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

Appraisal Stage | Date Prepared/Updated: 28-Jun-2019 | Report No: PIDISDSA25222

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Senegal	P162042	Investing in Maternal, Child and Adolescent Health	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	17-Jun-2019	28-Nov-2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Health and Social Action	

Proposed Development Objective(s)

The proposed Project Development Objective is to improve utilization of essential RMNCAH-N (Reproductive, Maternal, Neonatal, Child and Adolescent health and Nutrition) services meeting quality standards in priority regions.

Components

1. Improve availability of quality RMNCAH and nutrition services
2. Promote adolescent health and women's empowerment
3. Support reforms to strengthen equity and financing sustainability in health sector
4. CERC

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	150.00
Total Financing	150.00
of which IBRD/IDA	140.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	140.00

IDA Credit	140.00
Non-World Bank Group Financing	
Trust Funds	10.00
Global Financing Facility	10.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

A. Country Context

1. **Located in the western-most part of Africa's Sahel region, Senegal is one of the most stable and politically open countries in Africa**. It has a national territory that spans 196,712km^2, with 700 km of coast by the Atlantic Ocean and a population estimated at 15.7 million in 2018. Approximately half of the population lives in urban areas, with 23 percent of the total population living in the greater Dakar region, which accounts for 0.3 percent of the country's geographic territory. Senegal is a stable democracy and has strengthened its democratic structures in recent years(three peaceful political transitions and four presidents since its independence in 1960). The country's political system was further strengthened by the 2016 constitutional referendum that reduced presidential mandates from seven to five years and the recent peaceful presidential elections (Macky Sall reelected in February 2019)..

2. **With a real gross domestic product (GDP) per capita estimated at 1,410 US$ in 2018 (recent GDP rebasing), Senegal is classified since recently by the World Bank as a lower-middle-income country (LMIC), after several decades of being a low-income country. The pace of economic growth has recently improved,** following long periods of volatility. Senegal's GDP growth reached 6.8 percent in 2018 (slightly lower than the rate of 7.1 percent in 2017), while inflation remains under control. According to official estimates, all sectors contributed significantly to growth in 2018, but the primary sector continues to be the fastest growing, mainly due to agriculture. This is linked to ongoing support programs and the robust external demand. The secondary sector remains dynamic with construction, processed food and chemicals still growing robustly. Hospitality and financial services are the key drivers behind the tertiary sector. The economic outlook is favorable with progressively higher growth rates expected in the coming years.

3. **Senegal has developed an ambitious Plan to reduce poverty and accelerate growth: Emerging Senegal Plan, 2014 - 2035[1] (*Plan Senegal Emergent (PSE)*).** The PSE established a framework for the country's economic and social policy over the medium to long terms. The PSE focuses on three pillars: (i) structural transformation of the economy to achieve strong and sustainable growth; (ii) human capital, expanding access to social services and social protection, and preservation of conditions for sustainable development; and (iii) enhancing governance, and security through institutional strengthening and promoting peace. The services sector is also growing rapidly, helped by advances in transport and communications.

4. **The share of Senegalese people considered poor has declined (living below the 1.90 a day threshold) from 38% in 2011 to 33.5% according to the latest projections[2], but inequalities are rising.** Poverty is highly concentrated in rural areas. The rural poor are mostly working in the agricultural industry and are suffering from multiple deprivations and chronic poverty. In contrast, in urban areas, the poor are mainly unemployed or working in the informal sector, typically in commerce and other services, and construction Growth for the bottom 40 has been considerably slower than the average, indicating that the share of consumption for the poorest is continuing to shrink, confirming a trend started in 2005. Geographical disparities are also pronounced: 40 percent of rural households live in precarious dwellings compared to below 10 percent in urban areas

