### Project Context

#### Country Context

Senegal has made little economic progress in the last six years. Whereas the average GDP growth during the decade of 1995-2005 was 5%, it fell to only 3.3% in 2006-2011, which is little more than the annual rate of population growth (2.6%). This poorer performance was partly due to external shocks – poor rainfall in 2006 and 2011, the global economic slowdown in 2008-9, and the rising price of oil. But domestic policies were also to blame. Problems in the energy sector have been a recurring drag on the economy. There are also more fundamental and structural problems.

Governance problems have indeed contributed to low growth and unemployment. The economic environment in recent years was characterized by lack of transparency, cronyism and anti-competitive practices which have discouraged private sector investment. Senegal’s ranking on the Corruption Perception Index of Transparency International has fallen from 70th to 112th between 2006 and 2011. This is confirmed by the Worldwide Governance Indicators (WGI) of the World Bank, which indicate a drop in their measure for the control of corruption for Senegal, from the 56th percentile in 2004 to the 30th percentile in 2010. Similar drops have been estimated in the WGI for voice and accountability (from 55th to 36th), for rule of law (from 48th to 42nd), and for government effectiveness (from 50th to 37th).
In Senegal, poverty level has not decreased much and remains at a high level, even by West African standards. The rate of poverty in Senegal is still high, especially for a country which has just achieved lower middle-income status with a per capita income of US$1,090. In 2005, it was estimated that 48.5% of the population was below the poverty line of approximately $1.25 per day. In 2011, the most recent poverty survey found that poverty incidence had decreased by only 1.8 percentage point to 46.7%. This is far above that of Ghana (28.5%). Poverty remains very high in rural areas (57.1%). Poverty is lowest in the city of Dakar (26.1%). The slowdown in economic growth since 2006 has made further progress difficult. Overall, growth has not been very inclusive. The fruits of urban growth, while limited, must be better shared with the rural population or else migration to Dakar will accelerate to the point where it is unmanageable.

**Sectoral and institutional Context**

Health issues have a major impact on poverty

4. Healthcare issues are strongly contributing to poverty and to gender inequalities, with health-related shocks being the most frequent shocks faced by households in Senegal. An analysis of the latest poverty assessment (Echevin, 2012) has found that the most frequent shock experienced by households was related to the death, illness or injury of a revenue-earning household member (16.5% of households). This factor was even higher for the poorest households, as 18.2% of the poorest households had experienced such a health-related shock. This suggests that health-related shocks are a major contributor to vulnerability and poverty incidence in Senegal.

Poverty has also an impact on nutritional outcomes

5. One of the consequences of this vulnerability is that many households (and especially the poorest) are not able to provide adequate nutrition to their children. While, thanks to its national nutrition program, Senegal has made tremendous progress on addressing chronic malnutrition, acute malnutrition (wasting) has remained stubbornly at a high 10% since the early nineties. Also, although conclusive data is not available, UNICEF estimates that 18% of infants are born with low birth weight. Iron deficiency anemia, a major cause of low birth weight (as well as reduced productivity and compromised cognitive development) is also widespread and can be observed in 83% of under-five children, 58% of non-pregnant and non-lactating women; and 71% of pregnant women (see Table below). Moreover, the poorest children are the most affected.

6. In turn, malnutrition prevents the children and youth to fully benefit from education, both in terms of productivity and long term economic development. Malnutrition contributes to over one-third of all deaths of children under age 5. Of the 34,000 children under age 5 who died in Senegal in 2010, more than 12,000 died because of some form of malnutrition. Survivors are likely to start school later (7 months on average), more likely to drop out of school, and less able to learn. Iodine deficiency alone (concentrated in the Eastern part of the country) has been shown to permanently lower IQ by 10 to 15 points. Similarly, low birth weight - found in as many as 18 percent of newborn babies in Senegal - has shown to lower IQ by 5 points. Suboptimal breastfeeding (common among 66 percent of children under six months in Senegal) subtracts another 4 points. Stunting (which affects four out of five children under five) further lowers IQ by 5 to 11 points. And anemia - the most widespread nutrition disorder affecting as many as four out of five children
under five in Senegal - reduces the IQ by another 8 points.

