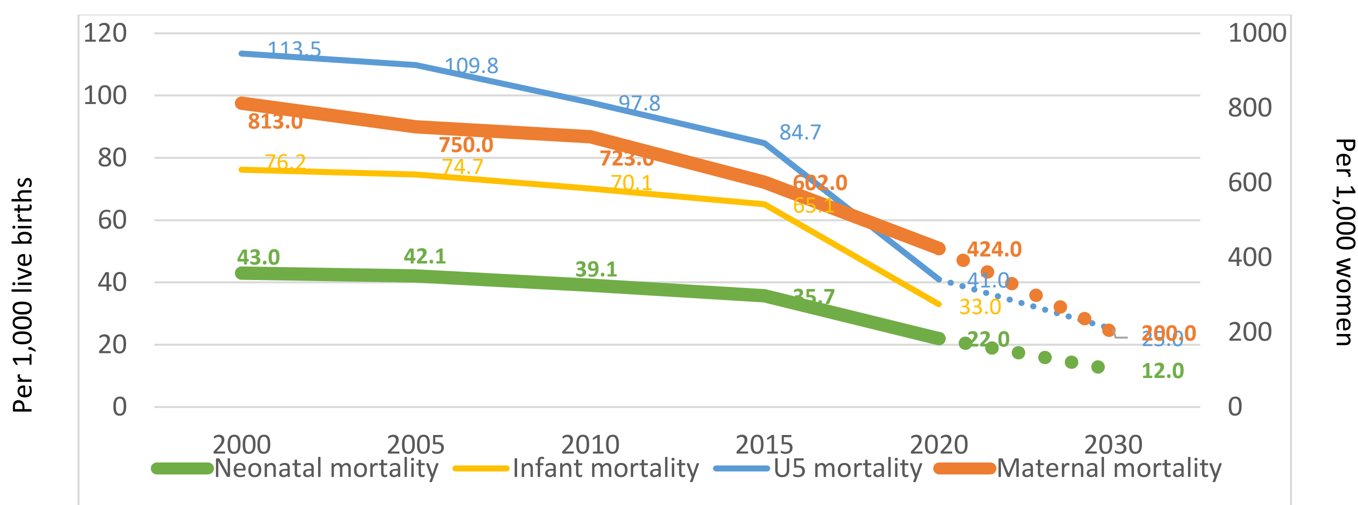
Expenditure Category	Contract Value (US$, millions)	Procurement Method	Contract Subject to Prior Review
	<6.0	Quality cost-based selection; quality-based selection; least-cost selection; fixed budget selection, direct selection	All contracts <1,000,000 are subject to post review (except task team leader decision)
	<0.6	Consultant qualifications selection	n.a
Consultants (individuals)	≥0.5	Expression of interest	All contracts
	<0.5	Expression of interest	Prior review for project implementation staff
	<0.1	Comparison of three résumés	
Short list of national consultants	<0.2	Consulting services	All contracts
	≦0.3	Engineering & construction supervision	All contracts

Notes: All terms of reference and technical specifications regardless of the value of the contract are subject to prior review.
An expression of interest must be published for recruitment of firms and individual consultants greater than US$100,000 and key project personnel and is highly recommended for recruitment of individual consultants less than US$100,000.