B. Sectoral and Institutional Context

5. **To benefit from a demographic dividend, Senegal needs to accelerate its fertility decrease. Despite a decreasing dependency ratio and an increasing labor force, Senegal is only partially taking advantage of its incipient demographic dividend, which accounted for a mere 0.5 p.p. of the per capita GDP growth since 2000.** Indeed, fertility rate is still high and decreases only at a slow pace (from 6.4 children per woman in 1986 to 5 in 2010-11 and 4.6 children per woman in 2017). Senegal is a pre-demographic dividend country due to its high fertility, declining mortality (under-five mortality decreased from 121 deaths per 1,000 live births in 2005 to 56 in 2017) and young age structure (half of the population under 24). Slow job creation among the youth is another key constraint for Senegal to leverage its demographic transition. As many as 300,000 young people enter the labor market every year, but their productive contribution to the economy is stifled, as they face very limited economic opportunities, showing the highest unemployment rate at 9 percent (against a national average of 6.1 percent), as well as high inactivity and underemployment rates, respectively at almost 60 and 22 percent. The demographic dividend is equally constrained by lagging, although improving, results in maternal and reproductive health, as well as important and persistent gender inequalities in accessing basic services and productive inputs, hampering women's capacity to accumulate human capital and pursue economic opportunities (SCD Senegal). Early pregnancies and early marriages are major concerns: 9.5% of girls are married before the age of 15 and 32% before the age of 18 (Demographic and Health Survey, 2017), with adolescent girls living in rural areas, with low level and education and poor being the most vulnerable. Adolescent health service coverage remains weak: indeed, health services do not specifically target this age group and less

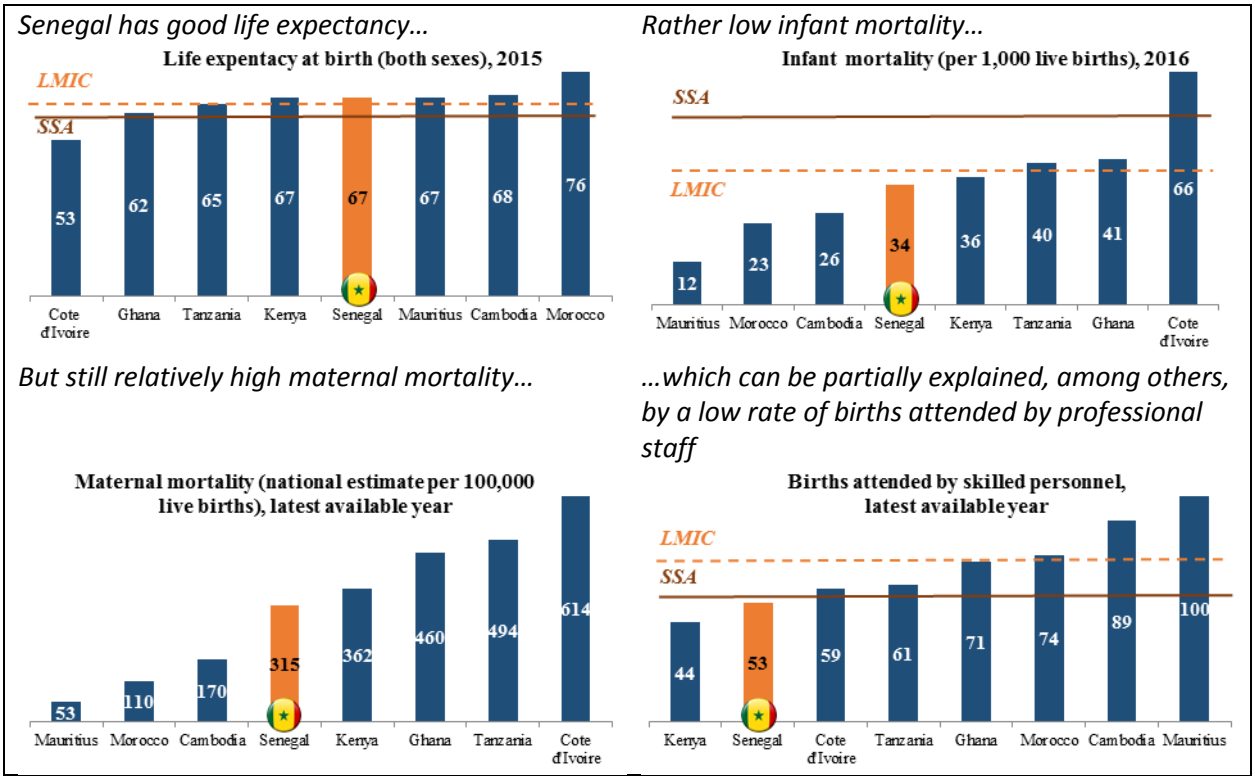
[1] Emerging Sénégal Plan
2 MPO 2019.

than 2% of adolescents have access to modern contraception methods. Investing in adolescents is at the heart of the potential for demographic dividend.