Poverty also hinders access to quality health care

7. The impact of poverty is not limited to nutrition. More broadly, the poorest households do not have access to good quality health care, especially as regards to maternal and reproductive health care. The poorest households have been the main beneficiaries of only a few high-impact interventions. This is the case for bednets. As shown in the figure below, the poorest households have been adequately targeted during campaigns for distribution of bednets and have now a better access to bednets than the richest. This successful experience is a major reason behind the decrease in child mortality in Senegal (see table 1 above for MDG indicators). Unfortunately, this experience is rather an exception. For many other basic health services, the poorest households have a limited access. As illustrated below, only 30% of the poorest women benefit from assistance by qualified staff during their child delivery, while 96% of the richest ones benefit from this service. That explains why maternal mortality is still rather high in the country (400 deaths for 100,000 live births).

A strategy for universal health coverage (UHC) could reduce the detrimental impact of poverty of health and nutrition

8. Several of the previously described health and nutrition issues could be addressed through universal health coverage (UHC) strategy. The previously-mentioned vulnerabilities in health and nutrition can be addressed in speeding up progress towards universal health coverage. Such an objective requires implementing at once two strategies, as illustrated in the graph below.

- First, demand for nutrition and health services must be further subsidized (and therefore increased) through various mechanisms, ranging from safety nets (including cash transfer and free care programs) to health risk pooling schemes (such as targeted exemption of user fees or subsidized health insurance).
- Secondly, the supply side has also to be strengthened, for ensuring that nutrition and health services will be (geographically) accessible and that their quality is adequate.

The next section reviews the efforts made over the last years by the Senegalese Government on these various policies. Until recently, the Government involvement in demand-side interventions for health and nutrition has been limited

9. On the demand-side, little has been achieved so far to provide adequate social & health protection. Safety nets could have reduced the impact of shocks. But, so far, the coverage and effectiveness of safety nets has been very limited. In 2011, the World Bank has conducted a review of the main safety net programs. The 12 programs that were analyzed are delivered by five different ministries, including for instance (i) the health services user fees exemption for the elderly (i.e. “Plan Sesame”), (ii) programs targeting vulnerable groups such as the disabled, (iii) in-kind support granted through a distribution of food and school meals, (iv) cash transfers and (v) food vouchers. Overall, the country supports an average of about 822,000 people annually, mostly students who receive school meals (90 percent), an initiative that does not necessarily target the poorest children. In other words, all these programs do not cover more than 4 percent of the national population (less than 1 percent if one excludes school meals). Therefore, it seems obvious that the existing safety
nets do not meet the needs of a country subject to cyclical and repeated shocks. Indeed, investment in safety net programs represented in 2011 only 0.2 percent of the GDP of Senegal. This rate is extremely low, even in the African context. Countries like Ethiopia have increased the size of their safety nets, implemented in the form of public works and cash transfers, until they reach 10 percent of the population and represent about 1.2 percent of GDP, this being based on specific targets for improving food security and household assets.

10. In addition to being underfunded, the existing safety net mechanisms are usually not targeted and too dispersed:

- There is no consistent targeting system. Programs implemented in Senegal have often been used as part of a social assistance, unconditional cash transfers to "vulnerable groups" more or less focused. Moreover, there is no national or local criterion and consensual definition of target groups.
- Safety nets are dispersed. The review of safety nets found that interventions were scattered across many small-scale programs implemented by several departments and agencies. This makes coordination at national and local level more difficult. Strategically, these programs were not designed as part of a comprehensive social safety net program but rather as isolated programs with low coverage. Each of these programs therefore used different approaches, management tools, targeting and monitoring and evaluation arrangements.
- Spending priorities are not linked to specific outcomes. There is little information on the impacts of spending by the current social safety nets programs. In some cases, the number of beneficiaries is not even available. This makes it difficult to link expenditure to outcomes.

