

**COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED
SAFEGUARDS DATA SHEET (PID/ISDS)
CONCEPT STAGE**

Report No.: PIDISDSC15732

Date Prepared/Updated: 03-Oct-2016

I. BASIC INFORMATION

A. Basic Project Data

Country:	Mauritania	Project ID:	P156165
		Parent Project ID (if any):	
Project Name:	Health System Support (INAYA) (P156165)		
Region:	AFRICA		
Estimated Appraisal Date:	12-Jan-2017	Estimated Board Date:	30-Mar-2017
Practice Area (Lead):	Health, Nutrition & Population	Lending Instrument:	Investment Project Financing
Borrower(s):	Islamic Republic of Mauritania		
Implementing Agency:	Ministry of Health		
Financing (in USD Million)			
	Financing Source		Amount
	BORROWER/RECIPIENT		2.00
	International Development Association (IDA)		15.00
	Financing Gap		0.00
	Total Project Cost		17.00
Environmental Category:	B - Partial Assessment		
Concept Review Decision:	Track I - The review did authorize the preparation to continue		
Is this a Repeater project?	No		
Other Decision (as needed):			

B. Introduction and Context

Country Context

1. Mauritania has undergone a rapid transition from a largely rural and nomadic society towards sedentary and urbanization. It is a mostly desert country, with a population of about 3.5 million. The capital Nouakchott has seen the second-highest urban expansion in Africa over the twentieth century, growing by 10.4 percent per year between 1950 and 2010, and now accounts for up to a quarter of the country's population.

2. Recently, Mauritania has enjoyed political stability after a series of internal shocks with the most recent being the 2008 military coup that deeply affected its political environment and weighed heavily on its economic performance.

3. Mauritania is a newly lower middle-income country, with a Gross National Income per capita (current US\$, Atlas method) estimated at US\$1,270 in 2014. Over the last five years, Mauritania has enjoyed strong growth, registering 6.4% GDP growth in 2014. As in many African countries, Mauritania recent mineral discoveries have stimulated growth and raised incomes. The outlook for the medium term remains cautiously optimistic, with an average of 6.4% real GDP annual growth between 2015 and 2017. The anticipated expansion in mining output will play the biggest role in maintaining the macroeconomic system sound.

4. Despite its natural resources and economic growth, poverty levels are high and social indicators remain low: Mauritania was ranked 161st out of the 187 countries tracked in the Human Development Index (HDI). Poverty still affects a major part of Mauritania population, particularly in rural areas. However, according to the latest available household data poverty assessment (Poverty Dynamics and Social Mobility, WB, 2016), poverty declined from 44.5% in 2008 to 33% in 2014. During the same period, inequality had decreased from 35.3% to 31.9%.

Sectoral and Institutional Context

5. Mauritania was off-track regarding the health MDGs and growing Government revenues have not translated into health gains for the population, especially the most vulnerable. In effect, Mauritania has some of the worst health outcomes in Africa. Except for HIV-AIDS, the country did not meet any of the health-related MDGs. As for maternal health, maternal mortality has slightly decreased, but the current rate is still one of the highest in Africa (602 deaths per 100,000 live births in 2015 in comparison with a ratio of 626 in 2011 and 686 in 2007). In terms of child health, under-five mortality rate is roughly stagnant at 118 deaths for 1,000 live births in 2011 (122%o in 2007) and infant mortality rate is still high at 75 deaths for 1,000 live births (MICS, 2007). Mauritania is actually one of the very few countries in Africa where child mortality has not decreased over the last few years. Indeed, Mauritania is also one of the few countries where coverage of key interventions has not significantly increased in the recent years. For instance, immunization coverage (fully immunized children between 12-23 months old) has been only slowly increasing at 75 percent in 2014 (from 69% in 2008, Mauritania Poverty Profile 2008 and 2014). Similarly, malaria prevalence has increased since 2008. In addition, coverage of high impact health interventions is still low: for example, only 70% of births are attended by skilled health workers, but only around 50% for women from the lowest wealth quintile (against more than 90% for women in the highest quintile, according to the Mauritania Poverty Profile 2014) and 20% of children with fever receive antimalarial drugs (MICS 2011). Even with some progress during the recent years, malnutrition is still an important issue and an obstacle to improve health outcomes with 12.1% of wasting prevalence, 21% of stunting and 20.4% of moderate underweight in 2015 (SMART Survey 2015).