6. **While Senegal has seen substantial progress in infant mortality over the last decade, more needs to be done to accelerate reductions in stunting and neonatal mortality**. The country has made tremendous strides in diminishing infant and under five mortality rates, which respectively decreased from 61 to 42 and 121 to 56 deaths per 1000 live births from 2005 to 2017. Such improvements are the result of better access to malaria treatment and prevention and enhanced vaccine coverage (which increased from 59% in 2004 to 74% in 2015). Yet, progress in nutrition is mixed: while Senegal has one of the lowest stunting rates in Africa (i.e., 17 percent in 2016), the prevalence of underweight children only decreased from 14.2% in 2005 to 13.5% in 2016 (DHS, 2005; 2016). Furthermore, the neonatal mortality rate has only decreased modestly, compared to the under-five and infant mortality rates, from 35 deaths per 1000 in 2005 to 19 (the lowest level reached) in 2014 (DHS) but increased again to 28 deaths per 1000 in 2017. Neonatal conditions are the leading cause of death for children under five (45%), followed by pneumonia (12%) and diarrhea (9%).

7. **Improvements in maternal health are modest, despite marked improvements in modern contraceptive prevalence.** The maternal mortality ratio (MMR), while still high, has steadily declined, from 401 deaths per 100,000 live births in 2005 to 273 in 2017 (DHS, 2017). Thanks to a well performing national program on family planning, the modern contraception rate increased from 10% in 2005 to 26% in 2017 (DHS), which has certainly contributed to decreasing the maternal mortality ratio. Despite a rapid progress in FP availability, the fertility rate has remained stable over the last decade (4.7 in 2016 and 5.3 in 2005) and particularly high among women from the lowest wealth quintile (7.1). Malnutrition is also a major risk factor in maternal mortality with over a fifth of all maternal deaths associated with undernutrition, particularly iron deficient anemia. Additionally, the rate of births assisted by trained personnel remains low at 68% (DHS 2017) and has improved only slowly since 2012 (51%). Skilled birth attendance also varies significantly across socio-economic gradients: 56% in rural areas versus 90% in urban areas, with skilled birth attendance at only 30% of births among women from lowest wealth quintile.