11. As for the health sector itself, there are very few mechanisms for pooling risks. One of them is the Community-Based Health Insurance Schemes (CBHISs or “mutuelles”). But these CBHISs cover less than 6% of the population. An important reason for this disappointing coverage is that CBHISs are not – so far – subsidized by the Government, thus preventing a large portion of the population to pay a premium for membership.

Another risk pooling mechanism is the free care programs (HIV-AIDS, maternal delivery, elderly people, etc.). For various reasons (including inadequate design and mismanagement), they have not significantly improved access to health care services for the poorest households. As mentioned above, despite the free maternal care program, the percentage of poor women delivering a child with the assistance of qualified health workers is still very low (30%). More generally, the 2011 DHS (see figure below) found that 68% of the poorest women (vs 29% for the richest) cited “lack of money” as a reason for not seeking care. This is the most prevalent reason, before the distance to the nearest facility. Interestingly, the situation is unchanged since 2005 (i.e. the proportion was 71%), although the Government has implemented since 2006 a free care policy for assisted deliveries and c-sections.

Another demand-side issue – much less prevalent – is related to the gender dimension. In 2010-2011, 20% of the poorest women could not seek care because they husband would not approve it. Except a project launched in 2009 where “godmothers / aunts” are selected in their communities to encourage women and their husbands to seek care more often (Project “Bajenu Gox”), very little has been done for influencing intra-household decisions on health care. Finally, another demand-side obstacle for utilization of health care and nutrition services is the existence of some cultural constraints, especially among the nomadic Peuls in the Northern part of Senegal.

Similarly, and until recently, the Government has not been much involved in strengthening the supply-side of its health system.
12. On the supply-side, the delivery of basic nutrition and health services is still hampered by poorly targeted investments and a low level of accountability of providers. On the supply-side, four types of obstacles are limiting the accessibility to quality health and nutrition services: (i) the density in health centers is low, thus reducing their geographical accessibility and their capacity for carrying out outreach activities; (ii) qualified health workers prefer to work in urban areas and especially in Dakar; (iii) the performance of these health workers (absenteeism, quality of care…) is rather weak, and (iv) health facilities have limited funding for ensuring availability of drugs and supplies.

13. One obstacle - especially in rural areas - is the distance for reaching a health facility or for benefitting from outreach services. Only 41% of households live less than 30 minutes away from a health center. Distance to the nearest facility is the second most frequently cited reason by the poorest households for not seeking care. Indeed, most of the poorest regions are also the ones where the density of health centers is the lowest. For instance, in Kolda, each health center serves about 300,000 people, although the WHO recommendation is to have a health center for no more than 50,000 people. As mentioned in the recently completed Public health Expenditures Review (PER), this situation is mostly due to (i) the lack of a health facility masterplan (i.e. decisions on investments are mostly discretionary and do not take into account accessibility and demographic considerations) and to (ii) the priority given to building new hospitals in urban areas.

14. Even when a health facility can be reached easily, it may not be adequately staffed. Overall, during the recent years, Senegal managed to meet the WHO minimal recommendations in terms of density of qualified health workers (nationwide). Unfortunately, the geographical distribution of these workers is still highly skewed in favor of Dakar. For instance, the capital city has a midwife for 4,000 women, but Kolda has only one for 30,000. The situation is similar for doctors and nurses. The main reason behind this situation is that – aside a short-lived attempt in 2006 (“plan Cobra”) – no policy has been designed nor implemented to encourage health workers to work in rural areas.