ANNEX 2: Trends in Maternal and Child Mortality Rates

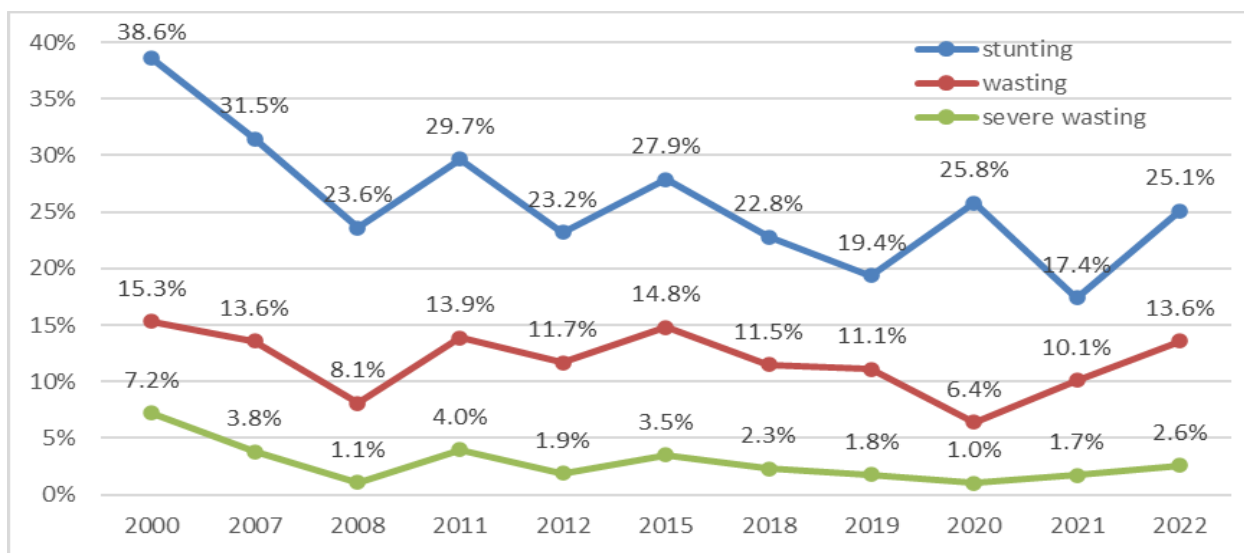
1. Figure 2.1 shows the trends in maternal and child mortality rates and Figure 2.2 shows the nutritional status among children under five years of age since 2000 against the 2030 targets.

Figure 2.1. Trends in Maternal and Child Mortality Rates



Source: United Nations Statistics Division http://unstats.un.org/

Figure 2.2. Trends of Under-Five Child Nutrition Status



Source: UNICEF/WHO/World Bank Joint Malnutrition Estimates Expanded Databases May 2023
https://data.unicef.org/topic/nutrition/malnutrition/

ANNEX 3: Selection of the Target Regions in Phase 1

1. The selection of the target regions was based on poverty rate, presence of refugees, neonatal mortality rate, prevalence of child stunting, percentage of assisted deliveries, coverage of health facilities within a 5 km radius, childhood vaccination coverage, prevalence of zero-dose children, and average public health spending. Table 3.1 shows (highlighted in red) the regions where their performance of the respective indicators is lower than the national average.

Table 3.1. Selection Criteria for the Target Regions in Phase 1

Wilaya		Population (projection in 2024)	Synergies with other interventions					Poverty rate	Neonatal mortality rate	Prevalence of child stunting	Percentage of deliveries assisted by a qualified health worker	Geographic coverage (within a 5km radius)	Vaccination coverage for PENTA 3	Number of zero dose children	Public expenditure on health (average in US$)	Number of indicators in red	**Ranking**
			Tekavoul	INAYA	SWEDD	CNAM	CNASS										
HEC	Hodh Chargui	568,434	Yes	Yes	Yes	Yes	2024	24.5	21	35.6	37.3	72.53%	44.1	> 1,000	9.08	6	1: Continuation from INAYA project
HEG	Hodh Gharbi	351,967	Yes	Yes	Yes	Yes	2024	34.2	24	30.7	51.1	69.68%	71.0	> 1,000	8.20	8	1: Continuation from INAYA project
GUD	Guidimagha	346,326	Yes	Yes	Yes	Yes	2024	48.6	23	27.9	56.0	83.87%	83.7	> 1,000	6.78	5	1: Continuation from INAYA project
ASS	Assaba	424,985	Yes		Yes	Yes	2025	39.4	24	28.0	64.9	72.35%	72.8		11.01	6	2: Synergy with SWEDD project
GOR	Gorgol	401,341	Yes		Yes	Yes	2025	34.3	31	27.3	68.6	82.59%	67.1		14.18	6	2: Synergy with SWEDD project
BRA	Brakna	340,644	Yes		Yes	Yes	2023	41.1	29	19.3	79.9	83.48%	80.0		7.53	3	3: Synergy with SWEDD project
TRA	Trarza	327,199	Yes			Yes	2026	24.8	19	23.0	92.8	86.12%	79.8		11.38	1	4: Geographical continuation in rural areas
ADR	Adrar	60,702	Yes			Yes	2026	34.9	45	32.9	78.5	87.26%	81.4		21.53	4	3
NDB	Dakhlet Nouadhibou	166,268	Yes			Yes	2025	10.9	16	13.0	98.5	98.68%	97.3		25.31	0	
Tag	Tagant	87,306	Yes			Yes	2027	45.0	42	37.0	61.1	69.41%	76.3		15.36	6	2
INC	Tiris Zemour	28,909	Yes			Yes	2026	15.5	20	22.5	97.9	82.33%	71.0		30.63	1	
TRZ	et Inchiri	59,534	Yes			Yes	2027	15.6				98.91%			76.62	1	
NKT	NKT Ouest	1,418,272	Yes			Yes	2023	14.3	12	14.5	98.8	100%	71.0		52.20	1	
	NKT Nord		Yes			Yes			17	18.3	99.2		86.8			0	
	NKT Sud		Yes			Yes			9	18.5	98.1		69.0	> 6,000		2	Higher ranking than Trarza, however, NKT Sud is urban area, which will require a different strategy. Thus, NKT Sud will be prioritized in Phase 2.
National		**4,581,887**						**28.2**	**22**	**25.8**	**70.4**	79.83%	**72.4**		**21.57**		
Sources								EPCV 2019-	EDS 2019-20	EDS 2019-2021	EDS 2019-2021	2022	EDS 2019-2021	IHME 2021	2017		

