Document of
The World Bank
FOR OFFICIAL USE ONLY

Report No: PAD2244

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 12.6 MILLION
(US$17.0 MILLION EQUIVALENT)

TO THE

ISLAMIC REPUBLIC OF MAURITANIA

FOR A

HEALTH SYSTEM SUPPORT PROJECT (INAYA)

April 28, 2017

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March 31, 2017)

Currency Unit = Mauritanian Ouguiya (MRO)

SDR1 = US$1.35685

US$1 = SDR 0.73700114

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AECID	Spanish Agency for International Development Cooperation
CCT	Conditional Cash Transfer
CERC	Contingent Emergency Response Component
CHW	Community Health Worker (*Agent de santé communautaire*)
DAF	Financial Affairs Directorate (*Direction des Affaires Administratives et Financières*)
DHP	Public Hygiene Directorate (*Direction de l'hygiène publique*)
DPCIS	Directorate of Planning and International Coopération (*Direction de la Planification et de la Coopération internationale*)
DSBN	Basic Health and Nutrition Directorate (*Direction de la santé de base et de la nutrition*)
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GRS	Grievance Redress Service
HMIS	Health Management Information System
IFR	Interim Financial Report
IT	Information Technology
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Nongovernmental Organization
PBF	Performance-based Financing
PDO	Project Development Objective
PNDS	National Health Development Plan (*Plan national de développement sanitaire*)
PPSD	Project Procurement Strategy for Development
RBF	Results-based Financing
RFQ	Request for Quotations
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
RVC	Regional Verification Committee
SOE	Statement of Expenditures
SORT	Systematic Operations Risk- Rating Tool
SWEDD	Sahel Women's Empowerment and Demographic Dividend
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Louise J. Cord
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Gaston Sorgho
Task Team Leader(s):	Moulay Driss Zine Eddine El Idrissi, Christophe Rockmore

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Lending Instrument
No		Investment Project Financing

[ ] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
19-May-2017	30-Jun-2021	B - Partial Assessment
Bank/IFC Collaboration		
No		

Proposed Development Objective(s)

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.

Components

Component Name	Cost (US$, millions)
Improving Utilization of Quality RMNCH Health Services through PBF	9.50
Increasing Demand for Health Services	2.50
Capacity Building and Project Management	5.00
Contingency Emergency Response Component	0.00

Organizations

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

[✔] Counterpart Funding	[ ] IBRD	[ ] IDA Credit [ ] Crisis Response Window [ ] Regional Projects Window	[✔] IDA Grant [ ] Crisis Response Window [ ] Regional Projects Window	[ ] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
19.00	19.00	0.00
	Of Which Bank Financing (IBRD/IDA): 17.00	

Financing (in US$, millions)

Financing Source	Amount
Borrower	2.00
IDA Grant	17.00
Total	**19.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2017	2018	2019	2020	2021
Annual	0.02	2.15	4.15	4.90	5.78
Cumulative	0.02	2.17	6.32	11.22	17.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Social Protection & Labor

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

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

9. Other	
10. Overall	Moderate

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

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✔	
Natural Habitats OP/BP 4.04		✔
Forests OP/BP 4.36		✔
Pest Management OP 4.09		✔
Physical Cultural Resources OP/BP 4.11		✔
Indigenous Peoples OP/BP 4.10		✔
Involuntary Resettlement OP/BP 4.12		✔
Safety of Dams OP/BP 4.37		✔
Projects on International Waterways OP/BP 7.50		✔
Projects in Disputed Areas OP/BP 7.60		✔

Legal Covenants

Sections and Description

Schedule 2 Section I. A. 7. The Recipient shall, no later than three (3) months after the Effective Date, (a) prepare and adopt the PBF Manual, in form and substance satisfactory to the Association; and (b) hire a procurement specialist with qualification and experience satisfactory to the Association.

Sections and Description

Schedule 2 Section I. A. 8. The Recipient shall, no later than four (4) months after the Effective Date: (a) install an

accounting software; and (b) hire external and internal auditors with qualification and experience satisfactory to the Association.

Sections and Description

Schedule 2 Section I. B. 2. The Recipient shall deposit, no later than September 30, 2017, one hundred United States Dollars (US$100,000) into the Project Account. The Recipient shall, no later than March 15 in 2018, 2019, and 2020, deposit five hundred thousand United States Dollars (US$500,000) into the Project Account, with the final payment in the amount of four hundred thousand United States Dollars (US$400,000) deposited into the Project Account no later than March 15, 2021.

Conditions

Type	Description
Effectiveness	The Recipient has adopted an Administrative and Financial Manual of Procedures in form and substance acceptable to the Association.
Effectiveness	The Recipient has selected an accountant with qualification and experience satisfactory to the Association.
Disbursement	Schedule 2. IV. B. 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (a) for payments made prior to the date of this Agreement, except that withdrawals up to an aggregate amount not to exceed fifty thousand United States Dollars ($50,000) may be made for payments made prior to this date but on or after February 6, 2017, for Eligible Expenditures under Category (1).
Disbursement	Schedule 2. IV. B. 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (b) for payments against activities under Part A.1.a. and Part A.2.b of the Project under Category (2) and Category (4), unless the Recipient has prepared and adopted the PBF Manual, in form and substance acceptable to the Association.
Disbursement	Schedule 2. IV. B. 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (c) for payments against activities under Part A.1.b of the Project under Category (3), unless the Recipient has prepared and adopted the PBF Manual and the community health strategy, both in form and substance acceptable to the

	Association.
Type Disbursement	Description Schedule 2. IV. B. 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (d) for payments against Conditional Cash Transfers under Part B.1.a of the Project under Category (5), unless all of the following conditions have been met in respect of said activities: (i) the Recipient has updated the Tekavoul Manual in form and substance acceptable to the Association; (ii) the Subsidiary Agreement has been executed on behalf of the Recipient and the Tadamoun Agency; and (iii) the Subsidiary Agreement has been duly authorized or ratified by the Recipient and the Tadamoun Agency and is legally binding upon the Recipient and the Tadamoun Agency in accordance with its terms.
Type Disbursement	Description Schedule 2. IV. B. 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (e) for Emergency Expenditures under Part D of the Project under Category (6), unless and until the Association has notified the Recipient of its satisfaction that all of the following conditions have been met in respect of said activities: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the CERC Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.F.3(b) of Schedule 2 to this Agreement, for the purposes of such activities; (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.F.2 of Schedule 2 to this Agreement, for the purposes of said activities; and (iv) the Recipient has adopted an CERC Operations Manual in form, substance and manner acceptable to the Association and the provisions of the CERC Operations Manual remain, or have been updated in accordance with the provisions of Section I.F.1(c) of Schedule 2 to this Agreement so as to be appropriate for the inclusion and implementation of said activities under the CERC Part.

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Moulay Driss Zine Eddine El Idrissi	Team Leader(ADM Responsible)	Team Leadership, Health Economy	GHN13
Christophe Rockmore	Team Leader	Health Economics, Service Delivery indicators	GHN13
Mountaga Ndiaye	Procurement Specialist(ADM Responsible)	Procurement	GGO01
Fatou Fall Samba	Financial Management Specialist	Financial Management	GGO26
Aissatou Chipkaou	Team Member	Operations, Quality Control	GHN13
Aissatou Diallo	Team Member	Disbursement	WFALN
Alain-Desire Karibwami	Team Member	Health and RBF	GHN01
Amba Denise Sangara	Team Member	Program Assistance	GHN07
Batouly Dieng	Team Member	Program Assistance	AFMMR
Dahlia Lotayef	Safeguards Specialist	Environmental Safeguards	GEN07
Eileen Brainne Sullivan	Team Member	Operations, Quality Control Leadership	GHN13
Faly Diallo	Team Member	Disbursement	WFALA
Hadia Nazem Samaha	Team Member	Health	GHN07
Matthieu Boris Lefebvre	Team Member	Social Protection	GSP07
Maud Juquois	Team Member	Health Economy	GHN13
Mohamed Vadel Taleb El Hassen	Team Member	Health	GHN07
Sachiko Morita	Counsel	Legal Counseling	LEGEN
Salamata Bal	Safeguards Specialist	Social Safeguards	GSU01
Sariette Jene M. C. Jippe	Team Member	Operations, Quality control and Tasks Management	GHN13
Sophie Naudeau	Team Member	HD program leadership	AFCF1
Sybille Crystal	Team Member	Operations and Quality Control Leadership	GHN07

Extended Team

Name	Title	Organization	Location

MAURITANIA
HEALTH SYSTEM SUPPORT (INAYA)

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

I. STRATEGIC CONTEXT

A. Country Context

1. **Mauritania is a sparsely populated, arid, and resource-rich country.** Its population of 3.5 million people is spread such that the average is 3.9 people per square kilometer, making it the fourth least densely populated country in Africa. The country has undergone a rapid transition from a largely rural and nomadic society (0.5 percent of the land area is arable) toward a sedentary, urban one. Due to intense rural-urban migration, 60 percent of the population is concentrated in urban areas. 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. 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.

2. **The recent increase in economic growth has translated into a faster poverty reduction, but poverty levels are still high, and social indicators remain low.** Mauritania has recently achieved the status of lower-middle-income country, with a gross national income per capita (current U.S. dollar, Atlas method) estimated at US$1,270 in 2014 (from US$700 in 2007). Over the last five years, Mauritania's gross domestic product grew by 22.5 percent in real terms. As in many African countries, Mauritania's recent mineral discoveries have stimulated growth and raised incomes. The anticipated expansion in mining output will play the biggest role in maintaining a sound macroeconomic framework. The latest poverty information shows a decline in poverty from 44.5 percent to 33 percent, while inequality (Gini Index) decreased from 35.3 percent to 31.9 percent in 2008–14 (Poverty Dynamics and Social Mobility, World Bank, 2016). Poverty is more concentrated in rural areas (43 percent versus 28 percent in urban areas) and in the south (ranging from 28 percent to 49 percent) rather than in Nouakchott (14 percent) or the north (15 percent to 37 percent).

3. **The level of human development of the Mauritanian population is still among the lowest in the world.** Mauritania was ranked 156th out of the 188 countries tracked in the Human Development Index (2015 estimates for 2014). Mixed progress has been made on the Millennium Development Goals (MDGs): notwithstanding achievements in reducing malnutrition, primary enrolment, and gender equity in education, the poverty, child malnutrition, and safe water access targets were not met. The information on health outcomes in the latest Multiple Indicator Cluster Survey (MICS) 2015 indicates there are generally no significant gender differences, which is similar to progress in primary education.

B. Sectoral and Institutional Context

4. **Mauritania has achieved some positive outcomes, but maternal and reproductive health remains concerning.** The MDG related to tuberculosis made a good progress (table 1). The under-five mortality rate decreased significantly from 118 deaths for 1,000 live births in 2011 (MICS 2011) to 54 deaths for 1,000 live births in 2015 (MICS 2015). However, maternal mortality was estimated at 602 per 100,000 live births in 2015 compared to the MDG target of 232 per 100,000 live births (41 percent

achievement). Nevertheless, despite progress made to date, Mauritania is among the countries with the highest level of maternal mortality in the region. Key intervention rates have not progressed significantly in the recent years. For example, immunization coverage (fully immunized children between ages 12 and 23 months) has only slowly increased at 48.7 percent in 2015 (from 38.4 percent in 2011, Mauritania MICS 2011 and 2015). Other countries have made better progress. The demographic transition has not yet started in Mauritania, with a total fertility rate of 5.1 (6.1 in rural, MICS 2015). Regarding HIV-AIDS, the prevalence is still low but nevertheless doubled between 1990 and 2015.

Table 1. Achievement of the Health MDGs in Mauritania

Indicator	1990	2015	MDG Target	Target/1990 Indicators	2015 / 1990 Indicators	Achievement
Mortality rate, under-5 (per 1,000 live births)	118	54	45	0.38	0.46	Fair
Maternal mortality ratio (modeled estimate, per 100,000 live births)	859	602	232	0.27	0.70	Extremely low
Incidence of tuberculosis (per 100,000 people)	434	107	-	-	0.25	Good achievement
Prevalence of HIV, total (% of population ages 15–49)	0.3	0.6	-	-	2.00	Prevalence exacerbated

Source: World Development Indicators, January 2017 update.

Supply-side Factors

5. **Health provision in Mauritania is pyramidal in nature.** As detailed in table 1, the public sector has 693 health posts that refer to health centers (112) and onward to regional and national hospitals (26). There is also a small private sector (138 health care facilities) that is heavily concentrated (76 percent) in the capital, Nouakchott. Using WHO Global Health Workforce statistics, Mauritania has the most nurses and midwives (0.672 per 1,000 people) and ranked second in physicians (0.12 per 1,000 people) compared to the Ivory Coast, Mali, Niger, Senegal, and The Gambia[1]

6. **Public health service provision in Mauritania is unequally distributed.** Facilities and staff are concentrated in the urban areas, particularly Nouakchott and Inchiri, to the detriment of other areas such as Gorgol, Guidimagha, Hodh Charghi, and Hodh el Gharbi (table 2). Despite efforts made during the last few years to increase the production of qualified health workers (creation of a school of medicine and five public health schools in remote regions), Mauritania is still characterized by a lack of qualified health workers.

[1]/ Data are for 2010, the last year in which there are data for all countries. WHO data are used to facilitate comparison across countries, although the latest available year and data may differ from the national data.