Figure 1: Selected Health Indicators of Senegal and Comparator Countries

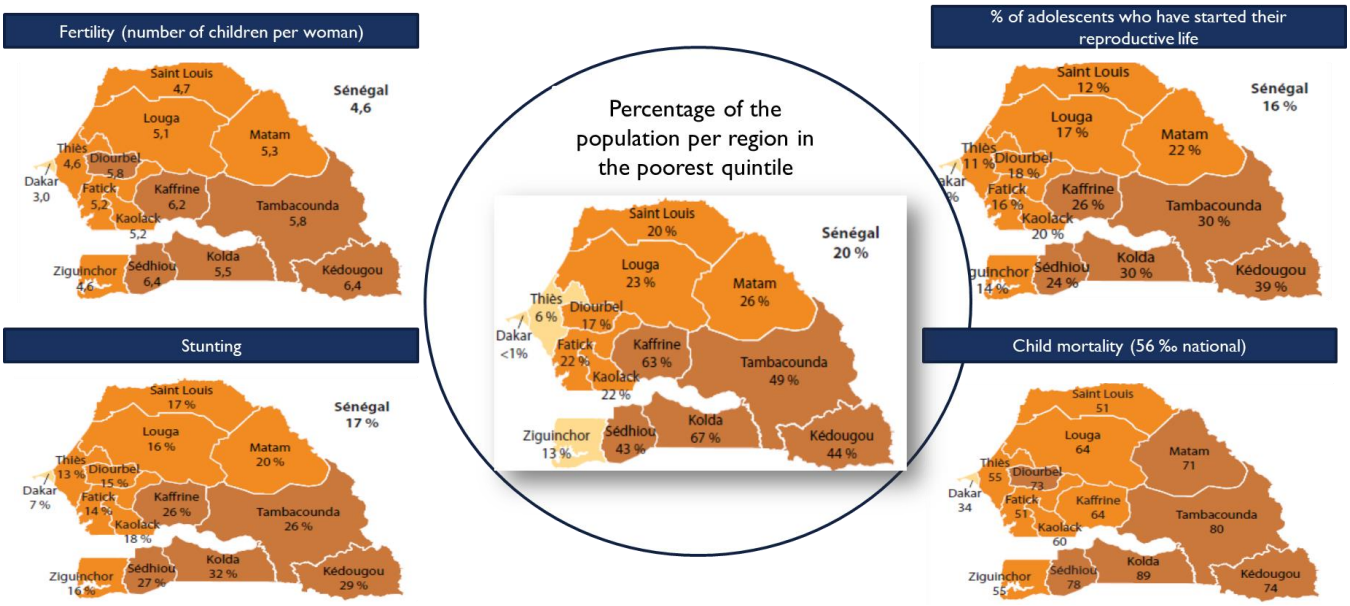


Source: World Development Indicators, Senegal Strategic Country Diagnostic

8. **Chronic malnutrition or stunting (i.e. children being too short for their age) has fallen from a rate of more than 30 percent before 2000 to approximately 17 percent in 2017, thus making Senegal one of the top performers in this area across continental SSA.** Malnutrition is expected to fall to or below 10 percent by 2025. Such progress was achieved largely due to the effective community-based approach of the *Cellule de Lutte contre la Malnutrition* (CLM). The CLM program success rests on its mainstreaming nutrition across sectors; decentralization of program delivery; and use of a community-based approach. The program currently intervenes in 400 communes (municipalities) and aims to expand to all 571 and reach full coverage of nutrition services in all children under five, as well as to intensify services for those mothers and children in the first 1,000 days in the communes where it currently intervenes.

9. **Notwithstanding the progress, Senegal still has a low Human Capital Index (HCI) of 0.42 and significant geographical inequities exist in maternal, reproductive and child health and nutrition**, aligned with the poverty map, as illustrated in the figures below :

Figure 2: Inequalities in maternal, reproductive and child health outcomes aligned with poverty map



Source : Demographic and Health surveys data 2017

Senegal reforms towards Universal Health Coverage

10. **Senegal's strategy to reach Universal Health Coverage is summarized in the four strategic directions stated in the Health Financing Strategy (HFS) to reach UHC: (i) improve the availability of quality health services; (ii) extend financial protection against health-related risks; (iii) strengthen high-impact multi-sectoral interventions; and (iv) increase resource mobilization.** The HFS was finalized in 2017 and was followed by a high-level forum chaired by the President on health financing in November 2017.

11. **The Government of Senegal launched its ambitious Universal Health Insurance program** ("*Couverture Maladie Universelle*" or CMU) in 2013 and created an autonomous Agency under the Ministry of Health and Social Action to manage this program in January 2015 (Agency for Universal Health Insurance- *Agence pour la Couverture Maladie Universelle* ACMU). Most of the program features had been designed (and sometimes piloted) between 2009 and 2012. But the major boost came in 2012 when the President (Macky Sall) made the launch of the UHC a formal commitment during his political campaign. The objective of the UHC is to cover 75 percent of the population by the end of 2021, and the ultimate goal remains the coverage of the entire Senegalese population. ACMU intends to provide coverage to members of the informal sector, including the most vulnerable. To do so, it relies on a well-developed network of CBHI (at least one per municipality), the central level (ACMU) is the ultimate payer, guaranteeing a high level of risk pooling. In addition, enrolment is either partly or fully subsidized. Senegal's poorest families—300,000 households, or about 20 percent of the population—benefit from

the *Programme National de Bourses de Sécurité famillíales* (PNBSF), which is implemented by the *Délégation Générale à la Protection Sociale au Sénégal* (DGPSN) and provides support to families to invest in the development of their young children, including through cash transfers, social promotion/information sessions. Enrollment of these families in CBHIs is supposed to be fully subsidized by the state budget. Annex 1 provides details on the design of the CMU in Senegal. In April 2019, the ACMU became an autonomous Agency under the Ministry of Community Development, and Social and Territorial Equity, hence institutionalizing a complete split between functions of provision and financing of care.