2. The prioritization was made to select the target regions in Phase 1, considering the continuation from the INAYA Project (Hodh Chargui, Hodh Gharbi, and Guidimagha) and the number of indicators lower than the national average. In terms of their performance, apart from the three pilot regions under the INAYA Project, Assaba, Gorgol, and Tagant regions have the highest number of indicators below the national average, followed by Adrar and Brakna regions. Nouakchott South was ranked higher than Trarza; however, it is located in an urban area and requires a different strategy from the one in rural areas. Additionally, considering the geographical continuity in the rural areas, as the project will require a stronger referral system, Trarza was selected as one of the target regions in Phase 1.

3. Additionally, Hodh Chargui and Hodh Gharbi host the majority of refugees. Thus, the proposed project is designed to address the need for refugees and host communities in collaboration and partnership with other sectors and other agencies such as UNHCR and UNICEF. This is in alignment with the Government's Strategy on Refugees and Host communities of July 2023, which aims to improve access to quality health services, prevent diseases and promote health for refugees with community participation in Mauritania. The intended interventions include building the resilience of health facilities to absorb acute inflows of refugees, improving supply and logistics of essential medicines, and advocating for sustainable funding. In the medium term, the Government will explore the introduction of financial participation in the health insurance scheme from refugees, as part of its strategy for integrating refugees into the national health systems.

4. All the nine selected regions have lower public expenditure in health despite having a higher poverty rate than the national average (except Hodh Chargui). Hodh Gharbi has all eight indicators lower than the national average. Hodh Chargui, Hodh Gharbi, Adrar, and Tagant have an alarming child stunting rate (more than 30 percent). Hodh Chargui, Hodh Gharbi, Assaba, and Tagant have lower geographical coverage of health services (see the non-coverage areas in Figure

3.1). Hodh Chargui has the lowest performance in service delivery in skilled birth attendance and childhood vaccination despite having better poverty rate than other selected regions.

Figure 3.1. Health Facility Map

Source: MoH Mauritania (modified by the World Bank Cartography Program)