Table 2. Health Supply Metrics

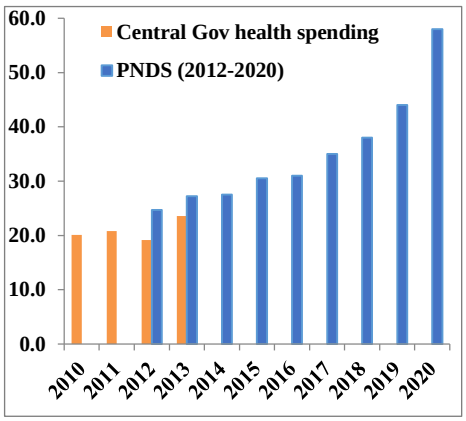
	Population	Public Sector Facilities			Population per Cadre		Private Sector Facilities	
Region	**2016 (Projection)**	**Health Posts**	**Health Centers**	**Hospitals**	**Doctor (per 1,000 People)**	**Nurses and Midwives**	**Pharma.**	**Health Care**
Adrar	61,269	28	5	2	0.16	1.73	21	0
Assaba	351,856	86	8	1	0.07	0.89	37	5
Brakna	317,673	86	11	2	0.07	0.58	20	0
Dakhlett Nouadhibou	134,965	10	9	2	0.14	0.85	71	11
Gorgol	352,246	61	7	1	0.06	0.86	25	0
Guidimagha	287,776	47	6	1	0.02	0.18	21	2
Hodh Charghi	466,848	144	13	1	0.04	0.71	45	2
Hodh el Gharbi	308,575	74	9	1	0.05	0.58	56	5
Inchiri	22,077	4	2	1	0.25	1.91	12	2
Nouakchott[a.]	1,079,290	28	19	10	0.25	1.35	343	106
Tagant	82,046	27	9	1	0.19	1.09	4	0
Tiris Zemmour	54,624	5	3	1	0.22	2.09	9	3
Trarza	286,413	93	11	2	0.08	1.14	27	2
Mauritania	3,805,658	**693**	**112**	**26**	**0.12**	**0.95**	**691**	**138**

Source: Facility information is from the '2017 Action Plan and 2016 review'; data on population are projections from the National Statistical Office (*Office National de la Statistique*) based upon the 2013 Population and Housing Census.
Note: a. 'Nouakchott' combines Nouakchott North, Nouakchott West, and Nouakchott South; 'Pharma.' refers to pharmacies and vendors with legal limitations on what they can sell, but without a pharmacist on staff.

7. **Health resources remain low compared to the region.** Total health spending (public and private) increased sharply by 27 percent in 2013, to US$120 million or 2.4 percent of gross domestic product, which is around the regional average. However, the amount of spending in 2013 remained below the funding needed to finance the interventions identified in the National Health Development Plan (*Plan national de développement sanitaire*, PNDS) (see Figure 1). Per capita spending at US$48 is well below an average of US$95 for selected African countries.

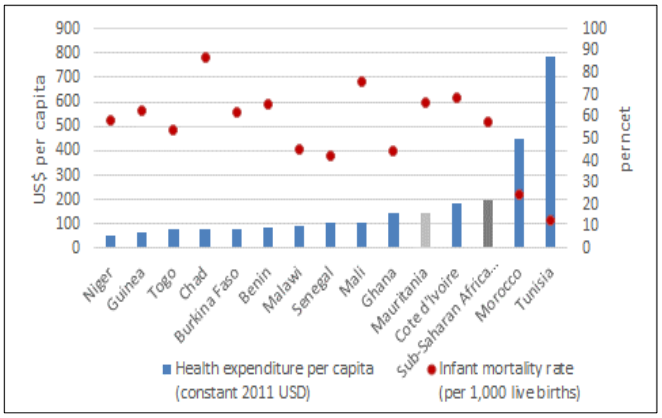
8. **The allocation of health expenditures is inefficient.** A comparison (see Figure 2) of health outcomes in these countries (using the example of infant mortality) shows that Mauritania has some scope to use its resources more efficiently (Public Expenditure Review 2015 and Systematic Country Diagnostic 2016). The low technical efficiency is aggravated by a weak allocative efficiency: public health spending is biased in favor of curative care rather than prevention, particularly at the hospital level. Hospitals consume 60 percent of the health ministry budget, primary health centers receive 21 percent, and preventive programs (immunization, reproductive health, malaria, and so on) receive only 4 percent. However, the share of primary health care rose gradually over 2010–13.

Figure 1. Actual Health Spending versus PNDS Required Funding, MRO billion (2012–2020)



Source: Ministry of Health (MoH)

Figure 2. Regional Comparison of Health Spending and Infant Mortality Rates, 2014

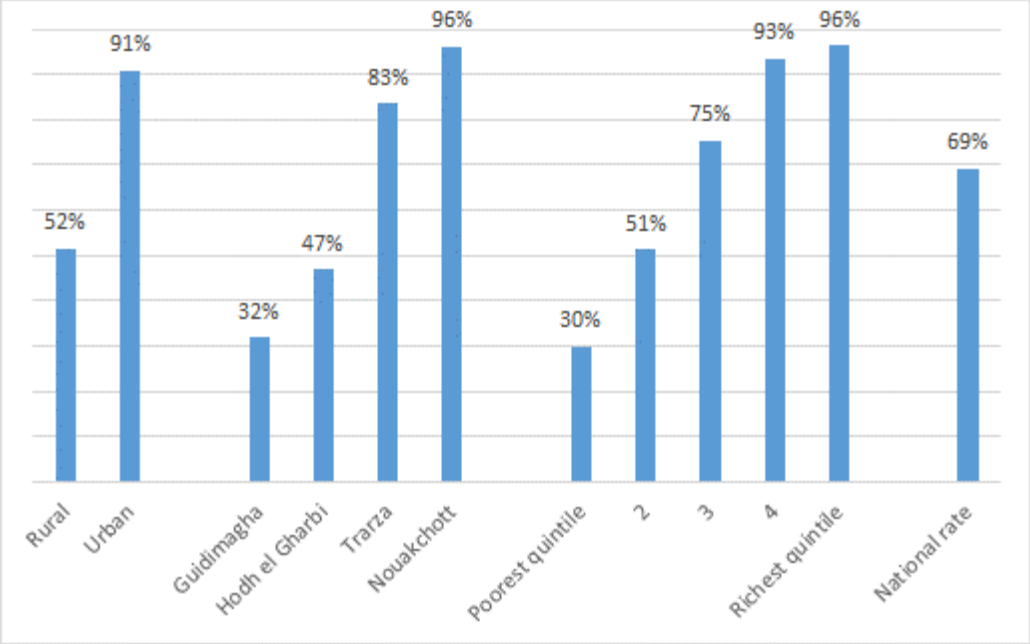


Source: World Development Indicators, 2013

9. **Coverage of high-impact health interventions is still low, especially for the poorest and in rural areas.** Even with some progress during the recent years, malnutrition is still an important issue and an obstacle to improve health outcomes with 12.1 percent of wasting prevalence, 21 percent of stunting, and 20.4 percent of moderate underweight in 2015 (SMART Survey 2015). The percentage of pregnant women whose deliveries were assisted by qualified health workers is strongly inequitable by regions, urban or rural areas, and level of wealth (figure 3). Nationally, 69 percent of births were assisted by trained staff, but only 52 percent of rural births were assisted as compared to 91 percent in urban areas. Looking at the regional variation, Nouakchott has 96 percent assisted deliveries, while Guidimagha (32 percent) is the worst region. The use of modern contraceptive methods shows similar patterns and remains very unequal between regions, especially between southern (range of 3.1 percent to 11.5 percent), Nouakchott (28 percent), and northern regions (16.3 percent to 33 percent). Women from the wealthiest quintile (26 percent) are 6.5 times more likely to use modern contraceptives than the women from the poorest quintile (4 percent). The differences between urban and rural are striking: even the richest rural women lag behind the poorest among the urban poor.[2]

Figure 3. Percentage of Women Ages 15–49 Years Who Had an Assisted Delivery with a Qualified Health Worker (among Women Who Had a Birth the Two Years before the Survey)

[2]/ Contraception and assisted deliveries are from MICS 2015; poverty and rural data are from the 2014 EPCV survey (Enquête Permanente sur les Conditions de Vie des Ménages).



Source: MICS 2015.

10. **Low utilization of health services and poor health outcomes result also from the weak quality of care because of the 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 is only 33 percent (approximately 4 out of 13 tracer drugs), no health facility has all of the 13 essential drugs, and only 47 percent of the health facilities have basic essential equipment (Service Availability and Readiness Assessment survey for health facility, 2016).

Demand-side Factors

11. **The poor health results stem from both systemic performance and demand problems, where financial and geographical obstacles to access health services are important factors.** More than 66 percent of the population lives more than 5 km away from a functional health facility or more than one hour away (Mauritania Poverty Profile Report 2014); this is partly due to the low population density. The joint World Bank-United Nations Children's Fund (UNICEF) Results-based Financing (RBF) feasibility study (2015) for the RBF strategy shows that linguistic and cultural obstacles were also mentioned in some of the regions where focus groups were organized. For example, in Hodh El Gharbi, women from nomad groups do not deliver at the health facility because of the presence of male health workers. In urban areas, the very rapid urbanization of Mauritania has put pressure on social services, worsened living conditions of the population, and weakened traditional support networks (in 2014, 51 percent of the population lived in cities compared to 9.1 percent in 2000).

12. **Poverty creates financial barriers to access, particularly in rural areas, that are not offset by insurance schemes.** According to the joint World Bank-UNICEF RBF feasibility study (2015), the primary

reasons given by women for not seeking care at health facilities were that costs for care and drugs are too high. In addition, women said quality of care was low given absenteeism of health workers and poor reception at health facilities. Out-of-pocket spending (direct payments made by households) represents approximately 44 percent of health spending. Although this is the average for Sub-Saharan Africa (National Health Accounts 2014), the WHO benchmark indicates that 1.5 percent of the population is likely to fall into poverty because of catastrophic health spending (more than 160 people a day). Insurance schemes do not provide sufficient coverage: neither the National Health Insurance (*Caisse Nationale d'Assurance Maladie*; 15 percent of the population) nor the Community-based Health Insurance (*Mutuelles de Santé*; 0.3 percent). The inefficient and underfunded free and subsidized health care programs (malaria and obstetrical care) are insufficient to address these effects.

13. **Despite a quasi-inexistence of significant disparity between women and men, a gender approach remains crucial for the health sector.** According the MICS survey 2015, there is no significant difference between males and females with regard to health indicators (access to health care services and health status). However, empowerment of girls and women remains very important in the health sector to achieve a positive change in behavior and a demographic transition (as supported by the Sahel Women's Empowerment and Demographic Dividend - SWEDD project - P150080—see below for more information).

Government's Response

14. **The Government developed the PNDS (2012–2020).** The PNDS states that health system strengthening strategies and reforms are the most important approach and focus will be on: (a) improving physical and financial access; (b) revitalizing the National Community Health Policy (Community Health Workers [*Agent de santé communautaire*, CHWs]); (c) reforming the pharmaceutical sector; (d) developing a hospital reform; (e) developing a strategic plan for human resources for health; (f) improving social health protection; and (g) reinforcing institutional capacities and improving efficiency, which includes an RBF strategy (see Box 1).

15. **Progress to date on the PNDS is mixed.** The PNDS defined three sets of indicators to analyze its results: effect (coverage), impact (morbidity and mortality), and products (resource requirements). With regard to coverage, the ministry added 152 health facilities between 2010 and 2015 (25 percent increase), which contributed to an increase in the population living within 5 km of a health facility from 73.5 percent to 82 percent.

16. **Outcome indicators show some progress, although the midterm objectives were not achieved.** Table 1 and paragraph 4 above describe some good achievements, mainly related to tuberculosis and child mortality. However, HIV-AIDS, immunization, maternal and reproductive health indicators did not improve.

17. **Resources for health.** The amount of central government spending between 2012 and 2015 remained below the funding needed to finance the interventions identified in the PNDS (2012–20). Health as a proportion of government expenditure rose 30 percent between 2012 and 2015, but represents 6 percent of total government expenditure, which is far below the Abuja Declaration (2001) target of allocating at least 15 percent of the budget to the health sector. Over the same period,

external financing rose from 6.7 percent to 11.9 percent of total health expenditure. The annual gap between projections and disbursements for donor funding is chronic and relatively high (Figure 1).

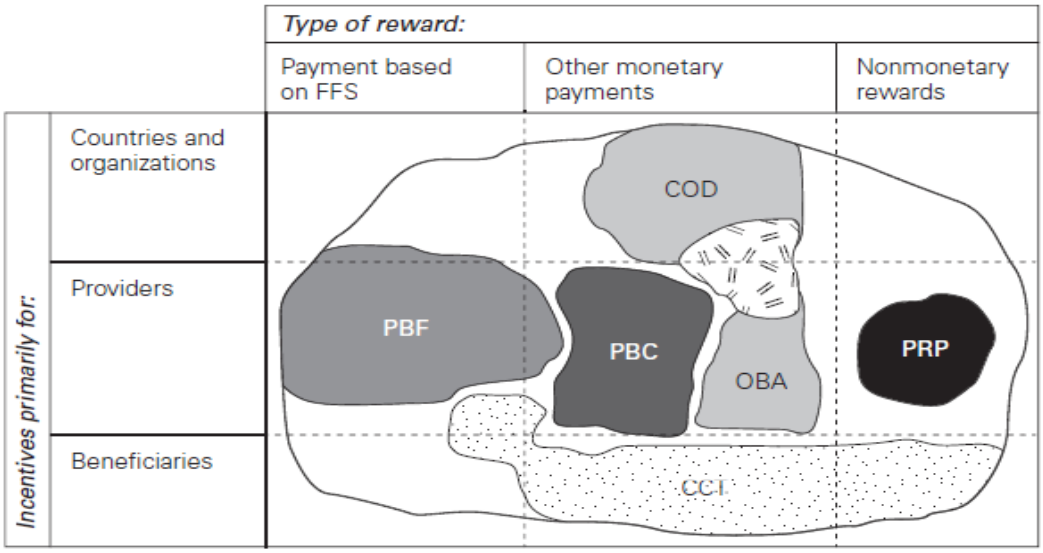
18. **According to the PNDS mid-term evaluation report, the epidemiological profile is still marked by the predominance of infectious and parasitic diseases**. The primary causes of mortality were infectious diseases (35.3 percent), birth-related complications (13 percent), and non-communicable diseases (9.7 percent).

19. **To improve efficiency and access to quality health services, the government developed and adopted an RBF strategy.** The government recognizes the need to address the weak allocative and low technical efficiency of its public health expenditure. One of the recommendations of the Public Expenditure Reviews for Health carried out by the World Bank and the 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 World Bank, UNICEF, and WHO, the Government of Mauritania developed a health RBF strategy (validated by the National Health Steering Committee in September 2016 and the Council of Ministers in October 2016). 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 (RMNCH). Mauritania's RBF strategy is composed of two components: the supply-side RBF (performance-based financing, PBF) and the demand-side RBF (conditional cash transfers, CCTs).

