Public Disclosure Authorized

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

Appraisal Stage | Date Prepared/Updated: 29-Jan-2020 | Report No: PIDISDSA27908

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Mauritania	P170585	Health System Support Additional Financing	P156165
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Health System Support	AFRICA	22-Jan-2020	10-Mar-2020
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Islamic Republic of Mauritania	Ministry of Health

Proposed Development Objective(s) Parent

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

Proposed Development Objective(s) Additional Financing

The Project Development Objective is to improve utilization and quality of Reproductive Maternal Neonatal and Child Health (RMNCH) services in selected regions.

Components

Improving Utilization of Quality RMNCH Health Services through PBF
Increasing Demand for Health Services
Capacity Building and Project Management
Contingency Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	18.00
Financing Gap	0.00

DETAILS

World Bank Group Financing	
International Development Association (IDA)	18.00
IDA Grant	18.00
Non-World Bank Group Financing	
Counterpart Funding	2.00
Borrower/Recipient	2.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Mauritania is a sparsely populated, arid, and resource-rich country, with high poverty levels in the South and rural areas.** The country's population of over 4 million people is spread across 12 wilayas and the capital area of Nouakchott. Mauritania is classified as a lower-middle-income country with a gross national income per capita of US$1,190 in 2018 (Atlas method; WDI). Since 2007, the gross domestic product (GDP) has grown by over 60 percent due to discoveries of mineral resources. However, growth is highly volatile, with drops in the GDP in recent years (World Development Indicators; WDI). Nationally, extreme poverty has declined from 45 percent to 31 percent, from 2007 to 2014. However, 44 percent of the population continue to live in moderate to extreme poverty in some region, with poverty concentrated in rural areas and in the South (Survey on Household Living Conditions, 2014; EPCV). The regions supported by INAYA and the proposed additional financing are among these poorest regions.

2. **Mauritania ranks low in terms of human development.** Mauritania also ranks among the 10 countries with the lowest Human Capital Index (HCI) in the world. The Mauritanian HCI is 0.35, meaning a child born in Mauritania today will be 35 percent as productive as when she grows up as she could be if she enjoyed complete education and full health. Stunting, child survival and adult survival, are key contributors, in addition to education factors. The actual and proposed INAYA regions are among those

with the worst health outcomes. The Human Development Index rates Mauritania 159th out of 189 countries.

3. **The arrival of refugees is exacerbating the existing poverty in the border area in the South-east and changing the needs for regional development of health and social services.** Hodh Charghi is a vast, rural (81 percent) and desert region with a population of over 500,000. The poverty rate in Hodh Charghi (28 percent living in moderate to extreme poverty or about 140,000 people; 14 percent or about 70,000 people in extreme poverty) is lower than the national average. The arrival of the refugees has increased the total population by more than 10 percent and the number of vulnerable households in the wilaya. The population of the moughata'a of Bassiknou has nearly doubled. Almost all the refugees arriving are classified as vulnerable and poor—UNHCR has classified about 34 percent of refugees to be in the most vulnerable group that risk living in severe poverty once humanitarian assistance is reduced in 2020.[1] The refugee and host population are living side by side in peace and have similar cultural practices. However, there are barriers of language, needs to provide health services for women and children, given the large number of women-led household among refugees, as well as needs for mental health support (about 400 cases are followed annually in the M'bera camp), and the concentration of refugees in Bassiknou and the M'bera camp is changing rural-urban settlement patterns, and putting pressure on water and vegetation for grazing animals and constructing homes—with implications on the Government's planning for regional development, and decentralization of health and social services. Moreover, the border situation remains fragile, with the ongoing conflict in Mali and continued arrival of refugees. Hence, the refugee population will likely continue to increase in the coming years.

Sectoral and Institutional Context

4. **In Hodh Chargui, progress on RMNCH and nutrition outcomes in the Mauritania host population remains inadequate, despite increasing Government health expenditures (Annex 1).** While under five mortality and stunting of children have decreased, 28 percent of children are chronically malnourished. Few children receive the complete series of vaccinations in their first year (24 percent), with 49 percent vaccinated by their second birthday. In terms of reproductive health, contraceptive utilization remains low (18 percent). In terms of maternal health, maternal mortality is high, assisted delivery remains low (69 percent), with many births taking place at home. Moreover, only 63 percent of women receive four or more prenatal visits (SMART Nutrition Survey 2017; Multiple Indicator Cluster Surveys, 2015; MICS). This is despite health expenditures increasing since 2007 from US$32 to US$47 per capita in 2017 (WDI), which has focused on hospital investments, rather than primary or periphery service improvements.