ANNEX 4: Climate Action and Contribution to Adaptation and Mitigation

1. Risk-reduction measures incorporated into project design are summarized in Table 4.1.

Table 4.1. Climate Action and Contributions to Adaptation and Mitigation

Components and Subcomponents	Climate Action and Contribution to Adaptation and Mitigation
Component 1: Improve quality and increase use of RMNCAH-N services (US$36.00 million, IDA)	
Subcomponent 1.1: Improve delivery of quality RMNCAH-N services using PBF (US$34.00 million, IDA)	**PBF grants to health facilities to improve RMNCAH-N services for pregnant women and children under five** will ensure that women and young children have access to health and nutrition services to address the effects of climate change such as vector-borne and water-borne diseases that can increase rates of malaria and diarrheal disease.
	PBF indicators for climate-sensitive diseases are included in the country's PBF checklist. Quantity indicators include the number of pregnant women who receive preventive treatment for malaria, the number of severely malnourished children under five who receive treatment, and referrals of suspected malnourishment cases by CHWs to appropriate health service providers. Quality indicators include the number of pregnant women who attend comprehensive prenatal care visits, including receipt of sulfadoxine-pyrimethamine and an insecticide-treated net; the number of severely malnourished children under five who receive treatment according to clinical standards; and assessment of nutritional status among outpatient individuals.
	Climate emergency plans and contingency measures for climate shocks and other health emergencies will be prepared for health centers and health posts. Development of climate emergency preparedness and response plans and micro plans at primary health facilities will enable adaptation to climate shocks and prevent disruptions to service delivery. Capacity building on contingency measures and disaster response protocols to guide health workers and facilities during climate-related events, including power outages from flooding and extreme heat, will also be integrated.
	Technical assistance will be provided to increase access to medicines and medical supplies during climate and health emergencies. The project will ensure that hospitals and health centers have sufficient capacity and resources to provide necessary medical treatments during climate emergencies, including a contingency plan to pre-position medicines and other essential supplies for quick deployment.
Subcomponent 1.2: Increase equity in use of RMNCAH-N services (US$2.00 million, IDA)	**Training sessions on climate emergency preparedness and response** will be provided for frontline health workers, including CHWs, and other community actors and members, including adolescents from youth clubs. Specific modules on climate emergency preparedness and response will be included. Incorporation of these modules into the various training sessions expected to be delivered will help increase the resilience of health service delivery to climate shocks. It will also increase competency levels on climate change and health promotion and prevention activities to increase the awareness of the population and improve their coping strategies for heat stress and exhaustion on hot days.
	Health worker training will be provided on prevention of diarrheal and vector-borne diseases. Through expansive, competency-based capacity building of health personnel, the project will provide training on climate risks in health facilities focused on anticipating and activating prevention measures to minimize increases in diarrheal diseases after weather events. Provision of these services would improve treatment of diarrhea and other climate-sensitive, vector-borne diseases in households with pregnant women and children under two years of age.

Components and Subcomponents	Climate Action and Contribution to Adaptation and Mitigation
	Health worker training on nutrition and food security, including climate considerations, will be provided. This subcomponent would support competency-based training for health workers in the provision of food security and nutrition support and in the climate considerations of undernutrition and food insecurity to increase the adaptive capacity of populations. Provision of these services would increase resilience in the face of the adverse health and nutritional consequences of climate change.
Component 2: Strengthen health systems (US$12.30 million, IDA)	
Subcomponent 2.1: Operationalize health sector reforms (US$5.00 million, IDA)	**Technical assistance will be provided to support development of climate-resilient infrastructure standards**, including building codes and licensing systems; accreditation of health facilities; and design of minimum quality standards for health facilities for climate resilience. This will facilitate adaptation and resilience to extreme weather events.
	Digital health information management systems will also be strengthened to ensure better integrated surveillance and monitoring of climate-sensitive diseases and better predictive capabilities of climate-sensitive disease outbreaks.
Subcomponent 2.2: Ensure health facilities meet standards (US$5.00 million, IDA)	**Rehabilitation of health centers and health posts will include climate-specific adaptive design features** such as flood protection (for example, stilts, protective drainage measures, and dikes) in flood-prone areas; natural ventilation for health facilities to benefit from evaporative cooling, such as locating facilities where winds are more prevalent and ensuring cross-ventilation; solar protection such as extension of roofs for shading (double-skin solar protection) and reflective roofs to keep buildings cool; thermal inertia to ensure comfortable temperatures indoors using roof and wall insulation that absorbs heat and keeps buildings cool; and rainwater and graywater management, which will enable water to be collected and used for non-potable applications and reduce the impacts of flooding, such as soak-away installation to drain gray waters back to the soil, native vegetation to reduce water use for irrigation, grid paving to help prevent runoff while avoiding the heat island effect, and permeable surfaces for roads, parking lots, and walkways. Other aspects will also be considered during E&S screening of the sites, such as location of the site (for example, high ground versus flood prone, known hazards such as mudslides versus low likelihood of hazards).
	Rehabilitation of health centers and posts will include climate-specific, energy-efficient design features. Climate-resilient, energy-efficient water supply and storage infrastructure will be built, which will increase water access and water-use efficiency. Health centers and posts will be equipped with solar panels, which enable 24/7 electricity generation and mitigate GHG emissions by reducing use of diesel-powered generators. Energy-efficient lighting (for example, Energy Star light-emitting diode lights) and light control measures (for example, dimming and occupancy sensors) will also be procured.
	Water, sanitation, and hygiene infrastructure will be improved to withstand climate disasters. This subcomponent will finance improved, energy-efficient water, sanitation, and hygiene infrastructure in health centers and posts, which will increase access to sanitation services during climate shocks, particularly flooding, to help reduce the incidence of waterborne diseases, which are climate sensitive in Mauritania.
	Essential energy-efficient medical equipment will be procured. Medical equipment such as ultrasound scanners, obstetrical stethoscopes, blood pressure monitors, and delivery tables will use standard Information, Education, and Communication 60601-1-9, *General Requirements for Basic Safety and Essential Performance—Collateral Standard: Requirements for Environmentally Conscious Design*, issued by the International Electrotechnical Organization (Geneva, Switzerland).
	Energy-efficient vehicles will be purchased for administrative purposes in Nouakchott (urban center) and for use in rural and remote regions of the country. These vehicles have a consumption rate of 7.9 L per 100 km, compared to older-generation vehicles that consume 15–20 L per 100 km. By using energy-efficient vehicles, the project aims to reduce its contribution to pollution and GHG emissions.