12. **Overall, as a result of the introduction of the CMU, Senegal has demonstrated a significant increase in financial health protection coverage (including all schemes) of the population from 20% in 2010 to 47% in 2017,** and the coverage rate by CBHIs has increased over the same period from 4 percent in 2010, 12 percent in 2014 to 17 percent in 2017**.** The ACMU (Universal Health Insurance agency) is indeed also subsidizing access to limited sets of intervention for specific population groups through the management of the free health care policies. Free care policies have been implemented targeting specific groups to increase access to care: free delivery care for pregnant women (2005), free health services for the elderly (*Plan Sésame*, 2006) and free services at primary level for under five years old children in 2013. However, these free health care programs have some limitations. Benefit packages are limited, and there are frequent issues of availability of drugs, delays of reimbursements to health facilities leading to their limited effectiveness in some regions (for example for the *Plan Sésame*).

13. **But critical challenges for the Universal Health Coverage Program need to be addressed for impact and sustainability of the approach**: (i) the scheme is currently voluntary and to ensure that health insurance coverage can be increased (and with the issue of a weak quality of care in public health facilities) it is crucial to develop strategies to have a large pooling of resources and limit adverse selection, including a potential move towards more mandatory approaches and (ii) the different mechanisms of care coverage for the population, especially the most vulnerable groups, need to be better integrated to ensure greater efficiency and sustainability of the Universal Health Coverage program.

14. **Using Public Private Partnership to achieve UHC by making essential inputs available at facility is critical but challenges remain.** Through the National Supply Pharmacy, Senegal is adopting the “last mile” model as part of supply chain reforms, which should be self-sustaining by June 2018. This approach focuses on improving distribution to “last mile” health facilities through the Informed Push Model, which relies on third-party private logistics providers to deliver contraceptives directly to health facilities, based on practices adapted from the commercial sector. In only three years, the model was scaled nationwide, dramatically reducing stock-outs to less than 2% of all public facilities. This model is now extending beyond contraceptives to include more than 100 essential medicines but is facing financial sustainability issues that the government is not able to cover in the next year.

15. **Fostering data quality and data use through Digital health is essential to reach UHC.** Senegal has developed a National Digital Health Strategy 2018-2023, also aligned with the orientations of the Plan Digital Senegal 2025 and the Plan Emerging Senegal (PSE). The vision is to use the digital tool for a more efficient health system. By 2023, the objective is to contribute substantially to the universal health coverage and to ensure decision-making by stakeholders based on quality and secure information. Areas of focus of the digital health strategy are to: i) promote access to quality care through e-health solution;

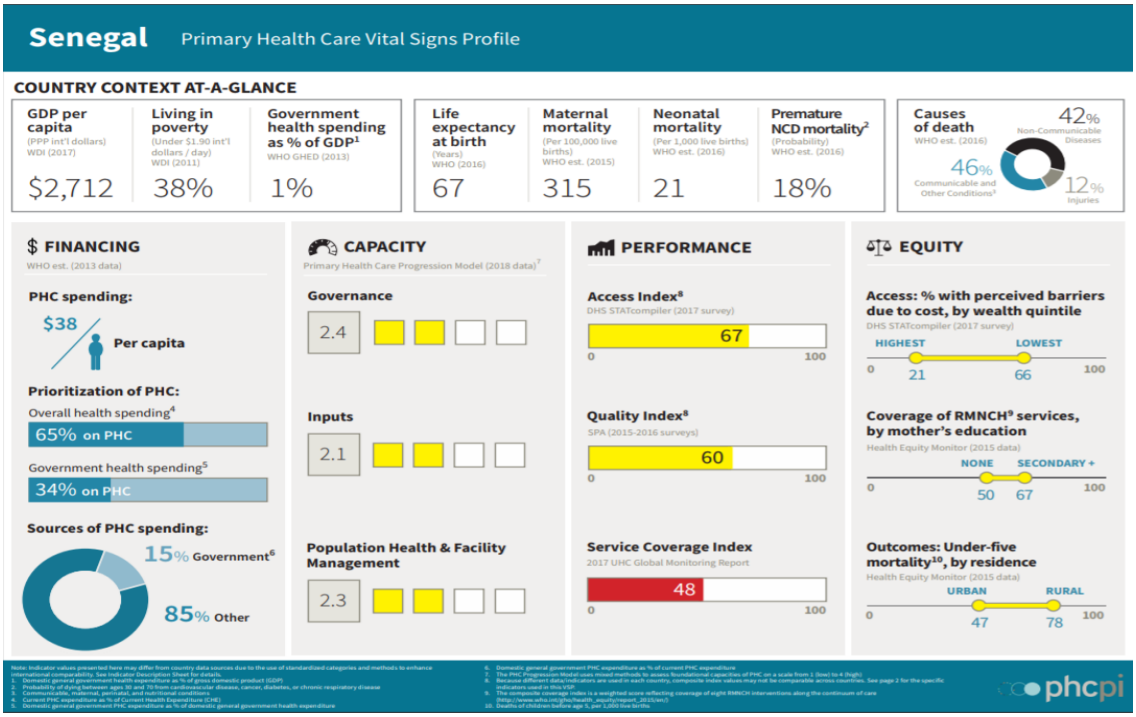
ii) promote the prevention and management of health risks through a wider dissemination of digitized health information through digitalization of the CMU; (iii) strengthen the performance of health personnel through the optimal use of ICTs in day-to-day work; iv) improve health governance through the availability of quality and secure information at all levels of the health system. To strengthen its health information system, the Ministry of Health launched the deployment of the District Health Information Software 2 (DHIS2), a platform for reporting and analyzing health and social data that is already operational at hospitals, health centers and health posts levels. Additionally, the Universal Health Insurance Agency is setting up an integrated management information system for Universal Health Coverage.