5. **Generally, health services offered are of poor quality.** Health facilities nationally often lack equipment, have inadequate space for consultation, and lack human resource competencies to deliver health services: 67 percent of facilities provide family planning; 58 percent provide the basic package of

[1] UNHCR, WFP-2019-Rapport de profilage socio-économique des ménages réfugiés du camp de M'Bera, Mauritanie. The grouping used the Consolidated Approach to Reporting Indicators of Food Security **(CARI)** methodology.

prevention services for children; and 69 percent provide assisted delivery services (Service Availability and Readiness Assessment Index of Availability and Operational Capacity of Services, 2016; SARA). Among Hodh Charghi facilities, 33 percent had no water, 28 percent were closed when visited due to absent personnel, 55 percent had not received a supervision visit in the past 6 months (UNICEF Real Time Monitoring, 2018; RMT). However, the results of the first semester 2019 of the PBF in the INAYA region (Guidimagha and Hodh Gharbi) show that the quality of services has increased from 14 percent to 37 percent from December 2018 to June 2019. These results are obtained despite the delay in the execution of the investment units. In line with improving services is the need to improve the decentralized coordination of services. Decentralization is still in the early phases in Mauritania.

6. **Utilization of health services is lowest among the poor and underserved communities, which are often in rural areas.** Extremely poor communities often have low utilization of health services: 70 percent of women give birth at home; only about 23 percent have a post-natal examination; and about 27 percent of children 12-23 months have a vaccination card. There is also inequitable allocation of resources across wilayas, and challenges reaching rural populations. The NCHS aims to reinforce community health committees, community agents and community-based organizations (CBOs) organized in basic health units to provide home visits, social and behavioral change communication (SBCC) and other outreach activities. However, these units often remain non-functional. Guidimagha and Hodh Gharbi, have a total of 161 basic health units that require reinforcement; and Hodh Charghi has 158 (Health Management Information System, 2017; HMIS).

7. **Over half of total health expenditure is out-of-pocket, implying financial barriers.** The 2016 National Health accounts place the private financing level at 55 percent, presenting a barrier for the poor. INAYA will address this through supply (fee waivers) and demand (conditional cash transfers) incentives for extremely poor households. The identification is done by the Unified Social Registry (Tekavoul Program), which is supported by the Social Safety Net Project (P150430) to facilitate social protection and access to services. As Table 1 shows, the actual and proposed INAYA regions have very low levels of health spending per capita compared to the national average.

8. **The M'bera camp has its own local leaders and health facilities that have been reinforced by humanitarian partners; these services need to be sustainably and equitably integrated within the Government system.** The health services received by the refugee community to date through humanitarian efforts are superior to those provided by the Government of Mauritania elsewhere in the wilaya – they provide over 5,000 medical consultations to refugees per month (UNHCR, August 2019). The refugee population has received a package of high quality RMNCH and nutrition services, including support for surgeries and mental health (300- 400 cases per year are supported in the camp), which have limited availability in the Mauritanian system outside of selected hospitals. The support for these services will be phased out starting in January 2020 and the health services in the camp require integration in the Government system. This needs to be done in a way that ensures a reasonable continuation of services as per the Government's strategy and addresses constraints to equitably

improving the utilization of services throughout the wilaya for refugees and the Mauritanian host community.