Box 1. Results-based financing (RBF) and Potential Positive Impact on the Health System in Mauritania

RBF is an instrument that links financing to predetermined results, with payment made only upon verification that the agreed-upon results have actually been delivered. RBF can help improve both supply- (for example, Performance-based financing (PBF)) and demand-side performance (for example, Conditional Cash Transfers (CCT)) of health systems striving for Universal Health Coverage (UHC). In an RBF program, payments are made based on the quantity and quality of health services delivered after verification (World Bank, 2013, Africa Health Forum).

Figure 4. Typology of RBF Programs



Note: COD = cash on delivery; FFS = fee-for-service; OBA = output-based aid; PBC = performance-based contracting; PRP = provider recognition program.

PBF is a supply-side RBF approach. PBF pays for outputs or results and this is different from classical programs, which focus on procuring inputs. In the health sector, such outputs or results include quality services produced by health facilities/providers and certain actions by the health administration. Income from PBF is used by health facilities and the health administration to procure necessary inputs and to pay performance bonuses.

CCTs are demand-side incentives, including cash rewards, provided to users of services or vulnerable groups (usually mothers), on consuming certain social services such as education or health care services.

International experience indicates that PBF approaches can be successful in rapidly increasing the use of cost-effective health interventions in a country like Mauritania. Studies of RBF in Cambodia and Burundi and randomized controlled studies in Rwanda and Zimbabwe have demonstrated its effectiveness. There are promising results from a number of countries in Sub-Saharan Africa that suggest that RBF may be a useful approach to address the types of challenges in Mauritania (inequity/social exclusions and low technical and allocative efficiency). The Rwandan experience has attracted considerable interest and has yielded results with regard to increasing the proportion of the right skills mix in public sector facilities, increasing financing to the district level, and improving the coverage of quality maternal and child health services.

20. **RBF will be one of the key instruments for UHC in Mauritania.** RBF has a positive impact on the UHC agenda, in general, through mainly three areas:[3] defining the basic and complementary health package and delivering these packages; expanding coverage of health services for the general

[3] Fritsche, G.B., Soeters, R., and Meessen B. 2014. Performance-based Financing Toolkit. World Bank.

population, especially for the poorest; and improving access to good-quality health services. With the assistance of its partners, including the World Bank, the government is preparing a National Health Care Financing Strategy. This strategy, which will include RBF, is expected to be finalized and adopted by the government in 2017 (calendar year).

21. **To support poverty reduction and improve human development outcomes, Mauritania developed a National Social Protection Strategy that includes a Social Registry and a Social Transfer Program (Tekavoul Program).** The Social Safety Net System Project (P150430) is funding the development of these key instruments that will assist the government in enhancing expenditure efficiency and poverty reduction. Among other aspects, the project supports good practice approaches to the development of the Social Registry and its use for unconditional cash transfers to the poorest households in Mauritania. The Social Registry is completed in the Gorgol region; work has started in Guidimagha (2016) and may continue in Hodh El Gharbi (2017 and/or 2018). The Tekavoul Program paid the first cash transfer in December 2016.

22. **Based on the criteria shown in Table 3, the government decided to pilot the RBF strategy in Guidimagha and Hodh El Gharbi.** Table 3 shows the indicators used to determine the pilot regions. Poverty and the share of rural population are major barriers to access, reducing deliveries outside facilities are a key objective of the project, and the low physical access to health care creates a need for demand-side activities (cash transfers). Because these regions are in the bottom three for health expenditure per capita, the project will be pro-poor and support the marginalized. In fact, the regions are located in the poverty triangle called '*Le Triangle de la misère*' (the Triangle of Poverty).

Table 3. Selected Indicators for the INAYA Regions and Mauritania

Geographic Level	Poverty	Deliveries Outside Facilities	Access to Health Facilities in 5 km	Tekavoul Presence (2017–2021)	Rural Population	Public Health Spending per Capita (US$)
Guidimagha	49 (1)	60 (2)	41 (9)	Yes	71 (7)	6.78 (13)
Hodh El Gharbi	39 (5)	67 (1)	25 (12)	For 2017 or 2018	85 (1)	8.20 (11)
Mauritania	31	31	33		49	22.29

Source: Public health spending from Public Expenditure Review 2015, Tekavoul presence from the Tekavoul Program, and all others from EPCV – Enquête Permanente sur le Niveau de Vie des Ménages (2014).
Note: Numbers in parentheses are the rank of the region (out of 13 total regions). Data are in percentages unless otherwise specified.

C. Higher Level Objectives to which the Project Contributes

23. **The development of an RBF policy is a part of the Country Partnership Strategy 2014–2017.** The proposed operation (INAYA) supports Pillar Two 'Economic Governance and Service Delivery', which aims at improving public sector performance and promotes increased access to basic social services. The project, which will be a pilot at first in two regions, seeks to increase access to quality maternal and child health services. The project targets the poor and will use PBF mechanisms to strengthen service delivery at the community, primary health care, and regional levels. Furthermore, through its demand-side intervention, the project will support access to basic health services for the most vulnerable households in selected regions (*wilayas*), especially for women and children.

24. **The project addresses the World Bank Group's twin objectives of reducing poverty and promoting shared prosperity,** the Africa Regional Strategy, which focuses on strengthening governance and public sector capacity, and the HNP strategy on UHC. The Mauritanian PNDS has identified RBF as a central strategy to address health system challenges and contribute toward achieving UHC. The higher-level objective to which this project will contribute is toward improving efficiency and effectiveness in the health system to improve human development outcomes. The selection of the project areas and the demand-side focus on the Social Register families will also ensure that the bottom 40 percent of the population are explicitly targeted.

25. **The project is also fully aligned with the Sustainable Development Goals, in particular Goal 3: Ensure healthy lives and promote well-being for all at all ages.** Goal 3 of the Sustainable Development Goals has several targets among which the proposed project directly supports: reduction of maternal mortality (Target 3.1), reduction of under-5 and neonatal mortality (Target 3.2), achieving universal access to sexual and reproductive health care services (Target 3.7), achieving UHC (Target 3.8), and increasing health financing and the recruitment, development, training, and retention of the health workforce (Target 3.c). The project also supports the achievement of Goal 1: End poverty in all its forms everywhere, through its links with social safety nets programs and improved financial protection (against catastrophic health expenditures) among the poor and vulnerable.

26. **Donors are interested in the RBF approach.** Both during the RBF approval process and in other meetings with the Government and the World Bank, the Spanish Agency for International Development Cooperation (AECID), Global Fund to Fight AIDS, Tuberculosis and Malaria, and particularly the European Union (EU) expressed their interest and will observe implementation of the pilot to determine their ability to participate in the project. The EU has already developed an EU-executed trust fund proposal (€46 million), which will support RBF (so far, its modalities have not been defined), community health strategy, health information system, human resources for health, and institutional capacities.

27. **The proposed RBF-based project will complement the (inputs based) IDA-financed, SWEDD project.** Similar to the RBF program (PBF and CCTs), the Sahel Women's Empowerment and Demographic Dividend (SWEDD) project works across five Sahelian countries and aims to increase women and adolescent girls' empowerment and their access to quality reproductive, child, and maternal health services. The two regions targeted by the project are among the four regions of the

SWEDD project's areas of interventions, which will ensure the synergy and complementarity between the interventions of the two projects. The SWEDD project supports the inputs of the health system including the human resources for health, the availability of medicines through supply chain strengthening, and the education and empowerment of young girls of childbearing age. The project will complement this effort by focusing on the results and performance of the health system, taking into account the specific needs of the poor and vulnerable population through the CCT system, by supporting the National Community Health Strategy and the national health information system.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

28. **The Project Development Objective (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.

29. **The project is pro-poor because it mainly targets poor households (demand-side intervention);** rural families; marginalized regions; and pro-poor health services (community health services, preventive services, and primary health care) and facilities/providers (CHWs and health posts/centers). This approach also aims to rebalance public health expenditure toward primary care (currently, 21 percent of expenditure) and preventive programs (4 percent) away from hospitals (60 percent). The PBF focus on primary health care will add resources that will be exclusively devoted to this level that are focused on nutrition, vaccination, and well-mother and child care (preventive), and will therefore begin to rebalance health expenditures towards primary care, away from tertiary.

B. Project Beneficiaries

30. **The entire population of the Guidimagha and Hodh El Gharbi regions, 620,000 people, will be the indirect beneficiaries of the project.** The two regions are projected to represent approximately 15 percent of Mauritania's population in 2021. The project aims at improving the performance of all public health facilities (121 health posts, 15 health centers, and 2 hospitals) in the two regions.

31. **The project will target women of reproductive age and children under the age of five.** The number of direct beneficiaries will reach approximately 31.2 percent of the population in the two regions. Girls and women represent 78.8 percent of the total direct beneficiaries of the project in the targeted areas.

C. PDO-Level Results Indicators

32. Four indicators will be used to measure the achievement of the PDO:

(a) Pregnant women completing four antenatal care visits to a health facility during pregnancy (number).

(b) Births attended by skilled health staff (number).

(c) Children 12-23 months fully immunized (number).

(d) Average score of the quality of care checklist (percentage).

III. PROJECT DESCRIPTION

A. Project Components

33. **The project seeks to help Mauritania to develop the culture of RBF.** The goal is to improve the performance and resilience of the health system in the selected regions.

34. **The proposed operation comprises four components (Table 4) that aim to improve utilization of quality RMNCH services in the selected regions, which have some of the highest poverty levels and highest non-facility birth rates in Mauritania**. The project focuses on rural health and both regions will be covered entirely under the project. The interventions target CHWs, public health facilities (health posts, health centers, and regional hospitals), poor households, local nongovernmental organizations (NGOs), and relevant institutions, mainly the MoH but also the Ministry of Social Affairs and the Tadamoun Agency, to enhance both supply and demand sides of the health system. The Tadamoun Agency, which manages the Tekavoul Program, is the National Agency in charge of fighting against the consequences of slavery, promoting insertion, and fighting against poverty.

Table 4. Synthesis of Components, Activities, and Entities Supported through the INAYA Project

Entities	Component 1	Component 2	Component 3	Component 4
Public health facilities	• Lump-sum financing (of very small investments/equipment) • Performance-based payments	—	—	CERC
CHWs	• Performance-based payments	—	—	
RBF administration/verification entities	• Financial and technical support • Performance-based payments	—	—	
Poorest families	—	• CCTs • Information, education, and communication	—	
Tadamoun Agency, the Ministry of Social Affairs, NGOs	—	• CCTs management • Other community activities to promote demand for health services	• Capacity building	
MoH departments	—	• Support to the community health strategy	• Project management • Capacity building	

35. **Implementation will be phased**, as shown in Figure 5. The first year (2017) will be dedicated to preparatory activities such as the PBF manual, training on PBF techniques, hiring consultants, preparing PBF contracts, information technology (IT) processes, and contracting with the Tadamoun Agency. The second year (2018) will see the start of the PBF activities. The CCTs component will be implemented according to the development of the Tekavoul Program. The first payments are expected in early 2019.

Figure 5. Implementation Phases for the Project

Component/Activity	2017	2018	2019	2020	2021
Preparatory activities					
Component 1:					
Performance-based payments for health facilities					
Performance-based payments for CHWs					
Component 2:					
CCTs					
Component 3:					
Capacity building and project management					

Note: The Contingency Emergency Response Component (CERC - Component 4) has not been triggered, and therefore, there are no activities at this time.

Component 1: Support to improving utilization of quality RMNCH services through PBF (Total Cost US$10.85 million), of which IDA financing SDR 7.3 [US$9.85 million equivalent])

Subcomponent 1A: Provision of PBF Payments to Health Service Providers

36. **Health services in public facilities (posts, centers, and hospitals)**[4] will receive PBF subsidies which will include nutrition services, prevention services, and maternal, neonatal, adolescent, infant, and child health services, along with treatment for malaria, HIV/AIDS, and tuberculosis and family planning. As the program evolves and more funding becomes available, the package may be adjusted. Services and performance indicators will be clearly defined in the PBF manual that differentiates the list of minimum package of activities for health posts/centers from the list of complementary package of activities for hospitals.

37. **PBF payments will be linked to predefined qualitative and quantitative indicators.** The quality assessment will be undertaken at: (a) the community level to evaluate the quality perceived by the population; and (b) the facilities level (technical verification). PBF payments will then be used to: (a) strengthen the motivation of health workers through bonuses based on their performance; and (b) improve the utilization and quality of care based on the development of business plans where key investments will be identified. Such activities could include conducting outreach activities, purchasing light equipment, commodities, drugs, and so on. The share of health workers' bonuses in the PBF

[4] According to the 2017 MoH work plan, there are very few private sector facilities in the two regions (two small 'clinics' and five 'cabinets,' concentrated in the regional capitals).

payments will not exceed 40 percent, with the remaining funds allocated to pre-agreed activities in the facility business plans.

38. **Small investment grants will be provided to public health facilities that meet certain criteria.** These payments, in the form of small lump sums, will finance small-scale upgrades to eligible facilities before starting the PBF process. Examples of eligible expenditures, to be fully detailed in the PBF manual, are technical equipment, computers, software, desk supplies, and minor renovation works focused on small-scale upgrading. Funds will be released to eligible health facilities once their investment plans are approved by the technical unit in charge of RBF.

39. **Once the community health strategy is ready, the project will support it.** Project proceeds will support the MoH to complete its community health strategy (by 2018), which will be the basis for the community PBF. Performance of CHWs will be linked to community-level activities that will be defined in the PBF manual. Examples of possible activities include (a) health promotion and prevention, (b) simple curative services, (c) referral services to appropriate health centers, and (d) community-based distribution of some inputs (for example, nutritional ingredients, condoms, and bed nets). The performance of CHWs will be assessed through a double evaluation grid to measure both the quantity and quality of services provided.

40. **Once evaluated, the CHWs will be paid through the health facility to which they are linked, to reduce transaction costs.** Each quarter, the performance of CHWs will be consolidated at the concerned health facility. Payment for their performance will be done in one operation directly to the facility. In turn, the facility will transfer the funds to CHWs who will be paid according to their individual performance.

41. Criteria for a facility to sign a PBF contract are the existence of an oversight body that includes civil society (for example, a facility management committee) and a bank account in the name of the facility. Facilities that do not meet these conditions will be combined for PBF purposes with the facility to which they are administratively linked.

42. Project proceeds will finance payments to facilities and providers for services rendered based upon the criteria set out in the PBF manual and as validated by the verification and counter-verification activities described in Subcomponent 1B.