6. Financial and geographical obstacles to access health services are partly explaining this

situation on the demand-side. More than 40% of the population lives more than 5km away from a functional health facility or at more than one hour away (Mauritania Poverty Profile report 2014) and population density in Mauritania is one of the lowest in the world with around 3 inhabitants per km². Moreover, with a poverty incidence of 33%, financial accessibility is an issue: About 44% of health spending is direct payments by households, which is average for SSA (NHA, 2014). Using the WHO benchmark, 1.5% of the population is likely to fall into poverty because of catastrophic health spending (more than 160 people a day). Only 15% of the population is covered by the National health Insurance Scheme (Caisse Nationale d'Assurance Maladie) and Health Mutuals (Community-Based Health Insurance Schemes) cover only 0.3% of the population. Vulnerable groups (mainly poor households) are the most affected by the financial burden of health care. Moreover, free health care and subsidized programs (malaria and obstetrical care) are underfunded and inefficient. Additionally, very fast urbanization of Mauritania has put pressure on social services, worsens living conditions of population and weakened traditional support networks (in 2014, 51% of the population live in cities in comparison with only 9.1% in 2000).

7. Low utilization of health services and poor health outcomes result also from the weak quality of care because of: lack of essential drugs and equipment, unequal distribution of human resources and low level of financing at the peripheral level. The average availability of essential drugs (13 tracers drugs) is only 33% (about 4 out of 13) and no health facility has all of the 13 essential drugs (health facilities assessment, SARA survey 2016). More than 50% of health facilities do not have essential equipment.

8. This situation is not explained only by a lack of Government resources. The government of Mauritania spends roughly 10% of its budget on health and social services, almost the same as Burkina Faso, Cote d'Ivoire and Kenya on per capita basis (PER Health 2015). Mauritania's health sector expenditures are low for a country of its wealth and not consistent with its stated development objectives. They are biased in favor of curative care rather than prevention, and particularly at the hospital level. 60% of the health ministry budget goes to hospitals, compared to 21% for primary health centers, and only 4 percent for preventive programs (Immunization, Reproductive Health, Fighting Against Malaria). However, the share of primary health care is gradually increasing. The weak allocative efficiency of PHE is combined with a low technical efficiency.

9. To face these challenges, the government developed a National Health Strategy (Plan National de Développement Sanitaire PNDS 2012-2020). The PNDS states the following Health System Strengthening strategies and reforms as the most important: (i) improving physical and financial access; (ii) revitalization of the national community policy (CHWs); (iii) reforming the pharmaceutical sector; (iv) developing a hospital reform; (v) developing a strategic plan for human resources for health; (vi) improving social health protection; (vii) reinforcement of institutional capacities and improving efficiency (through, among others, a Results-Based Financing-RBF strategy).

10. Mauritania has developed also a National Strategy for Social Protection and plans to implement a national program of unconditional social transfers. UNICEF has already implemented some pilot initiatives of cash transfers for the most vulnerable families (with PAM, FAO and EU). Moreover, a World Bank operation was approved in 2015 to support the Government to develop, pilot and fund the national program of social protection.

11. To improve efficiency and access to quality health services, the government developed an RBF strategy. The government is aware that to make any significant progress towards the SDGs, Mauritania needs to address the weak allocative efficiency and low technical efficiency of its public health expenditure. One of the recommendations of the Health Public Expenditure Reviews (Health-PER) carried out by the WB and MoH in 2011 and 2015 was to explore the potential of RBF mechanisms to address the efficiency and effectiveness issues at primary health care and hospital levels. With support from the WB, UNICEF and WHO, the Government of Mauritania has developed a health results-based financing strategy (validated by the National Health Steering Committee in September 2015). This strategy aims at ensuring efficiency of the health system and better access to health services, with a focus on Reproductive, Maternal, Neonatal and Child Health.