Components and Subcomponents	Climate Action and Contribution to Adaptation and Mitigation
Subcomponent 2.3: Increase national capacity for pandemic prevention, preparedness, and response (US$2.30 million, IDA)	**Strengthening the community-based disease surveillance system and early warning system to respond to shocks, including climate change,** will enable health facilities and communities to respond better to disease outbreaks and climate-related health impacts from extreme weather events. This will include meteorological/weather surveillance to improve use of information for detecting, investigating, responding to, and alerting/communicating public health threats.
	Increasing the use of health and nutrition data will help the MoH identify progress more effectively on interventions for nutrition and climate-sensitive diseases (for example, malaria, diarrheal diseases) and the status of health and nutrition outcomes. Health and nutrition data will be overlaid with meteorological data to clarify the relationship between health and climate change, which will help address nutritional and climate-sensitive health problems, increasing the country's resilience to climate change.

ANNEX 5: Synergies with the Existing World Bank-Supported Health Sector Projects

1. The proposed program will consolidate the existing health sector projects in Mauritania.

2. **Sahel Women's Empowerment and Demographic Dividend Project (P150080)—US$75.00 million equivalent (project closing date: December 31, 2024).** This regional project is designed to empower women and adolescent girls by facilitating their access to good-quality reproductive health services in the six target regions. The project has been closely working with the ongoing Basic Education Sector Support Project Phase II (P163143) and Social Safety Net System Project II (P171125). Major achievements include granting scholarships to disadvantaged girls to keep them in school, training health professionals, making 400,000 people aware of women's empowerment and reproductive health challenges, and creating safe spaces for young girls. The project has established a national legal platform and organized meetings with parliamentarians to support women's autonomy. The project piloted community-driven distribution of family planning commodities and mobile clinical teams to reach remote areas. Health workers and survivors of GBV in the target regions will be trained in prevention and management of and psychosocial support related to GBV.

3. **Mauritania COVID-19 Strategic Preparedness and Response Project (P173837)—US$40.20 million equivalent (project closing date: December 31, 2024).** The project helps Mauritania respond immediately to COVID-19 outbreaks and conduct intensive COVID-19 vaccination campaigns nationwide with timely acquisition of COVID-19 vaccines. The project has increased surveillance and diagnostic capacity through training for points-of-entry staff, laboratory staff and biologists; provision of ambulances, test kits and commodities; and strengthening of case management capacity with equipped isolation centers and reequipped health centers and hospitals, including GBV treatment and psychological support for GBV survivors. The project has enhanced the national vaccination system with the provision of cold chains, improved real-time data collection, analysis and use for decision-making, and deployment of vaccines to the subnational and community levels. The project further intensified risk communication and community engagement to prevent and control COVID-19 infection; promote the COVID-19 vaccination campaigns and routine vaccinations, which boosted overall COVID-19 vaccination coverage; and promote the continued use of essential health and nutrition services. The project supports the first resilience assessment in the health sector in Mauritania to help establish a network of disaster referral facilities under the MPA. Before its closure, the project will further increase prevention and preparedness capacity and strengthen the disease surveillance information management system at the decentralized level.