15. When a facility is accessible and adequately staffed, another challenge faced by households is the low performance of health workers. Absenteeism is widespread. On average, 20% of staff are absent from duty. And competence is very low. The 2010 Service Delivery Indicators (SDI) Survey found that less than 2% of the clinicians were able to diagnose a pelvic inflammation, a rather frequent clinical problem. Insufficient training may not be only explanation for this low performance. Another – and probably more important - factor is that there is a large “know-do gap”. In other words, health workers do much less than they know. Indeed, there are very few accountability mechanisms to ensure that health workers (in the Government sector) will perform adequately.

16. Finally, primary health care (PHC) facilities receive very little funding from the Government, which severely constrains their capacity to ensure continuous availability of drugs and other medical supplies. The previously mentioned SDI survey (2010) found that, on average, PHC facilities were receiving only $1.78 per capita, while – for instance -, Tanzanian PHC facilities were receiving $7 per capita. In addition to the previously mentioned low accountability of facilities and health workers, this weak fiscal decentralization explains why PHC facilities have so many difficulties for ensuring availability of drugs and medical supplies. This issue is further strengthened by the fact that a significant (43%) portion of recurrent public expenditures are eaten up by the hospital sector (as shown with 2011 Public Health Expenditures Review).
Since 2012, the new Government has launched an ambitious Universal Health Coverage (UHC) strategy, combining demand-side and supply-side interventions

17. One of the key priorities of the new Government is to improve the demand-side of social and health services, that is to say to provide better financial protection to the poorest.

18. First, the Government has launched its Universal Health Coverage scheme (“Couverture Maladie Universelle or CMU). Building on previous blueprints prepared in the recent years, the newly elected Government has decided to create a universal health insurance scheme (CMU). Basically, it targets the rural and informal groups (where health coverage is the lowest) through a voluntary and subsidized community-based health insurance scheme. At least one “mutuelle” (i.e. a community-based health scheme national social coverage scheme) will be created in each local council in Senegal (“commune” or “communauté villageoise). Premiums will be highly subsidized by the Government (50% of the premium costs) and paid through a national fund for health solidarity (Fonds National de Solidarité Santé or FNSS). In addition, for the poorest households (as identified by the national targeting system, currently under development), premiums and copayments will be entirely free and paid by a Health Equity Fund (managed centrally).

19. Beyond this CMU, the Government is considering creating a CAPSU for “Caisse Autonome de Protection Sociale Universelle” or Independent Fund for Universal Social Protection. The CAPSU would manage the CMU and a national social cash transfers program for about 250,000 large households (“Bourse de Sécurité Familiale”).

20. The Government has also embarked on strategies for improving the supply-side. Indeed, the Government wants to expand the scope of its existing community-based platform of services, currently focusing on nutrition. Through the child nutrition program (Programme de Renforcement de la Nutrition or PRN), Senegal has developed a very successful mechanism for delivering maternal and child nutrition services to local populations, in close coordination with local councils. These services included promotion of infant and young child feeding practices, growth monitoring, promotion of home care of common childhood infections, and promotion of family and health care for pregnant women. In addition, the program designed and implemented a successful cash transfer program (although of limited scale). Given the success of this community-based platform (in implementing both supply-side and demand-side interventions), the Government would like to expand its scope beyond nutritional services and thus include other health services.

21. Senegal is also piloting a Performance Based Financing (PBF) mechanism for health facilities. With support from the Bank and USAID, a PBF pilot in two districts has been designed and launched (in April 2012). This mechanism incentivizes health facilities (and their health workers) to improve the quality and quantity of their services (especially regarding child and maternal health).

22. To support the implementation of these interventions, the Government is also strengthening the capacity of health authorities, especially the Ministry of Health and Social Action (MSAS). A new Directorate for Planning has been created in 2012. Other Directorates as well as Regional Health Directorates are considered for further capacity building. In addition, two specific areas are viewed by the Government as priorities for capacity building.