Table 1. RMNCH and nutrition indicators for the INAYA wilayas

Indicators	Guidimagha	Hodh Gharbi	Hodh Charghi	National
Total population	308,457	324,165	502,594	4,077,347
Rural population (percent)	71	85	81	47
Population living in extreme poverty (percent)	34	19	14	17
Population classified as poor (percent)	49	39	28	31
RMNCH and nutrition				
Women utilizing modern contraceptives (percent)	10	16	14	18
Prenatal care utilization (percent)	68	73	80	86
Women having 4 or more prenatal visits (percent)	39	50	53	63
Births assisted by qualified personnel (percent)	33	49	51	69
Home births (percent)	66	50	49	30
Post-natal examination of newborn baby (percent)	28	14	42	57
Children 12-23 months vaccinated for measles (percent)	52	70	69	78
Children 12-23 months completely vaccinated (percent)	30	51	11	49
Children 0-5 months exclusively breastfed (percent)	52	38	51	41
Children 6- 23 months having minimum meals (percent)	30	32	40	37
Children 0-5 years with chronic malnutrition (percent)	25	28	27	20
Literacy of women 15-24 years of age (percent)	21	36	40	52
Health services				
Population greater than 5 km from a health facility (percent)	30	25	26	17
Population not utilizing health service package (percent)	57	65	46	40
Birth registration seen and confirmed (percent)	31	32	34	40
Nurses and midwifes (number per 5000 population)	0.9	0.5	0.6	1.5
Health centers (number)	8	9	11	117
Health posts (number)	52	93	147	733

Indicators	Guidimagha	Hodh Gharbi	Hodh Charghi	National
Basic health units for community interventions (number)	59	102	158	850
Public health spending per capita	6.8	8.2	9.1	22.3

Sources: MICS 2015; HMIS 2015; 2017, SMART Nutrition Survey 2017; EPCV, 2014; WDI 2017

Table 2. Progress on key project indicators in Guidimagha and Hodh Gharbi

Indicator	Baseline (2017)	2018[2]	First semester 2019 (cumulative)	Cumulative target end of project
Births attended by skills health staff (number, cumulative)	13,021	12,225	16475	78,812
Pregnant women completing 4 antenatal care visits (number, cumulative)	1,741	2,064	4518	41,211
Children 12-23 months fully immunized (number, cumulative)	19,388	15,974	21826	63,289
Average score of quality checklist (percent)	--	14	36.63	60
Women accepting modern family planning methods (number, cumulative)	8,969	11,957	24465	94,622
Basic equipment availability (percent)	--	45	45	94
Visits by children under 5 to health facilities (number, cumulative)	43,619	62,086	114514	450,169
Post-natal consultation visits (number, cumulative)	3,561	3,147	6325	26,764

Sources: HMIS 2017, 2018; PBF portal 2019

C. Proposed Development Objective(s)

[2] The indicators for 2018 are being verified to improve quality of data report, and in some cases, this results in a reduction of the indicator in year one. For example, immunization previously estimated full coverage using a proxy, and now will assess the full coverage of children.

Original PDO

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

Current PDO

Key Results

9. **PDO and results:** The PDO is "to improve utilization and quality of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services in selected regions, and in the event of an eligible crisis or emergency, to provide immediate and effective response to said eligible crisis or emergency" and will be reformulate as "to improve utilization and quality of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services in selected wilayas." The baseline of indicators will also be changed in 2017 to reflect that INAYA began implementation in 2018.

10. **An additional PDO indicator (PDO5) is added** (Table 3)**,** the "Poor and refugee women and children 0-5 years receiving the basic package of services (number)." This will enable INAYA to monitor the increased utilization of RMNCH and nutrition services by the poor.

Table 3. Proposed PDO indicators including revisions

Indicator	Rationale
PDO 1. Pregnant women completing four antenatal care visits to a health facility during pregnancy (number)	1. Assesses utilization of reproductive health and nutrition services and the continuity of care for quality services.
PDO 2. Births attended by skilled health staff (number)	2. Assesses utilization of maternal and neonatal services, and the quality concern around unassisted home births.
PDO 3. Children 12-23 months fully immunized (number)	3. Assesses the utilization child health services and the quality concern of reaching full immunization.
PDO 4. Average score of the quality of care checklist (percent)	4. Assesses the quality of the package of services delivered in health posts, health centers and hospitals.
PDO 5. Poor and refugee women and children aged 0-5 who have received the basic package of services (number)	5. Assesses the utilization of the package of RMNCH and nutrition services by vulnerable groups. *New indicator*

D. Project Description

11. **Component 1: Improving the utilization of quality RMNCH services through PBF**. Total cost under parent project: US$11.85 million. Total costs with AF: US$26 million. The parent project supports the PBF implementation and verification in Guidimagha and Hodh Gharbi. The AF will extend the PBF to Hodh Charghi to address challenges related to the delivery of quality services to refugees and the Mauritanian host population.