But major constraints to achieve UHC and trigger the Demographic Dividend remain

16. **A health system bottleneck analysis[3] conducted in 2017 showed that clinical quality, financial access and cultural acceptability are the top three barriers to effective coverage of the Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) package. Governance and financing issues in the sector are additional constraints that limit the impact of available resources to improve health outcomes.** Further studies show that the following obstacles are limiting the accessibility to quality health services: (i) the density of health centers is low, reducing their geographical accessibility and capacity for outreach activities; (ii) qualified health workers prefer to work in urban areas, especially Dakar; (iii) the performance of health workers is weak, and (iv) health facilities have limited funding for ensuring the availability of drugs and supplies. At the national level, care competence, organization, and management are the dimensions of the quality of care with the worst performance. Financial access is also an issue: 65% of total health expenditures for PHC services are paid by households. Furthermore, issues with cultural acceptance negatively impacts key priority interventions including FP, ANC, assisted deliveries and emergency obstetric and neonatal care (EONC). The figure below summarizes key primary health care performance indicators:

[3] Conducted by the Global Financing Facility for Every Woman Every Child Platform with support from the Primary Health Care Performance Initiative.

Figure 3: Vital signs profile for primary health care performance in Senegal (PHCPI, 2018)



17. **Despite the great strides made by Senegal to improve its overall primary health care (PHC) system, potential benefits remain largely dependent on having sufficient numbers of competent human resources that are geographically well distributed to deliver PHC services.** In 2018, the PHCPI's performance index for Senegal remained quite low regarding its workforce and inputs (2.1 on a maturity scale of 1 to 4). This situation is due essentially to three factors: insufficient number of students admitted for health training in universities; lack of adequate management of the hiring process for civil servants; insufficient incentives given to retain personal and foster a better distribution of human resources. In addition, the low level of competence of health care workers remained one of the top three hurdles identified to improve quality of care. Overall, only 22% of primary health care workers adhered to clinical practice guidelines for services (SDI 2010). As an illustration, only 7% of parents/caregivers are told their child's diagnosis (SPA 2016). Some barriers also persist in terms of geographical accessibility of health services, notably in regions that remain marginalized due to distance from urban centers and lack of adequate transport infrastructure. Overall, 68,5% of patients indicate that they had "no barrier due to distance". Senegal needs to maintain efforts to strengthen the foundations of the system, by consolidating infrastructure density and basic equipment. Indeed, there are clear disparities by region, with better coverage in Ziguinchor, Fatick, Saint-Louis, Dakar and Kedougou, while the regions of Diourbel, Kaffrine, Kolda and Louga remain the least covered (PNDS 2018).