Subcomponent 1B: Verification and Counter-Verification

43. **Rationale and types of verification.** Because payments are linked to the volume and quality of predefined services, there are incentives to inflate the reporting. Verification, done by the ministry, and counter-verification, done by third parties (NGOs and independent firms), will minimize the risk of fraud and errors in reporting. Furthermore, sanctions to be included in the contract with health facilities will mitigate the risk of fraud and over-reporting. There will be two aspects to the verification: (a) the ex-ante verification will be done every quarter, before the payment is made and (b) the counter-verification or ex post verification will be done every semester, after payment is made. If phantom patients or over-reporting is identified as a result of the counter-verification, the PBF amount will be deducted from subsequent payment to the concerned health facilities. The facilities will also receive a first warning so as to mitigate the risks of fraud.

44. **Verification and counter-verification agents will include:**

(a) The Regional Verification Committees in Guidimagha and Hodh El Gharbi, which will conduct the quantitative verification;

(b) The two regional health directorates (*Directions régionales de l'action sanitaire*) and district health offices, which will evaluate the quality of services provided by health centers/posts;

(c) Peers, who will assess the quality at the two hospitals;

(d) Local organizations (community-based), which are in charge of community verification (accuracy of health services provided) and the quality of health services perceived by users;

(e) Regional Verification Committees (RVCs) (*Equipe régionale de verification*)/Units and Health Centers/Posts, which will be in charge of the verification related to CHWs; and

(f) International NGOs/agencies, which will be in charge of undertaking counter-verification by independent entities.

45. The project proceeds will finance the verification and counter-verification activities, will pay performance bonuses to PBF-implementing bodies (the RVCs in Guidimagha and Hodh El Gharbi, the regional health directorates, and district health offices) and will support the coordination of the PBF program. These entities play a key role in the PBF operations and success of the program. They will receive bonuses for performance according to rules defined by the PBF manual.

46. **Surveys undertaken by local NGOs on perceived quality of health care by the users/population will be used to construct an indicator pertaining to the satisfaction of the beneficiaries**. Each quarter, this indicator will be automatically calculated through the PBF database. It will be a valuable indicator to regularly monitor the voice of the community under the project.

Component 2: Support to Increasing Demand for Health Services (Total Cost SDR 1.85 (US$2.5 million equivalent), of which IDA financing US$2.5 million)

47. The second component of the project will support activities on the demand-side to promote and facilitate access to health services, especially for the poorest. Demand-side RBF activities were identified in the National RBF Strategy as key to complement supply-side RBF intervention and impact on health outcomes (financial barriers to access to health services were identified as the main exclusion in the qualitative survey under the RBF feasibility study). Demand-side RBF interventions will build on the existing national social registry system and cash transfers program (implemented by Tadamoun with support from the World Bank-financed Social Safety Net Project - P150430, the Tekavoul Program) and provide additional cash transfers to the poorest families with conditions linked to the use of health care.

Subcomponent 2A: Conditional Cash Transfers to Stimulate Demand for Health Care

48. **Helping the most vulnerable to access services.** In light of the poverty and rural nature of the selected regions, the demand-side RBF feasibility study recommended that households receive financial support to facilitate their access (cost of services and travel) to health care. Thus, through this subcomponent, the poorest households will receive quarterly payments upon utilization of health services (estimated to be between US$50 and US$100 per year). Eligible households will be the ones already identified by the Tekavoul Program (households in extreme poverty) and with children under age 4,[5] as cash transfer conditions will be related to child health services. For these households, health CCTs will be additional to cash transfers received through the Tekavoul Program, which made its first payments in December 2016 and is expected to develop further in the coming years.

49. **Strengthening existing mechanisms to support demand-side interventions.** The Social Safety Nets Project (P150430) supports the establishment of key building blocks of the national social safety net system to provide targeted cash transfers to extremely poor households. Most relevant for the targeting of the poorest is the proxy means test that the Tadamoun Agency is implementing in a phased approach. The project will utilize the results of this process, which will have gone through the start-up phase before the beginning of the project's implementation. To strengthen coordination, reduce the burden on beneficiaries, and increase the impact on the poorest households, the project will rely upon the Tekavoul Program's implementation arrangements and targeting (the Tekavoul manual should be updated accordingly). This will be supplemented through additional community-based engagements as needed. The project will finance modifications to the Tekavoul database and applications to enable their use and will support the costs of database hosting and management.

50. **Conditionality and Monitoring.** Tekavoul organizes quarterly sessions that are mandatory for its beneficiaries; the project will use these to inform households of the project conditionality and to monitor households' adherence. Cash transfers from the project demand-side program will be conditional on children under age 4 receiving their vaccinations (until age 2), and having routine growth monitoring visits (until age 3). The Tekavoul session leader will monitor this through the child's health booklet, which will also be part of the RBF quality dimension. Information will be updated in the Tekavoul database through the existing Tekavoul reporting mechanism and will be subsequently shared with the RBF Technical Unit for processing, verification, and payment. Tadamoun Agency will receive the payment orders and funds from the RBF Technical Unit and will use their payment arrangements to add the funds to the safety net-financed transfers. Project proceeds will finance the health CCT payments, the additional costs to Tadamoun Agency with regard to staff time and verification and cross-verification.

Subcomponent 2B: Strengthening of Community Health

51. **Support to Operationalize the Community Health Approach.** The national community health policy provides a vision to strengthen the use of preventive and high-impact services, but does not provide a clear statement on the implementation of the policy and the roles and requirements for CHWs

[5] Early growth monitoring is undertaken for children ages 0–36 months, however, the lag in reporting requires eligibility to be extended another 12 months to capture all eligible households. Likewise, vaccinations are for children ages 0–12 months, but monitoring is done after the vaccination, so the window of eligibility is extended accordingly.

and local volunteers (*relais communautaire*). In the first phase (2017–18), project resources will support the development of a national community health strategy and a budgeted action plan with necessary implementation elements such as training manuals, profiles, and terms of reference. Once the plan is in place, the project will provide PBF to CHWs and volunteers for actions related to their terms of reference (through Component 1) according to the PBF manual.

52. **Strengthen Local Organizations' Capacity to Increase Demand for Service and Accountability.** Local health committees and community-based organizations are in charge of explaining to their communities their rights and obligations and help particularly vulnerable groups to access health services. In the south, NGOs are very active in the health sector. Through these community organizations and media, the component will provide information on the RBF program, with a particular focus on raising awareness among women about their rights and obligations as project beneficiaries. This will also serve to make the CCT component better known to all possible stakeholders.

53. Quarterly sessions organized by the Tekavoul Program will also be used as an opportunity for health awareness and empowerment of women and mothers on the importance of the following:

(a) Reproductive, maternal, newborn, child, and adolescent health.

(b) Gender equality in the use of health services.

(c) Elimination of harmful traditional practices affecting girls such as female genital mutilation, in conjunction with SWEDD-financed activities.

Component 3: Capacity Building and Project Management (Total Costs US$5.65 million, of which IDA financing SDR 3.45 [US$4.65 million equivalent])

54. The third component will finance project management and comprehensive capacity-building activities, including substantial technical assistance.

55. **Strengthening MoH Capacity.** The project will support the strengthening of the MoH's capacity and other entities involved in RBF and project management in various areas that include monitoring and evaluation (M&E), public financial management and procurement, the health management information system (HMIS), RBF methods, and database management.

56. **Preparing for RBF and shifting the focus to results.** The project will finance two rounds of Service Delivery Indicators (SDI) data collection to support the ministry in developing actionable information on provider absence, provider knowledge (for the PBF scheme), and health sector governance from the provider perspective. These analytical activities will fill a gap in the results chain between demand-side information contained in household surveys and health outcomes such as those found in DHS or MICS surveys. The work will be done in four phases, preferably with a local partner institution for data collection, to avoid a conflict of interest for the ministry. The phases are preparation (policy dialogue, technical adaptation work), data collection and processing (firm with support from the SDI team), data analysis and verification (technical team comprised of the SDI team and national counterparts), and release of the validated results (broad public dissemination). The data collected will

be anonymized and made available through a government web site (Ministry of Health or National Statistical Agency) and the World Bank for licensed public use.

57. **The project will also support (in collaboration with WHO and other development partners) the government to prepare and implement the UHC policy along with continuous quality improvement oversight through technical assistance**. The project will support the following activities: the health financing assessment framework, feasibility and actuarial studies, workshops, the UHC strategy, road map and action plans, and preparing laws and their related decrees.

58. **Project proceeds will finance operating costs and some equipment of the RBF Technical Unit and salaries of international and national consultants who will be hired by this unit.** The project will also support operating costs of the RVC as well as the coordination of the project. The Financial Affairs Directorate (*Direction des Affaires Administratives et Financières*, DAF) will receive financial and technical support, including appropriate staffing to ensure compliance with World Bank Group fiduciary requirements. Financing will also cover comprehensive technical assistance, including one international firm/NGO and two international experts (one based in Nouakchott and the second in one region in the targeted areas) during at least the first years of the project (2017–19). The international NGO or consulting firm specialized in PBF will be hired during the initial phase of implementation, to (a) coach all institutions and teams involved in RBF verification and counter-verification processes; and (b) help the government to undertake a massive training at all levels—central, regional, district, and facility. These will include retroactive expenditures to a limit of $50,000.

59. **Implementation of the environmental safeguards activities will be financed by the project.** The Public Hygiene Directorate (*Direction de l'hygiène publique*, DHP) is responsible for all environmental safeguards activities in the health sector. The project will support the directorate to implement the biomedical waste management plan in the intervention areas (Guidimagha and Hodh El Gharbi) by financing technical and material support. The project will also finance revisions and improvements to project-related safeguards instruments.

60. **Implementation of the environmental safeguards activities will be financed by the project.** The DHP, which will be responsible for implementation of the National Biomedical Waste Management Plan, will receive technical assistance to assess and improve the plan and support the installation of adapted waste disposal systems (for example, Montfort-type incinerators) as needed to improve biomedical waste management in Guidimagha and Hodh El Gharbi. The directorate will also work in close collaboration with the Directorate of Pollution Control at the MoH for the application of the project's Environmental and Social Management Framework. The project will also finance revisions and improvements to project-related safeguards instruments.

Component 4: Contingency Emergency Response (CERC) (Total Cost US$0.0 million, or which IDA financing US$0.0 million)

61. **A CERC will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints**. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

B. Project Cost and Financing

62. **The project cost is estimated to be US$19.0 million**: US$17.0 million from IDA and US$2.0 million from the government. Parallel co-financing from the Government (US$2.0 million) will finance sub-component 1B (US$1.0 million) and component 3 (US$1.0 million). The components are summarized in Table .

Table 5. Project Cost and Financing

Project Components	Project Cost (US$, millions)	IDA Financing (US$, millions)	Financing (%)
Component 1: Support to Improving Utilization of Quality RMNCH Services through PBF	**10.85**	**9.85**	**90.8**
1A: Provision of PBF Payments to Providers	9.35	9.35	100
1B: Verification and Counter-verification	1.5	0.5	33.3
Component 2: Support to Increasing Demand for Health Services	**2.5**	**2.5**	**100**
2A: Conditional Cash Transfers to Stimulate Demand for Health Care	1.5	1.5	100
2B: Strengthening of Community Health	1.0	1.0	100
Component 3: Capacity Building and Project Management	**5.65**	**4.65**	**82.3**
Component 4: Contingent Emergency Response (CERC)	**0.0**	**0.0**	**100**
Total Cost	**19.0**	**17.0**	

C. Lessons Learned and Reflected in the Project Design

63. **The project has taken into account lessons learned from other low- and middle-income countries in Africa and elsewhere**. These lessons pertain to the content of the project as well as its implementation, including all coordination efforts with the government.

64. **Lessons on RBF are derived from the design and implementation of both World Bank and non-World Bank operations in Africa**. RBF, especially on the supply side, leads to the following:

- Improved alignment between resources and maternal and child health priorities by purchasing priority service delivery indicators at higher rates;
- Improved quality of health services by purchasing services conditional on quality;
- Creation of incentives for health facility managers and health workers to expand the coverage of essential public health interventions and improve their quality by linking

facility payments to service delivery and quality indicators and offering health workers bonuses that are linked to facility performance;

- Improved governance through better verification and oversight of performance by providing incentives for good performance, involving communities for verification of health facility quality, involving civil society in assessing health service delivery results, and publishing results on a public website;

- Improved efficiency in the health system—RBF increases efficiency, for example, by setting the payments high for services (such as deliveries by trained staff in institutional settings, immunization, neonatal care, and so on) performed at health centers, allowing hospital resources to be used for complicated care, and so on. In Rwanda, RBF reduced the gap between provider knowledge and practice of appropriate clinical procedures by 20 percent, implying a large gain in efficiency; and

- Enhanced functioning of the public health administration at all levels.

CCTs have played a positive role, in Africa, Latin America and Asia, in increasing use of health services by the poorest, especially when they face significant indirect costs.

65. **The RBF programs obtain fewer results or no results when their counter-verification component is absent or weak**.[6] Results are neither significant nor lasting when RBF is: (a) implemented without any concomitant policy on the demand side; and/or (b) designed as an isolated program in the health system, especially when it is executed by an international agency/NGO.

66. **One of the strengths of the project is the involvement of NGOs at different levels**. Community-based NGOs and local elected officials will be engaged in the RBF program. They will be involved in assessing the subjective quality (perceived quality of services received in health facilities by the population), community outreach, and demand promotion for better use of health services by the communities, particularly the poorest.

67. **One of the project priorities is to target high-impact interventions, which will help to redress the current state of allocative inefficiency observed in Mauritania**. These include activities related to reproductive, maternal, newborn, infant, and child health, as well as nutrition. There are also strategic interventions aimed to improve the quality of care in general. Finally, from the demand side, PBF and CCTs remain a good combination.

68. **During the policy dialogue with the Government, an alternative was discussed, to increasing RBF bonuses for services used by the poorest instead of CCTs**. This option could allow the poorest to obtain free health care services. However, because basic requirements, such as a free health care policy/law, updated tariffs, and good knowledge of unit costs were not in place and/or hard to achieve in the medium term, this option was not suitable.

[6] Fritsche, G.B., Soeters, R., and Meessen B. 2014. Performance-based Financing Toolkit, World Bank.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

69. **The MoH will be responsible for project coordination and execution, through the Office of the Secretary General, which will be supported by the RBF Technical Unit.** Technical support to the RBF Technical Unit will be provided by the ministry's directorates, as summarized in Table . Project oversight will be handled by the MoH Steering Committee created by *Arrêté* MS 202/2012 to oversee implementation of the PNDS, which will meet regularly for this purpose. The Administrative and Financial Manual of Procedures and the PBF Manual will detail the roles and responsibilities of the various parties and make explicit any adjustments to national procedures required by IDA.