12. **Sub-component 1A**, Provision of payments to health service providers, the AF will support:

(a) **The expansion of PBF payments to all public health facilities in Hodh Charghi** and facilities in Bassiknou and in the M'bera refugee camp. The health facilities in the M'bera camp will be integrated into the health pyramid of the MoH. Some of the facilities are currently managed by NGOs, which will be progressively reduced their support since January 2020 with a stop of their intervention scheduled for June 30, 2020. A transition road map will be developed by the MoH and UNHCR to include these health facilities and refugee workers in the PBF. Non-government facilities will also be eligible for PBF support, as is the case in the INAYA parent project. Health facilities will receive PBF payments for the quantity of beneficiaries (per women or child) utilizing services, as well as a bonus for quality delivery of the package of services. The indicators and mechanisms will be clearly defined in the revised version of the PBF Manual.

(b) **The development of business plans by health facilities in Hodh Charghi**, including in Bassiknou and in the M'bera refugee camp, using a problem-based planning approach to quarterly review progress and identify actions to improve services. Business plans may include activities, such as training, community outreach, technical improvements, improving the stock of commodities, waste management, minor repairs, among others. Health facilities will receive a one-time small grant to support initial investments to improve the baseline quality score of services as with the parent project.

(c) **A PBF equity bonus for health facilities in Hodh Charghi to waive/reduce service fees for refugees and poor Mauritanians.** INAYA will work with Tekavoul and UNHCR to develop the eligibility requirements for the equity bonus. These bonuses will be PBF incentives paid to facilities for serving poor patients among refugees and host populations. The terms for the equity bonuses will be outlined in the PBF Manual adapted for Hodh Charghi. The bonus will focus on key indicators for the minimum package of RMNCH and nutrition services.

(d) **PBF to reinforce interventions of community actors** (community health workers, community sanitation workers, refugee leaders, women leaders, CBOs, etc.). This will consist of performance-based contracts with identified community actors and groups in moughataa. These actors will receive PBF payments to refer pregnant women to health centers, register home deliveries, conduct monthly home visits for child growth monitoring, and conduct SBCC sessions on targeted themes. This includes involving traditional birth practitioners in bringing women to the health facility to change the incentives around their support to home births.

13. **Sub-component 1B, Verification and counter-verification, the AF will support:**

(a) **Routine verification to reinforce M&E of health services (quantity, quality and beneficiary feedback).** A Regional Verification Committee (RVC) will be created in Hodh Charghi, including for services in Bassiknou and in the M'bera refugee camp, for the regular verification of the quantity of services delivered by health facilities. In terms of quality, the Regional Health Office and Moughata'a Health Office will conduct a quarterly assessment of the quality of the package of services. In addition, community health committees, refugee groups and CBOs will be identified for the community level verification of the quality of services.

(b) **External verification activities to reinforce the accountability of the health information system.** An agency has been recruited to support external counter verification of the PBF data, building

capacity of the Inspector General's Office to take over the function. Counter verification will involve validation of the M&E information on health services to ensure accurate reporting on indicators and payment for services delivered by health facilities.

PBF contracts with regulatory actors to strengthen the coordination of health services. Regulatory actors will receive PBF contracts including possibly i) central directorates of the MoH (such as units responsible for fiduciary aspects, public hygiene, refugees, and pharmaceuticals); ii) decentralized health pyramid structures, such as the RVCs and Regional Health Direction; and iii) decentralized structures, such as Regional Councils, moughata'a and communes, including the local government of the M'bera camp. These actors will receive PBF contracts with defined roles to coordinate health services. This will help to respond to systemic constraints, which impede service improvements, such as weak supervision and communication, weak management of drugs, and inadequate attention to vulnerable populations.

14. **Component 2: Support to increasing demand for health services.** Total cost under parent project: US$2 million IDA and US$1 million CF. Total costs with AF: US$4 million IDA; US$2 million counterpart funding (CF). The parent project supports conditional cash transfer (CCTs) and the community strategy in Guidimagha and Hodh Gharbi. The AF will support CCTs for poor Mauritanians and refugees and the community strategy in Hodh Charghi, with the view of increasing the demand for services, among the most vulnerable (poor, refugees and rural populations).