18. **Social, cultural and religious norms, including persistent gender inequalities, contribute to constrain improvements on reproductive health outcomes, as they affect women capacity to accumulate human capital and weaken their agency, and result in high fertility rates, including among adolescent girls.** While net enrollment for girls and boys has reached parity for both primary and

secondary cycles, girls are still more likely to drop out early, mainly due to cultural practices, such as early marriages (9.5% and 32% of girls are married before the ages of 15 and 18, respectively – DHS, 2016). This is also due to the lack of acceptability of use of family planning for unmarried women and economic incentives for a girl to be married early. As a result, and despite the encouraging intergenerational progress, adult women are systematically less educated than men, which, together with their lower access to productive inputs and discrimination, weighs heavily on their agency and access to opportunities[4]. 46% of women (15-49 years old) received no education (with major disparities as 78% of women in Tambacounda region has no primary level education, 64% in rural areas and 74% for women in the lowest economic quintile). According to DHS 2017, 74 percent of women do not decide for themselves about healthcare, and 20 percent of the poorest women do not seek care because their husband would not approve of it. Regional inequities are striking: only 1% of women in Tambacounda, 2% in Kolda and 2% of them in Kaffrine are involved in three major decision-making process[5].The traditional role attributed to women in Senegal has consequences for their agency and for adolescents' ability to take their own fertility decisions, increasing women's empowerment is thus key to improve maternal and reproductive health.

19. **Despite commitment to reach UHC by 2030, there is a low prioritization on health in the Government budget and direct payments remain a burden for households.** Total annual health expenditure in Senegal is approximately 4% of GDP (GHED, 2015). The share of domestic health government expenditure as percent of general government expenditure dropped from 8% to 4% from 2005 to 2015 (GHED). This is a large reduction in the prioritization of health. In 2014, the GGHE/GGE ratio was below the median of L-LMICs of 9.7%. Private spending on health are mostly supported by out-of-pockets (OOP) payments from households. According to National Health Accounts for Senegal, out-of-pocket-payments represent 44% percent of current health expenditure in 2014 and 2015, down from 45% in 2015 (GHED), which however still hints at a low level of financial protection of Senegalese citizens against health-related financial risks. The latest analysis report of catastrophic health expenditure and their impact on impoverishment and use of services in Senegal in 2005 & 2011 (MoH, WHO and ANSD, *Agence Nationale de Statistiques Démographiques*, 2013, using poverty surveys) found that the proportion of out-of-pocket expenditure in the total household expenditures was higher for the poor. Nevertheless, at the national Forum on Health Financing end of 2017, the President affirmed the commitment of the Government to reach the Abuja declaration target of 15% of the budget dedicated to health by 2022.

20. **Governance issues and limited efficiency in the health sector jeopardizes efforts to ask for more resources to the Ministry of Finance.** First there are issues in allocative efficiency: the latest NHA shows an insufficient allocation of funds to primary care and preventative services: Senegal spends half of total health expenditure on preventive care (15%) but the double on curative care (30%) while most causes of diseases could be prevented by preventive health measures. On the technical efficiency side, little is known about productivity or number of visits per medical personnel. A study examined technical efficiency of hospitals, but sample size is limited and did not highlight correlates of low or high productivity. Finally, donor coordination mechanisms are limited and aid at the regional level is fragmented while external funds finances a substantial share of total health expenditures in Senegal (21%. On the one hand, donors complement each other by supporting different regions, but on the other hand this contributes to fragmentation, with several systems being used, increasing transaction costs and

[4] Marzo, Atuesta 2017.
[5] DHS 2017, the three decisions are : healthcare for the woman, major purchases for the households and visits to family.

inefficiencies. Furthermore, only 45% of participating Development Partners have communicated their resources for the next 3 years to the MOH (IHP+, 2016 scorecard).

21. **Thus, the health system does not provide an equitable access to quality health services.** This is due to the inequity in allocation of resources between regions but also for rural and vulnerable areas. The results of the 2013 national health accounts show that the Southeast regions (with the highest child mortality rates in the country) are receiving fewer resources, and an important part of the financing for Reproductive, Maternal, Neonatal, Child and Adolescent Health services (RMNACH) is concentrated in a Dakar, Thiès and Kaolack triangle, regions with the lowest maternal and child mortality rates.

Senegal is engaged in prioritizing interventions and regions of focus to improve equity and maternal, adolescent and child health outcomes

22. **As part of the Global Financing Facility for Every Women Every Child (GFF), Senegal is engaged in prioritizing interventions and regions of focus to improve equity and maternal and child health outcomes, using the available resources.** The GFF is a global partnership which supports the improvement of the health and well-being of women, children, and adolescents. The objective is to strengthen the dialogue among key stakeholders under the leadership of governments and supporting the identification of a clear set of priority results that all partners commit their resources to achieving: (i) getting more results from existing resources and increasing the total volume of financing from four sources (Domestic government resources, Financing from IDA, Aligned external financing, and Private sector resources) and (ii) strengthening systems to track progress, learn, and course-correct.