4. **Regional Disease Surveillance Systems Enhancement Project Phase III (P161163)—US$20.00 million equivalent (project closing date: March 31, 2024).** This regional project made significant progress in increasing national and regional capacities for disease surveillance and epidemic preparedness and response in the event of a health crisis. The project has helped the Government establish a One Health platform to promote cooperation between environmental, animal and human health agencies. The platform has managed several outbreaks, including COVID-19, Rift Valley fever, Crimean Congo hemorrhagic fever, avian influenza, and polio. Other major achievements include increasing the capacity of laboratories; establishing a functional community-based disease surveillance with immediate reporting of any unusual event observed in animals or humans in nine regions; training 25 agents from the ministries of human, animal and environmental health in Masters in Epidemiology and more than 200 other staff from these three ministries in first-line epidemiology; establishing sentinel herds for hemorrhagic fever surveillance; reinforcing the Kobo toolbox real-time information system; and acquiring a mobile veterinary clinic. Furthermore, at the beginning of the COVID-19 pandemic the Mauritania-REDISSE Project also allocated about US$7.00 million for the response by purchasing personal protective equipment, masks, hydroalcoholic gels, reagents and consumables for diagnosing cases; training health workers in infection prevention and case management; purchasing hospital beds, respirators, and other equipment; and funding awareness-raising activities to prevent the spread of COVID-19.

ANNEX 6: Summary of Support from Development Partners

1. Table 6.1 provides a summary of the support received from various development partners in the health sector. It outlines the key domains and activities supported by each partner, along with any remarks or additional information. The development partners include the Global Fund to Fight AIDS, Malaria, and Tuberculosis, the Global Alliance for Vaccines and Immunization (GAVI), the European Union/Belgian Development Agency, *Agence Francaise de Développement* (French Development Agency), the United States Agency for International Development, WHO, UNICEF, UNFPA, and the Islamic Development Bank. The support provided by these partners ranges from combatting specific diseases to strengthening health systems, improving maternal and child health, supporting family planning, and enhancing supply chain management.

Table 6.1. Summary of Support from Development Partners

Development Partner	Key Domains	Remarks
Global Fund to Fight AIDS, Malaria, and Tuberculosis	• Activities to combat HIV, tuberculosis, and malaria. • Technical assistance for financing for public health system strengthening. • Support for the HMIS and other information systems and supply chain management in the health sector • Technical assistance for the community health program • Strengthening of laboratory networks	The next funding cycle in 2024–2026 is projected at US$20.00 million.
GAVI	• Technical assistance for childhood vaccination (introduction of new vaccines, routine vaccination, and vaccination campaigns for polio and measles) • Support for cold chain system • Support for decentralized operations includes activities such as supportive supervision, supply chain management, and data management	Collaborative efforts to strengthen the vaccination system. The next funding cycle in 2024–2026 is projected at US$7.00 million.
European Union/Belgian Development Agency	• Support for establishment and operationalization, including the accreditation system of the CNASS • Technical assistance for the MoH in development of norms and standards of human resources for health, equipment, and packages of services at various levels of care • Digitalization of human resources for health system and patient records • Support for the development of the interoperability strategy for digital in health	Exploring collaboration for health financing and development of norms and standards Ongoing project (2022–2024) at US$45.00 million
French Development Agency	• Public health service improvement for maternal and child health in targeted regions	Technical collaboration Ongoing project (2022–2024) at €5.00 million
United States Agency for International Development	• Technical assistance for leadership and governance in family planning and maternal and child health to advance Family Planning 2030 goals	Technical collaboration
WHO	• Technical assistance for health financing • Technical assistance for development of norms and standards, including revision of the Integrated Management of Acute Malnutrition Protocol	Technical collaboration

Development Partner	Key Domains	Remarks
	• Technical assistance for human resources for health • Greater access to medicines • Technical assistance for digitalized patient records	
UNICEF	• Support for decentralized social services for vulnerable populations, especially young girls, with changes in social norms. • Support of *Groupe d'Apprentissage et de Suivi des Pratiques Alimentation du Nourrisson et du Jeune Enfant* • Strengthening of the health system to adapt public services for climate change or global warming, with active citizen participation. • Case management of malnourished children • Early childhood development	Technical collaboration to improve adolescent health, community health, and the management and prevention of severe acute malnutrition in children, pregnant women, and lactating mothers
UNFPA	• Support for family planning through distribution of family planning commodities and delivery kits • Support for adolescent health with youth networks • Action against female genital mutilation	Technical collaboration for emergency obstetric and newborn care network and adolescent health
Islamic Development Bank	• Provision of health equipment • Exploration of the industrialization of the health sector for the production of essential medicines.	Exploring collaboration in supply chain management and EmONC networks strengthening The ongoing project (2023–2026) at US$18.19 million