15. **Sub-component 2A, CCTs to stimulate demand for health care, the AF will support:** extension of the CCTs to benefit households living in extreme poverty in Hodh Charghi (refugees and poor Mauritanians). Mauritanian poor and eligible refugee households will be identified in partnership with Tekavoul and UNHCR. The focus will be on supporting the most vulnerable refugee households. The list of recipients will be monitored annually with Tekavoul and UNHCR to assure the management of the CCTs is reflective of changes in the refugee population. Families will receive SBCC and CCT payment for utilization of child immunization, nutrition and birth registration services. This will help to alleviate inequalities faced by poor and refugee children, in terms of access and continuity of follow-up of these services to maximize outcomes for young children.

16. **Sub-component 2B, Strengthening of community health, the AF will support:** extension of activities to implement the NHCS in selected mougha'ata of Hodh Charghi and the M'bera refugee camp. The selection will include villages with significant refugee, poor and vulnerable rural populations. The ministry will contract local NGOs to implement social mobilization and capacity building of community actors to operationalize the NCHS, including health committees, CBOs, refugee groups and community health workers. These actors will be mobilized and receive training and coaching support to conduct home visits, SBCC activities and referral of cases to the health center. This will promote knowledge around the utilization of services and reinforce the community level PBF support in Component 1.

17. **Component 3: Capacity building and project management.** Total cost under parent project: US$4.15 million IDA: US$3.15 million IDA and US$1 million counterpart funding (CF). Total costs with AF:

US$7 million: US$5 million IDA, US$2 million CF. The parent project supports project management and technical assistance for Guidimagha and Hodh Gharbi. The AF will include technical support, learning, and coordination and research activities to strengthen the health system in Hodh Chargh, including coordination with humanitarian actors, M&E to review the regional situation, FM, reinforcement of the technical platform in health facilities, and learning to deliver new services to support refugees.

18. **Component 4: Contingent Emergency Response (CERC). Total cost under parent project: US$0 million.** The CERC manual will be updated to support eligible emergencies. The activities financed under the CERC will comply with the RSW eligibility criteria and focus on refugees and hosts where relevant.

E. Implementation

Institutional and Implementation Arrangements

19. The implementation arrangements will include minor adjustments to support Hodh Charghi. The Administrative and Financial Manual of Procedures and the PBF Manual will be updated to describe the roles and responsibilities of implementers and procedures required by IDA. **Error! Reference source not found.** presents the detailed list of changes.

(a) **Existing strategic and technical coordination mechanisms will continue.** The Secretary General will provide strategic leadership and the RBF Technical Unit will coordinate the overall technical support for the PBF with the central directorates of the MoH and regions. Project oversight is by the MoH Steering Committee overseeing the PNDS. However, the AF for Hodh Charghi will also coordinate with a multisectoral Working Group on the refugee strategy.

(b) **Technical assistance will be strengthened.** A PBF specialist will be based in Hodh Charghi financed by the project to support the implementation of the AF and coordination with humanitarian efforts. Moreover, an independent agency will support the Inspector General's Office to conduct counter-verification activities for the PBF. An RVC will be created to conduct internal PBF verification activities, including refugee representation. The Regional Council, Regional Health Direction and moughata'a will coordinate the PBF activities in the wilaya. However, communes and the local government in the M'bera refugee camp can also coordinate activities with performance contracts. NGOs and CBOs (including refugee groups) in communities will implement community verification and the NCHS.

(c) **The RBF Technical Unit will be reinforced to support the AF**. The RBF Technical Unit currently includes the following personnel: Technical Coordinator; Deputy Technical Coordinator; an FM team; M&E Specialist; Information Systems Specialist; Tekavoul Program Coordinator; and Environmental Specialist. The AF adds an international PBF specialist to support the RBF technical Unit, a Coordination and Communication Specialist to work with the MoH units to ensure the coordination of actions to support the wilaya, refugees and communication of PBF activities; and a Community Health Specialist, given the need for strong social mobilization support to rollout the NCHS in M'bera camp and rural areas.