12. With the assistance of its partners, the government is preparing a national health care financing strategy. This effort is led by the Ministry of Health, assisted by WHO and other Development Partners, including the WB. According to the timeline, this strategy will be finalized and adopted by the government in early 2017.

Relationship to CAS/CPS/CPF

13. The development of RBF policy is a part of the CPS 2014-2017 HNP Section. The proposed operation (INAYA) supports pillar 2 (economic governance and service delivery), which aims at improving public sector performance, with special emphasis on local government performance strengthening and food security, and promotes increased access to basic social services. The proposed Project (as pilot) has for objective to increase access to quality health services, especially among the poorest: indeed, through Performance-Based Financing (supply side RBF), the Project will strengthen of service delivery at community, primary health care, and district levels; and through its RBF demand-side intervention, the Project will support access to basic health services for the most vulnerable households in selected districts/Mougataa.

14. Other international partners, especially EU, are interested in the RBF approach. Many DPs (Spanish Cooperation, Global Fund, EU) expressed their interest during their meetings with the WB and also when they participated in the national consensus workshop where the RBF strategy was approved. The EU has developed an EU executed Trust Fund proposal (Euro 46 million) which will support RBF, community health strategy, health information system. The project will start by November-December 2016.

C. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The Project Development Objective is to improve access to quality health services with a particular emphasis on Reproductive Maternal Neonatal and Child Health (RMNCH) services in selected districts.

Key Results (From PCN)

- Pregnant women receiving antenatal care during a visit to a health provider (number)
- Births attended by skilled professional (number)
- Children 12-23 months fully immunized (number)
- Average score of the quality of care checklist
- Direct project beneficiaries
- Conditional Cash Transfers Beneficiaries

The key results including intermediate outcome indicators will be refined during the preparation

D. Concept Description

17. The proposed Project is an RBF Pilot based on the National Health RBF Strategy (2015). RBF for health has been defined as "a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken." (www.rbfhealth.org).

18. The proposed operation comprises three components that aim to improve access to quality health services in selected districts (covering around 20% of the population; targeted districts have the highest poverty and morbidity prevalence, and all located in the south of the country). The interventions are targeting community health workers, health facilities (health centers and district hospitals), poor households, local NGOs and relevant institutions (mainly Ministry of Health but also Ministry of Social Affairs and Ministry of Interior) in order to enhance both supply and demand sides of the health system in the targeted areas.

Component 1: Supply and Demand Sides Results-Based Financing (RBF) Payments: US\$11 million

19. The first component, which accounts for the bulk of the project funds (US\$10 million), will pay bonuses to community health workers (CHWs) and facilities, according to their performance, as well as conditional cash transfers (CCTs) to poor households, according to their utilization of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services.

20. This component is subdivided into three sub-components:

21. The sub-component 1A will pay RBF bonuses in the targeted Districts (i) to CHWs for providing selected preventive, promotional, referral and basic curative health services; and (ii) to public health facilities, health centers and district hospitals, for provision of pre-identified services in the RBF package. Health services to be paid for through the RBF mechanism include, among others, primary health care and preventive services for pregnant women, deliveries and post-partum care, immunization services, care for children under the age of 5, family planning. The RBF payments will be linked directly to both quantitative and qualitative pre-defined indicators.

22. The sub-component 1B will pay some small grants to public health facilities at the beginning of the intervention. These payments will be in form of lump sums (between US\$ 15,000 for health centers and US\$ 50,000 for hospitals). They will finance light equipment and infrastructure investments in order to upgrade concerned facilities before starting the RBF process (and once investment plans are approved by the National Unit in charge of the Performance-Based Financing).

23. The sub-component 1C will pay CCTs to poor households (~ 20,000) listed in the National Social Registry (supported by the WB Social Protection project in Mauritania). The payment of CCTs will be done according to their utilization of Reproductive, Maternal, Neonatal and Child

Health (RMNCH) pre-defined services. This sub-component, fully coordinated with the WB SP Team, will use the new national social safety net program called Tekavoul for verification and payment.