70. **The RBF Technical Unit will be staffed with civil servants nominated or appointed competitively and consultants will be recruited where civil service cannot provide the skill sets**. A PBF specialist will be assigned to the RBF Technical Unit in Nouakchott to support coordination. Another PBF specialist will be based in one of the two regions to support implementation in both regions, including for the verification and validation processes.

Table 6. Summary of Institutional Arrangements

Task/Activity	Responsible Entity	Comments
Project oversight [a.]	MoH Steering Committee	—
Project coordination [a.]	Coordinator: Secretary General	Deputy Coordinator: Head of the RBF Technical Unit
RBF general coordination [a.]	RBF Technical Unit	Supporting entities at the regional level: the RVCs
Purchasing, verification, validation, and counter-verification [a.]	RVCs	Supporting entities: international and local technical assistance
CCTs [a.]	Tekavoul Program/Tadamoun Agency	Supporting entities: Local NGOs
Promoting demand for health care [a.]	Direction de la Santé de Base et de la Nutrition	Supporting entity: Ministry of Social Affairs
MoH Technical Support to the RBF Technical Unit by focal area and department		
CHWs and Health Centers	Nutrition and primary health care (DSBN)	Each directorate will provide support to the PBF program through its current mandate. For example, the DH will assist the program in establishing the RBF package at the hospital level; defining criteria for assessing quality and quantity of services provided by hospitals, and so on.
Hospitals	Hospital (DH)	
Health information system and M&E	Planning and international cooperation (DPCIS)	
Safeguards	Public hygiene (DHP)	
Fiduciary	Financial affairs (DAF)	
Reproductive, maternal, and child health	Fighting against diseases (DLM)	

Note: a. Indicates a new responsibility for the institutions involved in the `project. DH = Hospitals Directorate (*Direction des Hôpitaux*); DLM = Directorate to Combat Diseases (*Direction de lutte contre les*

maladies); DPCIS = Directorate of Planning and International Coopération (*Direction de la Planification et de la Coopération internationale*); and DSBN = Basic Health and Nutrition Directorate (*Direction de la santé de base et de la nutrition*).

71. **Counter-verification, as required for PBF, will be undertaken every semester by contracted community-based organizations and independent agencies.** The RBF Technical Unit will be responsible of the hiring process with technical support from the DAF. Counter-verification will be undertaken every six months.

72. Figure 6 shows the PBF information, verification, counter-verification, and payments flows.

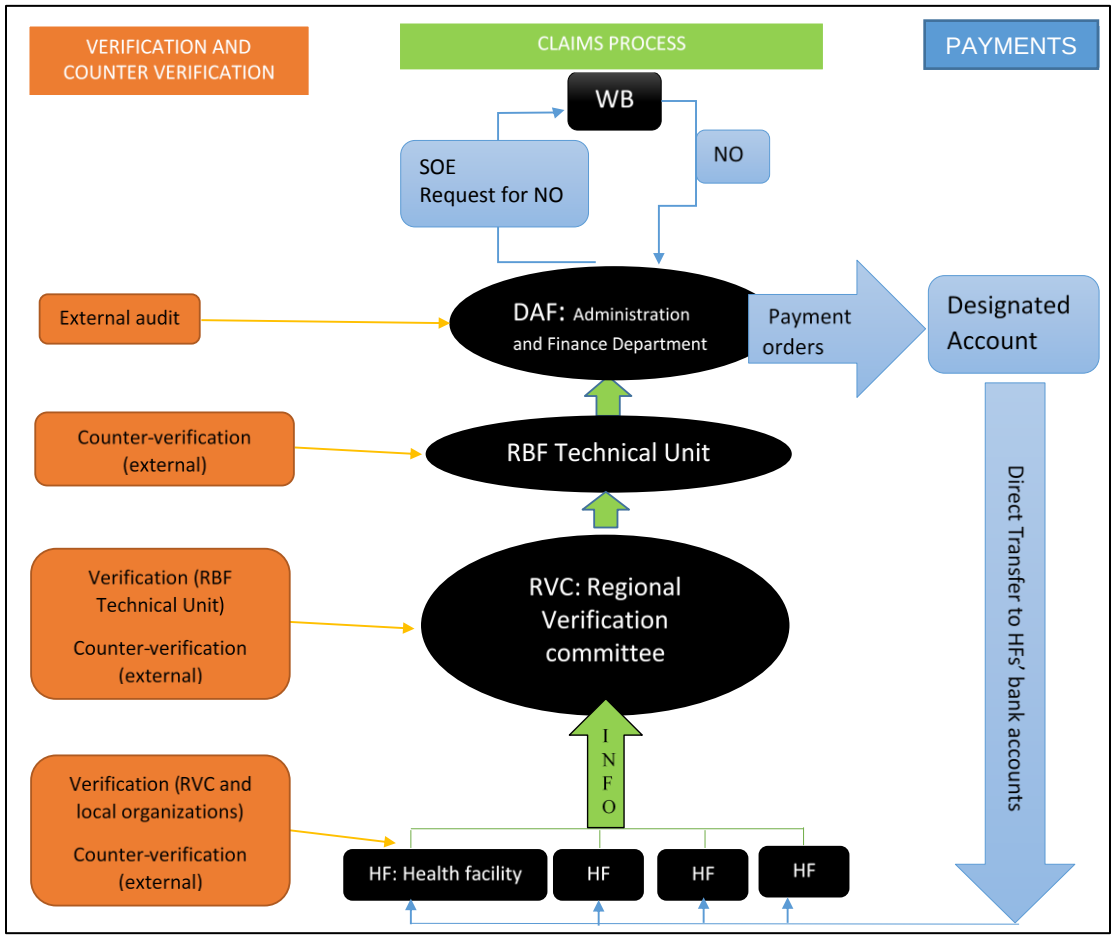


Figure 6. PBF Information Flows, Payment Arrangements, and Verification

Note: WB = World Bank; SOE = Statement of Expenditures; NO = No-objection; HF = Health Facility.

73. **The CCT activities will be contracted to the Tadamoun Agency.** The Tekavoul Program is receiving support from the Social Safety Net Project (P150430). Project activities will use this platform to target those evaluated to be among the poorest in the project areas.

B. Results Monitoring and Evaluation

74. **The routine system needs improvement.** Available information for 2015 shows that roughly one health facility in two submitted its reporting forms on time, although the submission of the reports overall was generally complete in Guidimagha (90 percent) and somewhat lacking in Hodh El Gharbi (76 percent). Recent evaluations suggest that the HMIS remains weak, although the project's interventions will help address a number of concerns as detailed in Table 7.

75. **Donors and the Government are developing work plans to roll out the District Health Information System-DHIS2 system in Mauritania.** Exploratory missions have taken place and there is a consolidated program of activities with sources of funding and timetables, but resources are insufficient. A number of donors may support the reform, including the SWEDD project financed by the World Bank. This is expected to be the primary mechanism to support the rollout of the new system in Mauritania for the World Bank.

76. **Strengthening Routine Systems for Monitoring.** Project indicators are derived from the national strategies (for example, Reproductive Health Strategy 2016–20) and from the PBF implementation. The PDO indicators, which are regional in nature, are the outcomes of the PBF interventions. Wherever possible, the project will rely on the HMIS. RBF-related indicators will come from two sources. Indicators related to supply and CHWs will come from the PBF database. For the demand side, information will flow from the Tekavoul Program to the RBF Technical Unit.

77. **The project will finance PBF monitoring and some HMIS strengthening.** The project will finance activities to strengthen reporting timeliness, completeness, and reliability for the HMIS in conjunction with support from the SWEDD project to the two regions. The project will also finance modifications to the Tadamoun Agency's database for M&E of the demand-side intervention and the marginal costs of Tekavoul staff time in organizing outreach sessions and reporting on the CCT component.

Table 7. M&E Risks, Project Interventions, and Residual Risks[7]

Element	Project Pathway(s)	Expected Effect	Residual Risk
Integration of hospitals and private sector	• Direct support from the ministry (and through project) • Demand for data/PBF incentive to report	• Hospital integration underway (MoH) complemented by project	• Private sector may fail to report because it is not included
Insufficient trained staff	• Training to health facility staff engaged in reporting	• Improved reporting and reporting quality	• Moderate, financial incentives will reduce it
Reporting is not timely	• PBF incentive to report	• Increased timeliness	• Moderate, financial incentives will reduce it

[7] The diagnosis of weaknesses based upon information in the National Reproductive Health Plan 2016–20.

Element	Project Pathway(s)	Expected Effect	Residual Risk
Irregular and weak supervision	• The RBF Technical Unit's quality assurance and project support to the ministry supervision function	• Improvement in frequency and quality	• Moderate, financial incentives will reduce it
Overloaded staff	• Possible support to indicator harmonization • PBF incentives will increase reporting	• Reduced reporting burden • Improved reporting	• Substantial, to be coordinated with other DPs • Moderate, financial incentives will reduce it
Very limited data analysis	• The RBF Technical Unit will use this to pay and the ministry at various levels will use the information to plan	• Increased analysis	• Moderate, to be addressed with training on data analysis and planning
Data quality concerns	• The RBF Technical Unit will use this to pay and the ministry at various levels will use the information to plan	• Increase data quality	• Moderate, financial incentives will reduce it
Low data availability over the Internet	• The PBF portal will make public many indicators at a regular frequency	• Significant increase in data availability	• Low for project areas

C. Sustainability

78. **The National RBF Strategy has been adopted by both the national health sector steering committee (involving multiple ministries, several public agencies, key development partners, and civil society) as well as the Council of Ministers.** The government also created a new MoH budget line for FY2017, dedicated exclusively to RBF preparatory activities (supply side). On the demand side, the Tadamoun Agency is already in place and working on the Tekavoul Program which is funded by the government and development partners. These two aspects demonstrate the government's commitment in relation to the RBF program, particularly the pilot that the project is supporting. The aim is to gradually make it a nationwide program, starting from 2021.

79. **In addition to the government's commitment, there is a good margin for improving the fiscal space for health because the sector is underfunded (see Section II).** The health sector as a share of the government budget is less than 10 percent compared to the 15 percent recommended by the Abuja Declaration. A part of the additional fiscal space could be dedicated to the RBF scaling-up.

80. Moreover, many development partners have expressed an interest to support the RBF (PBF and CCTs) during their upcoming operations (EU; Global Fund to Fight AIDS, Tuberculosis and Malaria; and AECID).

81. **The preparation of a PBF cost containment strategy is planned to be a part of the PBF manual.** This strategy is important even in the early stages. It will help the country not only to optimize the utilization of project resources but also to scale up the RBF program with a reasonable cost.

82. **Sustainability is not only financial but also technical and institutional.** That is why the project will provide technical strengthening support to the MoH, the Tadamoun Agency, and the Ministry of Social Affairs. The technical support will be made not only through training activities and the international and national technical assistance included in the project but also through an additional technical assistance financed outside the project as a parallel and complementary activity (for example, to prepare a Health Financing Assessment Framework with GAVI and support to the UHC policy preparation and implementation with WHO).

D. Role of Partners

83. The main development partners (WHO; UNICEF; EU; GAVI; Global Fund to Fight AIDS, Tuberculosis and Malaria; United States Agency for International Development - USAID; French Development Agency (*Agence Française de Développement-AFD*); AECID; and the United Nations Population Fund-UNFPA) are supporting the government's health system strengthening agenda (human resources, drugs supply, service delivery, national health information system), through input-based and technical assistance projects and operations. Avenues of collaboration may include the AECID-funded activities in Guidimagha, where their project on supply chain rationalization will complement the SWEDD project's focus on drug supply and the RBF-driven needs for additional inputs. In addition, the planned AECID study on drug prescriptions will provide information on patient costs and provide information on provider behavior.[8]

84. **With the assistance of its partners, the government is preparing a national health care financing strategy, as a component of the UHC policy.** This effort is led by the MoH and assisted by WHO and other development partners, including the World Bank. RBF will be one of the key approaches for UHC in Mauritania. According to the timeline, this strategy will be finalized and adopted by the government in 2017 (calendar year).

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

85. **The overall risk of the proposed operation, which will serve to pilot the RBF approach in health, is rated Moderate after the mitigation measures are implemented.** The two most significant risks are related to institutional capacity (including environmental safeguards) and fiduciary elements.

[8]. The project is the '*Appui institutionnel au Ministère de la Santé ciblant la disponibilité et la prescription de médicaments, la planification opérationnelle et l'information sanitaire*.'

86. **Institutional capacity.** The project is embedded within the MoH, which does not have experience with PBF and CCT approaches. The complexity comes from the need to ensure that the mechanisms for verification and payment are functional and transparent. Two mitigation measures are proposed. Conceptually, the project has been designed using the experience from other countries, which will also be used to guide project implementation. Support will also be provided to the ministry by an RBF advisory firm for a limited period and by internationally recruited consultants for a longer duration both to mitigate the risks and to build capacity through knowledge transfer. The tools and systems will remain with the government after the project closes, to support sustainability. To date, the ministry staff have participated in workshops and study tours related to RBF. An additional challenge is the coordination with the Tadamoun Agency's Tekavoul Program. Mitigation measures include starting in one region (to learn before expanding) and waiting for Tekavoul to have enough experience to avoid the cumulated difficulty. The capacity of the concerned authorities to implement the World Bank's environmental and social safeguards is limited, and the enforcement of the national environmental and social impact assessment system is weak. Capacity-building activities and support for the implementation of the biomedical waste management plan are included in the project's design.

87. **Fiduciary risk.** The MoH has some experience with World Bank-financed operations, but the last project closed in 2011. The DAF will be responsible for the fiduciary aspects and will be supported by consultants for procurement and financial management. Project proceeds will finance the revision of the Administrative and Financial Manual of Procedures to integrate IDA's guidelines and the purchase of the accounting software.

88. **Other risks are either moderate or low, as summarized in table 6.** Mitigation measures have been designed to address the remaining risks.