23. The regulation of the hospital sector deserves a major overhaul. As described in the PER,
many hospitals (especially in Dakar) have built up huge amounts of debt and have to be bailed out by the Government. This situation has “crowded out” investments in other priority areas (such as immunization or building new PHC facilities). To address this issue, the Government has started contracting with the most indebted hospitals. This contracting process needs now to be strengthened. First, the Directorate in charge of controlling hospitals requires substantive capacity building to properly monitor hospitals performance. Secondly, hospitals themselves need help for improving their information systems, so as they can better monitor their production, revenues and costs.

24. Secondly, and more broadly, the Government is trying to improve radically its capacity to monitor health outcomes and performance of health services. To that end, Senegal is the first country in Africa to have launched a “continuous survey”. This survey is an annual DHS, complemented with facility and health workers survey. The entire process is supported by Macro International. USAID has funded the start-up costs for this effort, but additional funding is necessary.

25. Finally, the Government is keen on boosting harmonization and alignment of development aid. The Government and several major donors have recently signed an IHP (International Partnership for Health) Compact, which will constitute the roadmap for implementation the Paris declaration in the Senegalese health sector. The Government is fully aware that better alignment of aid will require a strengthening of its fiduciary and governance arrangements.

The proposed World Bank – USAID support to these Government policies

26. With USAID cofunding, the Bank proposes to support these various policies through a 3-component project ($42.5 million). The 3 components will respectively support (i) supply-side interventions (through an extension of the RBF pilot in 6 regions), (ii) demand-side interventions (with support to the CMU) and (iii) capacity building for health authorities. The overall architecture of the project is described below.

27. Several features of the proposed project are noteworthy.

28. First, the project will combine supply-side incentives and demand-side incentives for improving key health and nutrition services. Indeed, for instance, antenatal care will be supported through supply-side (RBF) incentives and demand-side incentives (Conditional Cash Transfers or CCTs). An impact evaluation (described later one) will assess the effect of such a combination.

29. Secondly, the project will target six (6) of the most underserved regions in Senegal. It is expected that the project will target four of the poorest regions (Tambacounda, Kedougou, Sedhiou, Kolda, Kaffrine and Diourbel), which are not already benefiting from other partners’ involvement through any health program. The estimated number of beneficiaries would therefore be about 4 million people.

30. Thirdly, the project will be cofinanced with USAID (for an amount of $2.5 million). USAID and the Bank are indeed fully aligned with the Government priorities. Some activities have actually already been supported jointly. That includes the design of the RBF pilot and the “continuous survey”. Additional details on this partnership with USAID are provided later in this PAD.
II. Proposed Development Objectives
The overall project objective is to improve health and nutritional outcomes among women and children in regions among the poorest. To that end, the proposed Project Development Objective (PDO) is to increase utilization and quality of maternal and child health care and nutritional services, especially among the poorest households in selected regions of Senegal.

III. Project Description

Component Name
1. Strengthening the supply-side of health system through Result Based Financing for Health and Nutrition Services
   Comments (optional)

Component Name
2. Demand side interventions for improving accessibility of health care services
   Comments (optional)

Component Name
3. Strengthening capacities for better M&E and supervision, and Project Implementation
   Comments (optional)

IV. Financing (in USD Million)

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V. Implementation
38. The lending instrument will be an Investment Project Financing (IPF), financed under an IDA grant of $20 million, a grant of $20 million from the Multi-Donor Trust Fund for Health Results Innovation and a $2.5 million grant from USAID. Bank support is planned for 4 years (2014-2017).

39. The project budget indeed includes a $20 million grant from the Multi-Donor Trust Fund for Health Results Innovation. This grant will exclusively finance the Result-Based Financing (RBF) component of the Project. More precisely, this grant will finance the Sub-Component 1 (RBF credits) of component 1.

40. The $2.5 million USAID grant will fund RBF activities.
41. The overall project objective is to improve health and nutritional outcomes among women and children in regions among the poorest. To that end, the proposed Project Development Objective (PDO) is, in selected regions: to increase the utilization and quality reproductive, maternal and child health care and nutritional services, especially among the poorest households.

VI. Safeguard Policies (including public consultation)

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Comments (optional)

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