Component 2: Support to the RBF process and technics: US\$3 million IDA and US\$2 million counterpart

24. The second component will support the external verification and payment processes. It will also be used for technical assistance, capacity building and impact evaluation.

25. It will support the strengthening of Ministry of Health capacity and other entities involved in RBF (supply and demand sides) in various areas that include monitoring and evaluation (M&E), impact evaluation, public financial management (PFM) and Procurement, health information system management, and RBF technics and database management. The component also supports verification activities - including internal and external controls- for the reported levels of services, the quality score, and utilization of RMNCH services to mitigate the risk of falsifications and errors in reporting.

Component 3: Promoting demand of health services at community level through local NGOs: US \$1 million

26. The third component is complementary to the CCTs. It will finance selected local NGOs that can foster the demand for better health utilization at community level.

27. It will support capacity building of local health committees and community-based organizations to increase service demand, promote healthy behavior, explain to their communities their rights and obligations, and help particularly vulnerable groups to access health services (other outreach activities could be developed during the preparation of the project). This activity is a perfect complement to the CCTs sub-component (1C).

II. SAFEGUARDS

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

The project will be implemented in selected districts, covering around 20% of the population and having the highest poverty and morbidity prevalence. All districts will be located in the southern parts of the country bordering the Senegal river, with a focus on rural areas. The interventions are targeting community health workers, health facilities (health centers and district hospitals), poor households, local NGOs and relevant institutions (mainly Ministry of Health but also Ministry of Social Affairs and Ministry of Interior).

B. Borrower's Institutional Capacity for Safeguard Policies

The institutional capacity in the country and the overall regulatory framework to undertake and supervise safeguard policies and procedures is relatively weak in Mauritania. Specific measures to improve this capacity and strengthen the system need to be included in the project design/activities. Targeted groups should include concerned staff at the ministry of environment, the ministry of health, the ministry of social affairs as well as the beneficiary communities, local health committees and community-based organizations.

C. Environmental and Social Safeguards Specialists on the Team

Dahlia Lotayef (GEN07)

Salamata Bal (GSU01)

D. POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>The proposed project will induce an increase in the production of health services (primary health care and preventive services for pregnant women, deliveries and post-partum care, immunization services, care for children under the age of 5, family planning, Malaria, TB, etc.) and the provision of medical supplies, light equipment and infrastructure investments in order to upgrade targeted facilities. The infrastructure investments may involve small-scale civil works which could have localized and site specific environmental and/or social impacts. Other activities will also lead to the generation of relative amounts of healthcare waste, and may involve some aspects of vector control under its malaria and TB activities.</p> <p>No large-scale, significant or irreversible impacts are anticipated.</p> <p>An Environmental and Social Management Framework (ESMF) will be prepared. The team will investigate during preparation whether a national health care waste management plan exists or has been developed in the context of other projects to guide the implementation of the project activities.</p>
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/ BP 4.12	No	The policy is not triggered as no civil works or land acquisition is planned under the Project.

Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

E. Safeguard Preparation Plan

1. Tentative target date for preparing the PAD Stage ISDS

01-Dec-2016

2. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the PAD-stage ISDS.

Finalization of the terms of reference and hiring of the consultant(s) for the preparation of the ESMF, including the Health Care Waste Management Plan and the Pest Management Plan (if needed) by beginning of mid-October 2016.

Completion of the final draft of the ESMF by mid-December 2016.

Dates to be confirmed during preparation.

III. Contact point

World Bank

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IV. For more information contact:

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V. Approval

Task Team Leader(s):	Name: Moulay Driss Zine Eddine El Idrissi
<i>Approved By</i>	

Safeguards Advisor:	Name: Maman-Sani Issa (SA)	Date: 03-Oct-2016
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 05-Oct-2016
Country Director:	Name: R. Gregory Toulmin (CD)	Date: 02-Nov-2016

1 Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.