Table 8. Systematic Operations Risk- Rating Tool (SORT)

Risk categories	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environmental and Social	Moderate
8. Stakeholders	Low
Overall	Moderate

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Economic Analysis

89. The objective of the Health System Support Project ("INAYA") 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". The project will pilot the Results-Based Financing strategy for the health sector that was adopted by the Government of Mauritania in October 2016. It will contribute to improving the health status of women of reproductive age, infants, and children by improving their survival and improving their health outcomes, thus increasing their chances for more productive lives.

90. **As detailed elsewhere, the project will target increased provision and utilization of higher-quality services through a mix of supply- and demand-side incentives**. Direct project benefits will include the survival of childbirth by more mothers and their infants, the ability for women to more closely achieve their desired fertility rates, improved management of childhood illnesses, and reduction in malnutrition. Indirectly, the project will increase the potential economic attainment of individuals through its interventions related to the first 1,000 days after conception. Over time, this will compound into macroeconomic effects.

91. **The sector diagnostic highlights the resource imbalance in which high-impact, low cost preventive programs (immunization, reproductive health, malaria) receive four percent of resources, primary care receives 21 percent, and hospitals receive 60 percent**. The overwhelming majority of facilities benefitting from the project will be health centers and health posts. This will support the most cost-effective approach to provide high-impact health services. The focus on results, including data quality, will also help the sector to more strategically align its resources to where they can most productively contribute.

92. **The rationale for public sector engagement is clear: public health interventions such as these are public goods, subject to under-provision in general, and have a societal return (externalities) that is greater than their cost**. The investments in the performance of the health system, including the functioning of the routine health information system will not find private resources and will increase overall efficiency in the ministry.

93. **World Bank engagement in this project builds on the Public Expenditure Reviews (2011 and 2015) and the work on the Results-Based Financing strategy for the sector**. The value-added of the institution going forward is both its technical ability to support the process with experiences gained elsewhere and the ability to help government to mobilize additional resources to support the development of the sector. An example of this is the support for the Health Financing Strategy.

94. **A cost-effectiveness evaluation was performed based upon the approach presented in Shepard, Zeng, and Nguyen (2016)[9]**. The model developed using the Lives Saved Tool (LiST) generated projections of the impact of the interventions over the project period and allowed for comparisons to a "no change" case. The incremental lives saved were 256 children under the age of one month, 508 children between the ages of one and 59 months, and five mothers. Where possible Mauritania-specific parameters were used, the others were drawn from the best available evidence. The relatively low

[9] Shepherd, D, W. Zeng, and H. Nguyen. 2015. Cost-effectiveness analysis of results-based financing programs: A toolkit. World Bank. Washington DC.

number of maternal lives saved is driven by the burden of mortality and the expected impact of project interventions.

95. **An Incremental Cost Effectiveness Ratio (ICER) was estimated for the overall program cost**. Trimming the Global Burden of Disease estimates to reflect current life expectancy in Mauritania, the cost per year of life lost is estimated to be US$388. This is roughly one-quarter of GDP per capita (US$1,371 in 2014). Assuming that children saved will have average productivity between ages of 15 and 49 and zero economic growth, the ICER is 1.01, primarily because of the overhead of setting up the program (capacity building and technical assistance in the first 18 months). Sensitivity tests using per capita growth of 0.25 percent per annum (ICER = 1.06) or 0.5 percent (1.14), or extending the productive life to 55 years of age (1.02) all show higher returns.

Financial analysis

96. **Mauritania is a resource-rich country that has enjoyed political stability since the 2008 military coup**. It 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 (from US$700 in 2007). According to the World Development Indicators, Mauritania's per capita GDP growth of 1.51 percent (2009-2014) ranks 18th in Sub-Saharan Africa. Growth variation, measured in standard deviations, is in the second-lowest quartile. Compared to the average of low and middle-income Sub-Saharan African countries, Mauritania's growth is just above the regional average (1.47 percent) and nearly triple the variation (2.95 versus 0.79).

97. **The latest IMF Article IV Report (16/115 of May 2016) indicates that real economic growth in Mauritania has remained positive since 2012 and the forecast is for positive growth until at least 2021**. However, the decline in ore prices observed at end-2015 had halted plans to expand mining in Mauritania and the economic picture has worsened overall in part due to a persistent negative terms-of-trade shock. Overall risks to the economic outlook were mostly negative due to vulnerability to higher-than-forecast oil prices and/or lower iron ore prices, deterioration in regional security, and domestic policy implementation risks. Potential positive risks were a rebound in iron ore prices, an expansion in gold mining capacity, and accelerated exploration associated with a recent gas discovery that could boost economic prospects.

98. **Mauritania's fiscal situation is difficult and government was expected to reduce its spending to accordingly improve its savings**. After broadly decreasing over 2009-2012, the public debt rose approximately 10 percentage points of GDP per year since 2013 to reach 93 percent of GDP in 2015. To address this, the Fund projects that government revenues, as a percent of GDP, will remain around the 28 percent estimated for 2015. The Fund staff recommended that government be ready to increase targeted social transfers to mitigate the effect of fiscal consolidation on the poor.

Health sector expenditure

99. **Health financing in Mauritania is primarily domestically-financed (88%), with 44 percent from government, 44 percent from households, and only 12 percent from abroad in 2014**. The IMF has warned that social programs will need to be sustained and perhaps strengthened through targeted transfers to offset the effects of fiscal consolidation. The latest data estimate that one-third of the

population is poor, with higher concentrations in the south and rural areas. The project will be implemented in some of these higher-poverty areas (Guidimagha and Hodh El Gharbi).

100. **Since the 2008 crisis, government allocations for health have averaged 6.1 percent of the budget as compared to 6.4 percent over the 2002-2014 period**. The share of total health expenditure financed by government has averaged 34 percent while varying between 29 percent (2012) and 44 percent (2014) in the 2009-2014 period. The trend over the 2002-14 period is broadly negative, with a new pattern of increase between 2012 and 2014. This last increase has raised health expenditure per capita to US$148 per person (2014), which places Mauritania in 20th position among Sub-Saharan Africa countries. However, as shown in the Public Expenditure Review (2015), the efficiency of health spending is lower than in comparator countries.

101. **External financing for health, measured as gross disbursements in constant 2014 US$, has been cyclical in the 2002-15 period, according to the Organization for Economic Cooperation and Development - Development Assistance Committee Creditor Reporting System database**. There were troughs in 2005, 2006, and 2012, and the 2015 level (US$18.11 million) is the highest recorded over the period. This latest upswing is largely driven by GAVI, who disbursed US$7.2 million in 2014 and US$6.2 million in 2015 primarily for specific diseases. There are also plans for a €44 million project funded by the European Union over six years, primarily for health systems strengthening. Taken with the project, these amounts would represent a large inflow of foreign financing for the sector and will require close coordination and management to disburse and deliver results.

102. **This project, at US$17.0 million over four years, most of it back-loaded in 2019-2021, will be the largest flow of funds directly to health providers**. The latest budget data for the Ministry of Health (2015) show that the capital budget was 3.88 billion MRO (US$12.5 million), of which 94 percent was executed. Comparatively, approximately US$4.0 million will be disbursed annually by the project between 2019 and 2021. Project inflows will be important, but not overwhelming compared to government expenditure. Although a general consolidation of the fiscal position is anticipated, the government has indicated that it will provide the US$2.0 million in counterpart funding (parallel co-financing) over the project's duration.

103. **The Ministry of Health has been actively involved in the project preparation phase and is moving rapidly to prepare the implementation of the project**. The Ministry of Finance has approved the no-PIU approach and committed in writing to make funds available. While these are not guarantees that future funds will be available, they are indications of the priority of the project and the likelihood of receiving future funds. The relative magnitude of the commitment is three percent of the 2015 executed health budget, so this should not be at risk.

B. Technical

104. **The project is relevant and consistent with the aim of improving Mauritanian health system's performance.** Indeed, the focus on results instead of inputs will only improve efficiency and several health system pillars such as governance, quality of health service delivery, and health financing (strategic purchasing), particularly in the two targeted regions (Hodh El Gharbi and Guidimagha). The project components are complementary, and the budget for each component and subcomponent is reasonable and balanced.

105. **RBF has a clear, positive, and better impact on the health system when the supply side and demand side are combined.** A World Bank evaluation (Development Economics, 2016) showed that stand-alone PBF programs did not have a clear positive impact on the health system; however, when it is combined with schemes promoting the demand side, it has a better impact (cases of Argentina, Burundi, Rwanda, and so on). The demand-side component is included in part based upon this evidence and the levels of poverty in the project areas.

106. **The project arrangements are based on the best practices in RBF projects in other low- and middle-income countries in Africa, Asia, and Latin America.** The integration of the project in public institutions will facilitate the ownership and rapidly improve the technical capacities of these institutions (MoH, Ministry of Social Affairs, and Tadamoun Agency).

C. Financial Management

107. An assessment of the financial management arrangements for the project to be implemented by the DAF of the MoH was carried out in accordance with requirements under OP/BP 10.00 and the Financial Management Manual for World Bank Investment Project Financing Operations, updated on February 4, 2015 and effective from March 1, 2010. The objective of the assessment was to determine whether the DAF has acceptable financial management arrangements in place that satisfy the World Bank's OP/BP 10.00. These arrangements will ensure that the implementing entity: (a) uses the project funds only for the intended purposes in an efficient and economical way; (b) prepares accurate and reliable accounts as well as timely periodic financial reports; (c) safeguards assets of the project; and (d) has acceptable auditing arrangements.

108. **The fiduciary capacity of the DAF to implement World Bank financed projects is weak.** The financial management system has the following capacity constraints:

(a) Lack of sufficient financial management staff with experience in World Bank financial management procedures: the DAF teams comprising the Director and one financial management analyst are not sufficient to undertake the additional financial management activities related to the project

(b) Weak internal control environment: lack of financial management manual and lack of internal audit

(c) Lack of accounting software

109. **As a result of the financial management weaknesses identified, the project will:**

(a) **Before effectiveness**: develop an administrative and financial manual of procedures satisfactory to the World Bank and select an accountant with skills and experience satisfactory to the World Bank.

(b) Within **four months after effectiveness**: recruit an internal auditor with skills and experience satisfactory to the World Bank, recruit an external auditor with skills and experience satisfactory to the World Bank, and install an accounting software.

110. **The conclusion of the financial management assessment is that the financial management arrangements of the DAF have to be reinforced to meet the requirements of OP/BP 10.00.** The overall risk rating is **Substantial**, and it will become Moderate once the mitigation measures are implemented and the DAF financial management team and financial management system become fully operational.

Financial Management and Disbursement Arrangements

111. **The following are the financial management arrangements for the project.**

Internal Control and Internal Auditing Arrangements

Internal Control Arrangements

112. The Administrative and Financial Manual of Procedures will provide a clear description of the approval and authorization processes with respect to the rule of segregation of duties.

Internal Auditing Arrangements

113. The internal inspectorate of the MoH is not yet able to carry out the internal audit of the project's activities.

Accounting Arrangements

114. The current accounting standards in use in Mauritania for ongoing World Bank financed projects will be applicable. Project accounts will be maintained on an accrual basis and supported with appropriate records and procedures to track commitments and to safeguard assets. Annual financial statements will be prepared by the DAF.

115. An accounting software will be installed to generate the necessary information.

Budgeting Arrangements

116. **Every year, the DAF will prepare an annual budget based on agreed annual work program and annual procurement plan.** The budget will be adopted by the Program Steering Committee before the beginning of every calendar year, and its execution will be monitored on a quarterly basis. The budgeting process and monitoring will be clearly defined in the Administrative and Financial Manual of Procedures. Annual draft budgets will be submitted to the World Bank's no-objection before adoption and implementation no later than November 15 every year. Periodic reports of budget monitoring and variance analysis will be prepared by the financial management team.

Financial Reporting Arrangements

117. **The DAF will prepare quarterly Interim Financial Reports (IFRs) for the project in form and content satisfactory to the World Bank.** These IFRs will be submitted 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 IFRs during negotiations. The DAF will also prepare the project financial statements in compliance with International Accounting Standards and World Bank requirements.

Auditing Arrangements

118. **The Financing Agreement will require the submission of audited financial statements for the project to IDA within six months after the end of each fiscal year.** The audit report should reflect all the activities of the project. An external auditor with qualifications satisfactory to the World Bank will be appointed to conduct annual audits of the project financial statements.

Table 9. Audit Report Timeline

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

119. **In addition, results supposedly achieved will be controlled before payment.** In many cases, this role is assigned to an independent entity or the external auditor. Details will be reflected in the Administrative and Financial Manual of Procedures.

Flow of Funds and Disbursement Arrangements

Disbursement Arrangements

120. **The following disbursement methods may be used under the project:** reimbursement, advance, direct payment, and special commitment as specified in the Disbursement Letter. In accordance with the Disbursement Guidelines for Investment Project Financing, dated February 2017, disbursements will be transactions-based whereby withdrawal applications will be supported with an SOE.

121. **All replenishments or reimbursement applications will be documented using customized SOEs for RBF Payments and standard SOEs for all other expenditures.** Detailed supporting documentation will be retained at the DAF for review by the World Bank staffs and auditors. The Disbursement Letter will provide details of the disbursement methods, required documentation, Designated Account (DA) ceiling, and minimum application size.

Banking Arrangements

122. **A DA for the project will be opened in the Central Bank of Mauritania and a Project Account will be opened in a commercial bank in Nouakchott on terms and conditions acceptable to the World Bank.** The DA will be used for all eligible payments financed by the credit as indicated in the specific terms and conditions of the Financing Agreement.

123. **Flow of funds arrangements.** Flow of funds arrangements for the project are shown in Figure 7.