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

The parent project has been implemented in 2 regions (Guidimagha, Hodh El Gharbi), comprising approximately 16% of the overall population of Mauritania and having the highest poverty and morbidity prevalence. The area of intervention of the project, known as the Pilot Zone of the Results Based Performance program (RBF) is divided administratively in 6 Moughataas and 45 communes. The activities have mainly been implemented in rural areas. Guidimagha is an agricultural region producing rice, fruits, etc. It is located in the valley area or the Sudano-Sahelian strip of the south-eastern extremity of the country, occupying only 0.5% of the land and receiving between 400 and 600 mm of rain per year. Hodh El Gharbi is part of the Sahelo-Sahelian zone, covering 12.5% of the territory, with a rainfall of between 100 and 200 mm. The AF will scale-up INAYA to improve the utilization and quality of reproductive, maternal, newborn and child health (RMNCH) and nutrition services in the Hodh Charghi region (wilaya) of Mauritania, benefiting refugees and the Mauritanian host population. More specifically, the M'bera refugee camp and in the moughata'a of Bassiknou in the Hodh Charghi wilaya, just 50 kilometers from the border with Mali, will receive the focus of INAYA Additional Financing efforts. Hodh Charghi is a vast, rural (81 percent) and desert region with a population of over 500,000 and a poverty rate lower than the national average. The arrival of the refugees has increased the total population and the number of vulnerable households in the wilaya. The population of the moughata'a of Bassiknou has nearly doubled. The concentration of refugees in Bassiknou and the M'bera camp is changing rural-urban settlement patterns, and putting pressure on water and vegetation.

G. Environmental and Social Safeguards Specialists on the Team

Tracy Hart, Environmental Specialist
Nicolas Kotschoubey, Environmental Specialist
Mame Safietou Djamil Gueye, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Performance Standards for Private Sector Activities OP/BP 4.03	No	
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
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

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

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

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

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

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

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

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

In conformity with the World bank policies and national EIA regulations, an updated Environmental and Social Management Framework (ESMF), which includes guidance for both the parent project and the Additional Financing activities, has been prepared. The updated ESMF has been disclosed both on World Bank external website as well as by the Government on January 15, 2020. Specific guidance on safety and security measures during the works (mainly rehabilitation of some facilities in existing health centers) are included in the technical clauses of the contractors.

The National Health Care Waste Management Plan (NHCWMP), developed by the Ministry of Health will be used in

conjunction with the ESMF, for the management of all health care waste generated by the beneficiary health care facilities participating in the project.

The Ministry of Health, as the main recipient and executing agency of the project, has previous experience implementing the parent project INAYA. The Department of Public Hygiene of the Ministry of Health has been responsible for INAYA environmental and social safeguards implementation and will continue with INAYA Additional Financing. The Department of Public Hygiene has carried out a strong, nation-wide training program on public health and hygiene for health workers and community-based health and sanitation workers.

The borrower has some demonstrated experience in applying the National Health Care Waste Management Plan (NHCWMP). The parent project INAYA is assisting the participating health care centers to carry out medical waste management assessments and prepare simple site-specific medical waste management plans. In addition, the review and improvement of the NHCWMP has also been integrated as an INAYA project activity.

A full-time environmental and social safeguards specialist has been hired as part of the project unit and is technically responsible for the implementation of the safeguards documents. Previsions have been made in the project's overall budget to finance this position.

Lastly, the updated ESMF includes measures to integrate lessons learned from the parent project, especially those voiced through the consultations held for the Additional Financing. The Department of Public Hygiene has adapted medical waste management plan formulation and implementation to local contexts and local languages. The Additional Financing activities will have a stronger emphasis on public health related communications.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The key stakeholders are the Ministry of Health, its decentralized services, local NGOs in the 2 targeted regions of intervention, as well as the Ministry of Social Affairs and the Ministry of Interior. The civil society is involved in all aspects of project activities and assessment of the service delivery results: communities will play a role in the verification of the performance of the participating public facilities, by involving civil society in assessing health service delivery results and by publishing results on a public website. Consultations with the stakeholders (potentially affected populations and authorities at the central and regional levels) were organized by the Ministry of Health. These instruments have also been published in the municipalities and the web sites of the Ministry of Health and the Ministry of Environment.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors

"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

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