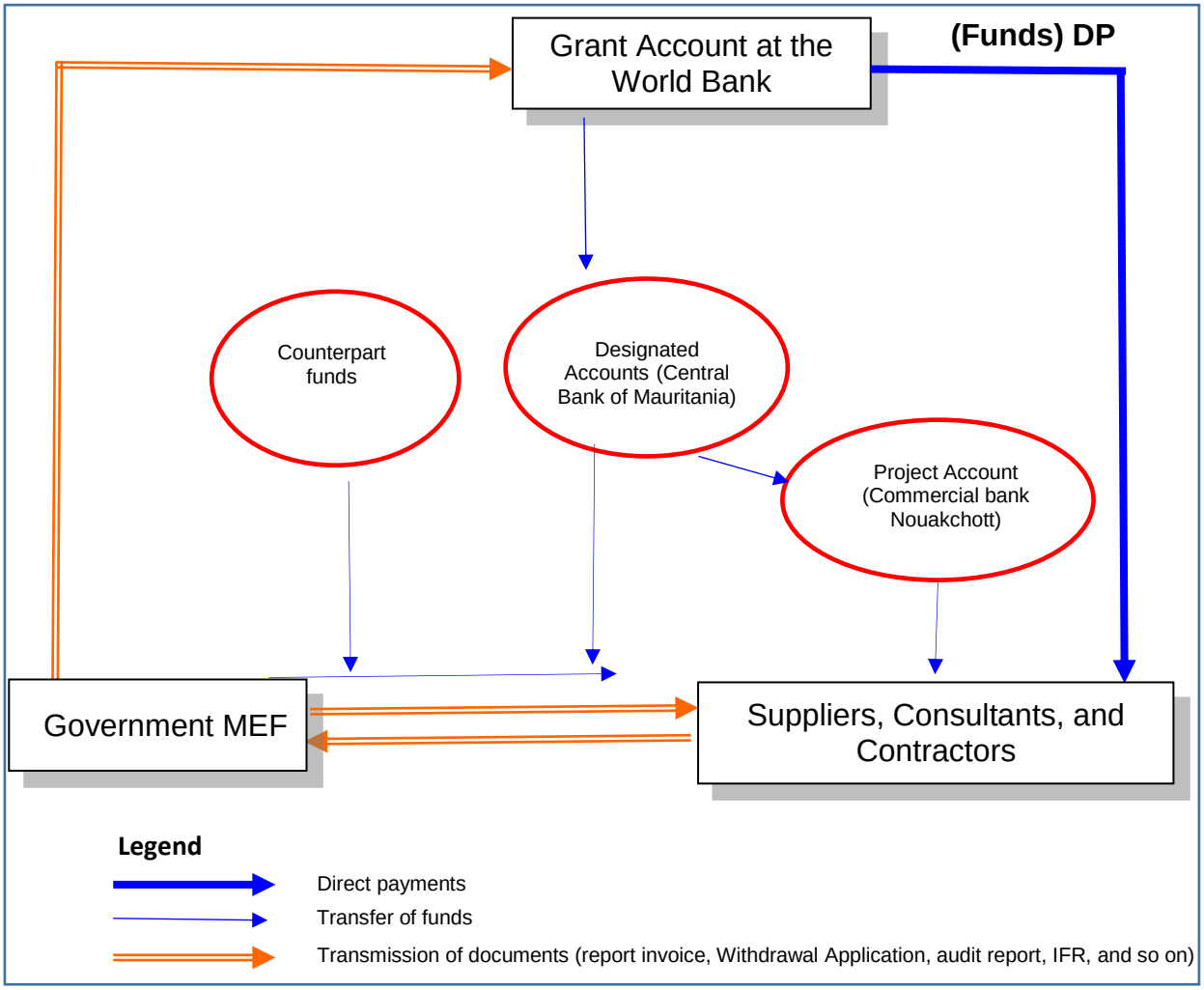


Figure 7. INAYA Flow of Funds Arrangements

Action Plan

124. Table details the necessary actions to be taken to enhance the financial management arrangements for the project.

Table 10. INAYA Financial Management Action Plan

Action	Due Date	Responsible Entity
Prepare and agree with the World Bank on the format of the IFRs	Done	DAF
Set up an administrative and financial manual of procedures	By effectiveness	DAF
Select an accountant with competence and experience satisfactory to the World Bank	By effectiveness	DAF
• Installing an accounting software • Select an external auditor with competence and experience satisfactory to the World Bank • Select an internal auditor with competence and experience satisfactory to the World Bank	Not later than four months after effectiveness	DAF

Implementation Support Plan

125. Based on the outcome of the financial management risk assessment, the following implementation support plan is proposed. The objective of the implementation support plan is to ensure the DAF maintains a satisfactory financial management system throughout the project's life.

Table 11. Implementation Support Plan

Financial Management Activity	Frequency
Desk reviews	
IFR review	Quarterly
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 the financial management system	Annual for implementation support mission
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 and when needed.

126. **Conclusion of the assessment.** The financial management arrangements of the DAF have to be reinforced to meet the requirements of OP/BP 10.00.

127. **The overall risk rating is Substantial.** It will become moderate once the mitigation measures are implemented and the DAF financial management team and financial management system become fully operational.

D. Procurement

128. Procurement for goods, non-consulting, and consulting services to be financed by the Grant will follow the procedures specified in the 'World Bank Procurement Regulation of Goods, Works and Non-Consulting Services' under 'World Bank Procurement Regulations for Borrowers under Investment Project Financing' dated July 1, 2016 and the World Bank's Anti-Corruption Guidelines: 'Guidelines on Preventing and Combatting Fraud and Corruption,' revised in January 2011 and as of July 1, 2016.

129. All goods and non-consulting services will be procured in accordance with the requirements set forth or referred to in Section VI. Approved Selection Methods: Goods, Works and Non-Consulting Services of the 'Procurement Regulations,' and the consulting services will be procured in accordance with the requirements set forth or referred to in Section VII. Approved Selection Methods: Consulting Services of the 'World Bank Procurement Regulation for Borrowers under Investment Project Financing' dated July 1, 2016, the Grant's Project Procurement Strategy for Development (PPSD), and Procurement Plan approved by the World Bank. The Procurement Plan specifies for each contract (a) a brief description of the activities/contracts, (b) the selection methods to be applied, (c) the estimated cost, (d) time schedules, (e) the World Bank's review requirements, and (f) other relevant procurement information. The Procurement Plan covers the first 18 months of the project implementation. The recipient shall submit to the World Bank, for its review and approval, any updates of the Procurement Plan for approval by the World Bank. The recipient shall use the World Bank's online procurement planning and tracking tools to prepare, clear, and update its Procurement Plan and conduct all procurement transactions.

130. **The DAF will be responsible for procurement implementation under the project.** The DAF will designate a staff who will be responsible for procurement activities of the project. The designated agent will work closely with the procurement specialist of the World Bank Office and will be technically supported by an expert/consultant hired by the project. S/he will be exposed to procurement clinics and training organized by the World Bank. According to an evaluation undertaken between pre-appraisal and appraisal, the overall procurement risk has been rated Substantial; this will be updated during implementation. Table summarizes the main risk factors identified and their proposed mitigation measures.

Table 12. Procurement Risk Assessment and Mitigation Measures

Risk	Action	Completion Date	Responsible Entity
Accountability for procurement decisions in the MoH (implementing agency) **Internal manuals and clarity of the procurement process**	• Prepare a project specific manual (Administrative and Financial Manual of Procedures) and ensure that the procurement decision making is fully covered in the manual and available/known to staff • Avoid confusion between the World Bank and national procedures	By effectiveness Throughout project implementation	MoH
Staffing **MoH/DAF procurement capacities to be enhanced**	• Hire a procurement expert/specialist who will provide technical support to the DAF • Train project team in World Bank basic procurement procedures, particularly on the new Procurement Framework that will apply to the proposed project, especially at the launching of the project • Train project team in STEP (new procurement tracking system)	Three months after effectiveness By effectiveness	MoH World Bank Staff/MoH
Record keeping and document management system	• Implement a strong procurement record keeping	Throughout project implementation	MoH
Procurement planning	• Update the PPSD regularly and develop and maintain procurement planning that minimizes variances between planned and actuals in cost and schedule • Intense supervision	Throughout project implementation	MoH

131. **Brief summary of the PPSD.** Based on the main conclusions of the PPSD, the environment is considered favorable for the execution of public contracts. The IT equipment required for the project, including the laptops, desktops, and tablets, can be procured in the domestic market by using 'Request for Quotations' (RFQ). Regarding office supplies, a wide domestic market exists, including a number of large enterprises capable of fulfilling the contract. In addition, it will be possible to open an RFQ to allow small businesses to also participate. With regard to consulting services, for positions in which there are a sufficient number of qualified individuals within the domestic market, the project will issue an open call

for Expressions of Interest, published in newspapers, United Nations Development Business online, and other relevant electronic portals to reach the maximum number of applicants.

Table 13. List of Major Contracts for Works, Goods, Non-Consulting Services, and Consulting Assignments

Contract Title, Description, and Category	Estimated Cost (US$) (Risk Rating)	Bank Oversight	Procurement Approach/ Competition	Selection Methods	Evaluation Method
Purchasing of IT equipment comprising computers and the office equipment's for archiving	128,000 (Substantial)	Post review	Open/ National	RFQ	Qualifying criteria/lowest evaluated cost
Archiving office extension and redevelopment	22,000	Post review	Open/ National	RFQ	Qualifying criteria/lowest evaluated cost
Purchasing of an electronic system for digital document management	23,000 (Low)	Post review	Open	RFQ	Qualifying criteria/lowest evaluated cost
Purchasing 5 vehicles	126,000 (RISK)	Post review	Open/ National	RFQ	Qualifying criteria/lowest evaluated cost
Selection of an international firm or an international NGO for massive training and coaching	500,000 – 1,000,000 (Substantial)	Post review	Open	QCBS	Technical and financial scores combined
Selection of an international consultant for counter-verification	300.000 (Substantial)	Post review	Open	QCBS	Technical and financial scores combined
Selection of 2 consultant NGOs for community verification	160,000 (Substantial)	Post review	Open	CQS	Expression of interest. Simplified Request for Proposal
Selection of an international consultant for RBF WEB Designer (Supply and Installation)	70,000 (Substantial)	Post review	Open	QCBS	Expression of Interest. Simplified Request for Proposal
Purchasing of an integrated financial and accounting management system (Tompro or equivalent)	26,000 (Substantial)	Post review	Open	RFQ	Qualifying criteria/lowest evaluated cost

Contract Title, Description, and Category	Estimated Cost (US$) (Risk Rating)	Bank Oversight	Procurement Approach/ Competition	Selection Methods	Evaluation Method
Selection of 2 international consultants	180,000 (Low)	Post review	Open	IC	3 CVs at least compared
Recruitment of a financial management specialist	80,000 (Low)	Prior review	Open	IC	3 CVs at least compared
Recruitment of a procurement specialist	80,000 (Substantial)	Prior review	Open	IC	3 CVs at least compared
Recruitment of an external auditor	50,000 (RISK)	Prior review	Open	CQS	Expression of Interest. Simplified Request for Proposal

Note: CQS = Selection based on Consultants' Qualification; CV = Curriculum Vitae; QCBS = Quality- and Cost-Based Selection; and IC = Selection of Individual Consultants.

E. Social (including Safeguards)

132. **The project will have positive social impacts.** It will support activities on the demand- side to promote and facilitate access to health services, especially for the poorest and vulnerable group living in areas targeted by the project (known as the triangle of poverty zone; *triangle de la misère*). The project will improve the social inclusion of poor communities, particularly the excluded groups (women and children) who are the principal recipients of primary health care, to access to better health services. The project activities will engage communities to promote healthier behaviors and the use of health services, which will be complemented by the CCT that will facilitate access to health services by vulnerable groups.

133. The project will strengthen citizen engagement in the project areas, drawing from RBF tools such as beneficiary report cards (extracted from the RBF database) and social audits to disclose the results of monitoring of health care services and get feedback from users (see below).

134. **For the time being, the project has no social safeguards risks.** The project's social and environmental category is currently rated B. The project will neither finance land acquisition nor involuntary resettlement. No social safeguards policy is triggered.

135. **The government's grievance redress mechanism and citizen engagement.** One of the strengths of the project is the involvement of civil society at different levels. Community-based NGOs and local-elected officials will be engaged in the RBF program. Indeed, they will be involved in quarterly assessments of the perceived quality (quality of services received in health facilities perceived by the population), community outreach, and demand promotion for better use of health services by the communities, particularly mothers and children. Elected officials also play an important role through the PBF RVCs and health facilities management committees and boards (*comités de gestion* et *conseils d'administration*). Both perceived quality and the existence of functional facility management structures will be monitored in the Results Framework.

136. **Moreover, the project will allow communities to expand their engagement with the public health service facilities, especially in the areas of nutrition, reproductive, maternal, and child health**. The proposed Project will engage citizens through (a) consultations, (b) participation in data collection and recording, (c) capacity building in nutrition and healthy life style sessions, and (d) establishment of a grievance redress mechanism. Grievance redress and citizen participation in monitoring will be achieved through the setting up of a telephone hotline by the MoH for complaints, recommendations, and feedback. The telephone hotline will be located at the central level. All complaints, recommendations, and feedback received through phone calls will be documented as well as the relevant action carried out to resolve complaints. Complaints, recommendations, and feedback will be transmitted quarterly to the ministry when users/beneficiaries give their opinions about the perceived quality of services at health facilities (RBF quality verification at community level).

137. **All grievances must be resolved at the local level within seven days (after the call if the hotline is used or after the opinion is expressed in the RBF community survey used for assessing the perceived quality of health care)**. If the grievance is satisfactorily addressed, the action carried out will be recorded. In the event that the issue is not addressed within seven days, it will be escalated to the next level, either the *mouqhataa*/district or region—a record of this action must be registered at the local level. If untreated within seven days at either level, records will indicate that the issue has been escalated to the DSBN of the MoH who will resolve the issue, communicate the response to the complainant, and provide a record of the response provided. Where the DSBN is unable to address the issue, it will escalate the matter to the Steering Committee or to the justice system, in extreme cases. All actions must be recorded.

F. Environment (including Safeguards)

138. **The proposed project will induce an increase in the production of health services and the provision of medical supplies and light equipment and an upgrade of targeted health facilities.** This will lead to an overall improvement of the health and hygiene conditions and potential job creation for local populations.

139. **The increased health services will, however, lead to the generation of relatively larger amounts of health care waste.** The current health care waste management system in Mauritania is weak and poor management can cause serious health and environmental risks if no appropriate arrangements are implemented.

140. The MoH has, in that respect, very recently developed the first Biomedical Waste Management Plan, validated by a technical inter-ministerial committee comprising representatives of concerned agencies (MoH, Ministry of Environment, WHO and UNICEF). The project will support the operationalization of this plan in the areas of intervention and work closely with the ministry to improve it.

141. **Safeguards.** Given the nature of the project and the activities, only Subcomponent 1A concerning the limited rehabilitation work and the installation of biomedical waste disposal systems (both referred to as 'subprojects') may have potential negative environmental impacts in the areas of intervention of the project. However, these potential impacts are considered moderate, reversible, and very site-specific; therefore, simple mitigation measures can be implemented. As a result, the project is

classified as category B and only OP/BP 4.01 on Environmental and Social Assessments of the World Bank is triggered.

142. **An Environmental and Social Management Framework has been prepared and consulted upon both in Nouakchott and in Hodh El Gharbi, which will be used in conjunction with the Biomedical Waste Management Plan.** It has been disclosed on the MoH's website on February 23, 2017 and the World Bank InfoShop on February 24, 2017.

G. World Bank Grievance Redress

143. **Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB'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 WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Mauritania
Health System Support

Project Development Objectives

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.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Pregnant women completing four antenatal care visits to a health facility during pregnancy		Number	4444.00	41211.00	Annual	HMIS - Monthly HMIS indicator (ANC4 + urine test)	DPCIS
Description: Number of pregnant women who have completed four antenatal consultations before giving birth in the current year							
Name: Births attended by skilled health staff		Number	12278.00	78812.00	Annual	HMIS - Monthly HMIS indicator	DPCIS

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Number of births assisted by trained personnel in the year. Trained/qualified personnel: doctor, midwife, and nurse. Must be in an institutional setting.							
Name: Children 12-23 months fully immunized		Number	9046.00	63289.00	Annual	HMIS	DPCIS
Description: Number of children under the age of 2 years who are fully immunized. Initially, DPT3 will be used as a proxy while the complete vaccination indicator is finalized.							
Name: Average score of the quality of care checklist		Percentage	0.00	60.00	Semi-annually	RBF system	DPCIS, RBF Technical Unit
Description: Average of quality checklists for RBF health facilities, measured as a progression from the previous reporting period. Data are not yet available. The team has entered an estimated total that will be revised once the baseline information is available.							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Women accepting modern family planning methods		Number	8969.00	94622.00	Annual	HMIS	DPCIS
Description: Number of modern family-planning methods users for both new and continuing users among women.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: People who have received essential health, nutrition and population services		Number	94427.00	1761769.00	Semi-annually	HMIS with RBF database	RBF Technical Unit with HMIS unit
Description: Future Corporate Results Indicator Women and children who have received basic nutrition services refers to the total beneficiaries reached by any of the following services: Direct feeding programs (supplementary feeding for pregnant and lactating women and infants and young children under age 5 years); programs promoting appropriate infant and young child feeding (for example, promotion/support for exclusive breastfeeding and adequate and timely introduction of complementary foods); nutrition programs for adolescent girls, including nutrition education, micronutrient supplements, and so on, delivered through school health/nutrition programs or other programs reaching adolescent girls; provision of micronutrient supplements to pregnant/lactating women and children under age 5 years including vitamin A, iodine, iron/iron folic acid, supplemental zinc, and multiple micronutrient powders; food fortification (for example, iodized salt); deworming; monitoring of nutritional status; nutrition and food hygiene education; nutrition components of early childhood development programs; home gardens and small livestock production for improved dietary diversity; targeted emergency food aid; and treatment of severe acute and moderate acute malnutrition. Although the same individuals could receive more than one of the above services, they should be counted only once.							
Name: Children under the age of five treated for severe and acute malnutrition		Number	321.00	1878.00	Semi-annnually	HMIS	DPCIS
Description: Sum of the number of children under the age of 5 years treated for severe and acute malnutrition. Moderate malnutrition is managed at the community level.							
Name: Women and children who have received basic nutrition		Number	4885.00	43089.00	Semiannually.	HMIS with RBF database	RBF technical unit with HMIS unit.

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
services							

Description: Future Corporate Results Indicator.

Women and children who have received basic nutrition services refers to the total beneficiaries reached by any of the following services:
Direct feeding programs (supplementary feeding for pregnant and lactating women and infants and young children under age 5 years); programs promoting appropriate infant and young child feeding (for example, promotion/support for exclusive breastfeeding and adequate and timely introduction of complementary foods); nutrition programs for adolescent girls, including nutrition education, micronutrient supplements, and so on, delivered through school health/nutrition programs or other programs reaching adolescent girls; provision of micronutrient supplements to pregnant/lactating women and children under age 5 years including vitamin A, iodine, iron/iron folic acid, supplemental zinc, and multiple micronutrient powders; food fortification (for example, iodized salt); deworming; monitoring of nutritional status; nutrition and food hygiene education; nutrition components of early childhood development programs; home gardens and small livestock production for improved dietary diversity; targeted emergency food aid; and treatment of severe acute and moderate acute malnutrition. Although the same individuals could receive more than one of the above services, they should be counted only once.

Name: Health facilities without essential medicines stockouts over the last three months		Percentage	0.00	94.00	Semiannually.	RBF information system as part of verification. Baseline derived from HMIS data.	RBF technical unit

Description: 100 × RBF health facilities without essential medicines stock-outs over the past three months / number of RBF facilities.

Essential medicines are those defined by the MoH. For the health post, these are Amoxicilline (cap and gel), Cotrimoxazole, Ampicillin (injectable), Ceftriaxone, Artemisin-based combination therapy, quinine (injectable), oral rehydration salts, zinc, iron and folic acid, dextrose (injectable), sodium chloride (injectable), Diazepam (injectable), Vitamin A (capsule), Albendazole, magnesium sulfate (injectable), Gentamycin, and lidocaine (2 percent). Hospitals add Ciproflaxin (injectable), Metronidazole (injectable), Lysine aspirin (injectable), Atenolol, Metformine, Atropine (injectable), Ketamine, Bupivicain, Halotane, Thiopental (powder), Simvastatine, and Amitryptyline.

Name: Basic equipment availability		Percentage	19.50	94.00	Semiannually	RBF information system as part of verification. Baseline	RBF Technical unit

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						derived from HMIS data.	
Description: 100 × RBF health facilities which have basic equipment / total number RBF health facilities							
Name: Visits by under-5 children to health facilities		Number	68185.00	450169.00	Semiannually	HMIS	DPCIS
Description: Sum of consultations by under-5 children to health facilities, whether for curative or preventive care							
Name: Post-natal consultation visits		Number	2568.00	26764.00	Semiannually	HMIS	DPCIS
Description: Sum of postnatal consultations in the 42 days following the child's birth							
Name: Conditional cash transfer beneficiaries (% eligible households receiving full transfers)		Percentage	0.00	60.00	Annual	Tekavoul information system	Tekavoul and RBF technical unit
Description: Percentage of CCT-eligible households that have met the conditions in the year and received all four tranches							
Name: Districts that implement the community		Number	0.00	6.00	Annually	DSBN	DSBN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
health strategy							
Description: Count of the districts that have implemented the strategy							
Name: Pregnant women referred for ANC1 by community health workers		Number	0.00	23084.00	Semiannually	RBF database	RBF technical unit
Description: Sum of pregnant women referred during the first trimester for ANC1 by all types of CHWs							
Name: Health facilities transmitting complete HMIS reports on time		Percentage	0.00	95.00	Semiannually	HMIS	DPCIS
Description: Facilities reporting on time and fully / total number of facilities expected to report Timeliness: reporting between the first and tenth of the following month Completeness: facility-relevant information completely entered (by type: post, clinic, and hospital)							
Name: User satisfaction with health care services		Percentage	0.00	80.00			
Description:							
Name: Health facilities with functioning		Percentage	39.70	100.00	Semi-annually	RBF database	Regional verification teams

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
management committees							
Description: Number of health facilities with a functioning management committee relative to the number of health facilities in the targeted regions							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Pregnant women completing four antenatal care visits to a health facility during pregnancy	4444.00	4926.00	10804.00	18501.00	27955.00	41211.00	41211.00
Births attended by skilled health staff	12278.00	12716.00	26641.00	42303.00	59750.00	78812.00	78812.00
Children 12-23 months fully immunized	9046.00	11970.00	24593.00	29996.00	45639.00	63289.00	63289.00
Average score of the quality of care checklist	0.00						60.00

Intermediate Results Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Women accepting modern family planning methods	8969.00	9347.00	22357.00	40617.00	64338.00	94622.00	94622.00
People who have received essential health, nutrition and population services	94427.00	419012.00	747980.00	1081388.00	1419298.00	1761769.00	1761769.00
Children under the age of five treated for severe and acute malnutrition	321.00	357.00	722.00	1096.00	1480.00	1878.00	1878.00
Women and children who have received	4885.00	5282.00	11526.00	19597.00	29435.00	43089.00	43089.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
basic nutrition services							
Health facilities without essential medicines stockouts over the last three months	0.00	0.00	50.00	80.00	92.00	94.00	94.00
Basic equipment availability	19.50	50.00	80.00	92.00	94.00	94.00	94.00
Visits by under-5 children to health facilities	68185.00	70987.00	156452.00	245357.00	343083.00	450169.00	450169.00
Post-natal consultation visits	2568.00	2855.00	6960.00	12362.00	19115.00	26764.00	26764.00
Conditional cash transfer beneficiaries (% eligible households receiving full transfers)	0.00	0.00	0.00	50.00	70.00	60.00	60.00
Districts that implement the community health strategy	0.00	0.00	6.00	6.00	6.00	6.00	6.00
Pregnant women referred for ANC1 by community health workers	0.00	0.00	3010.00	9174.00	15859.00	23084.00	23084.00
Health facilities transmitting complete HMIS reports on time	0.00	0.00	50.00	60.00	90.00	95.00	95.00
User satisfaction with health care services	0.00		60.00	70.00	80.00	80.00	80.00
Health facilities with functioning management committees	39.70	50.00	100.00	100.00	100.00	100.00	100.00

Indicator Description

Project Development Objective indicators				
Indicator name	**Description (definition, and so on)**	**Frequency**	**Data source/methodology**	**Responsibility for data collection**
Pregnant women completing four antenatal care visits to a health facility during pregnancy (number)	Number of pregnant women who have completed four antenatal consultations before giving birth in the current year	Annual	HMIS - Monthly HMIS indicator (ANC4 + urine test)	DPCIS
Births assisted by skilled health staff (number)	Number of births assisted by trained personnel in the year Trained/qualified personnel: doctor, midwife, and nurse. Must be in an institutional setting.	Annual	HMIS - Monthly HMIS indicator	DPCIS
Children fully immunized (number)	Number of children under the age of 2 years who are fully immunized. Initially, DPT3 will be used as a proxy while the complete vaccination indicator is finalized.	Annual	HMIS	DPCIS
Checklist quality average score (% annual increase)	Average of quality checklists for RBF health facilities, measured as a progression from the previous reporting period	Semiannually	RBF system	DPCIS, RBF Technical Unit
Intermediate results indicators				
Indicator name	**Description (definition, and so on)**	**Frequency**	**Data source/methodology**	**Responsibility for data collection**
Users of modern family-planning methods (new and continuing; number)	Number of modern family-planning methods users	Annual	HMIS Monthly HMIS indicator	DPCIS

People who have received essential health, nutrition, and population (HNP) services	The indicator measures the sum of the number of children immunized, the number of women and children who have received basic nutrition services, and the number of deliveries attended by skilled health personnel, through operations supported by the World Bank.	Annual	HMIS and RBF databases	RBF Technical Unit with HMIS unit
Children under the age of 5 treated for severe and acute malnutrition (number)	Sum of the number of children under the age of 5 years treated for severe and acute malnutrition. Moderate malnutrition is managed at the community level.	Semiannually	HMIS Monthly HMIS indicator	DPCIS

Women and children who have received basic nutrition services	Women and children who have received basic nutrition services refers to the total beneficiaries reached by any of the following services: Direct feeding programs (supplementary feeding for pregnant and lactating women and infants and young children under age 5 years); programs promoting appropriate infant and young child feeding (for example, promotion/support for exclusive breastfeeding and adequate and timely introduction of complementary foods); nutrition programs for adolescent girls, including nutrition education, micronutrient supplements, and so on, delivered through school health/nutrition programs or other programs reaching adolescent girls; provision of micronutrient supplements to pregnant/lactating women and children under age 5 years including vitamin A, iodine, iron/iron folic acid, supplemental zinc, and multiple micronutrient powders; food fortification (for example, iodized salt); deworming; monitoring of nutritional status; nutrition and food hygiene education; nutrition components of early childhood development programs; home gardens and small livestock production for improved dietary diversity; targeted emergency food aid; and treatment of severe acute and moderate acute malnutrition. Although the same individuals could receive more than one of the above services, they should be counted only once.	Semiannually	HMIS with RBF database	RBF Technical Unit with HMIS unit

Health facilities without essential medicines stock-outs over the last three months (%)	100 × RBF health facilities without essential medicines stock-outs over the past three months / number of RBF facilities[a.]	Semiannually	RBF information system as part of verification. Baseline derived from HMIS data.	RBF Technical Unit
Basic equipment availability (average; %)	100 × RBF health facilities who have basic equipment / total number RBF health facilities	Semiannually	RBF information system as part of verification. Baseline derived from HMIS data.	RBF Technical Unit
Visits by under-5 children to health facilities (number)	Sum of consultations by under-5 children to health facilities, whether for curative or preventive care	Semiannually	HMIS Monthly HMIS indicator	DPCIS
Postnatal consultation visits (number)	Sum of postnatal consultations in the 42 days following the child's birth	Semiannually	HMIS Monthly HMIS indicator	DPCIS
Conditional cash transfer beneficiaries (% eligible households receiving full transfers)	Proportion of CCT-eligible households that have met the conditions in the year and received all four tranches	Annual	Tekavoul information system	Tekavoul, RBF Technical Unit
Districts (*moughataa*) that implement the community health strategy	Count of the districts that have implemented the strategy	Annual	DSBN	DSBN
Pregnant women referred for ANC1 by community health workers (number)	Sum of pregnant women referred during the first trimester for ANC1 by all types of CHWs		RBF database	RBF Technical Unit
Health facilities transmitting complete HMIS reports on time (%)	Facilities reporting on time and fully / total number of facilities expected to report Timeliness: reporting between the first and tenth of the following month Completeness: facility-relevant information completely entered (by type: post, clinic, and hospital)		HMIS	DPCIS

User satisfaction with health care services (%)	Score of quality of health services delivered by health centers as perceived by beneficiaries	Semiannually	RBF database	RBF Technical Unit
Proportion of health facilities with functioning management committees, total (%)	Number of health facilities with a functioning management committee relative to the number of health facilities in the targeted regions	Semiannually	RBF database	Regional verification teams