23. **Through the GFF process, Senegal has developed an RMNCAH Investment Case (IC) based on a thorough analysis of the system bottlenecks and evidence-based interventions, strengthened coordination with its financial and technical partners and built a strong consensus on the priorities the country should focus on to significantly improve maternal, child and adolescent health outcomes.** A GFF platform was created (building on the existing RMNACH group) with representatives from key Ministries (health, finance, interior, education), partners, civil societies organizations and private sector. The GFF Platform delivered an RMNCAH Investment Case in 2018 (validated technically in March 2018). Partners and the government are engaged and have a better understanding where the gaps are and where to re-align. The GFF Investment Case focuses on the following five key priority areas: 1) Provision of a high-impact RMNCAH package; 2) Enhanced financial access to and socio-cultural acceptability of the RMNCAH package through demand side financing; 3) Improved adolescent health through multi-sectoral approaches; 4) Strengthened supply of healthcare services by scaling up high-impact human resources and supply chain interventions to address low RMNCAH effective service coverage; and 5) Strengthening health system governance.

24. **The IC took an equity lens by focusing on the regions with the weakest health and socio-economic indicators.** The Senegal IC targets five priority regions based on a composite index comprised of the following indicators: poverty rate, neonatal mortality, under-five mortality, assisted delivery, contraceptive prevalence, proportion of adolescents with active sexual life and ANC coverage. The regions in the south of the country, e.g., Sedhiou, Kolda, Tambacounda, Kedougou and Kaffrine have the lowest index. Increasing quality and accessibility of adolescent, maternal and child health services will support

Senegal in its efforts to reap the benefits of the demographic dividend. The IC is aligned with the Domestic Resources Mobilization agenda of the Health Financing Strategy (HFS) and its related HFS workplan.

Current Health Portfolio and complementarity with other sectors

25. **The Bank supports the Government to strengthen the health system and in reaching Universal Health Coverage through lending operations and analytical work.** The proposed Project will build on lessons learnt from current Health and Nutrition Financing Project (to close in June 2019, ***details on links between current and proposed operations in table 3 under section F: Lessons learned and reflected in Project Design***) and be complementary to other operations.

- **The Senegal Health and Nutrition Financing Project (PFSN *Projet Financement de la Santé et de la Nutrition*)** is a five-year US$ 40.8 million project slated to close on June 30th, 2019. The objective of the Project is to increase the utilization and quality of maternal, neonatal and child health and nutritional services, especially among the poorest households in targeted areas of Senegal. The Project contributes to support Senegal in reaching UHC, by improving financial accessibility for health and protection for the poorest (through the extension of community-based health insurance, a community nutrition program and maternal vouchers) and improving the quality of care (through Results-Based Financing scheme).

- **The REDISSE Project is a US$ 30 million regional and multi-sectoral Project**, effective since December 2016. It supports Senegal to address systemic weaknesses within animal and human health systems that hinder effective disease surveillance and response. Its specific objective is to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in West Africa, and in the event of an eligible crisis or emergency, to provide immediate and effective response to said eligible crisis or emergency.

- **An Advisory Services and Analytics (ASA) task "Support to Universal Health Coverage and pandemic preparedness"(P164017) provides support for Senegal's UHC agenda** by (i) monitoring Senegal's progress reaching Universal Health Coverage and health-related Sustainable Development Goals and (ii) strengthening pandemic emergency response capacities, especially coordination. This US$ 1 million Bank-executed ASA is funded by the PHRD Trust Fund.

- Additionally, the bank-executed GFF Trust Fund supports analytical work on adolescent health, health financing and efficiency, health system performance at the primary level, human resources for health and health information system.

- The Primary Health Care Performance Initiative (PHCPI) is a bank-executed Trust Fund supporting the government of Senegal on international performance comparisons and analytics, access to global knowledge and best practices related to performance improvement, and multi-country learning for the primary health care system.

- Cross-cutting ASAs such as the Policy Note on Equity of Social Spending that was finalized in 2018 and Public Expenditures Review which includes the health sector (to be delivered in FY20) also will support the interventions proposed in the Project.

26. The proposed operation will also complement interventions of the Early Years, Education and Social Protection Projects, as well as the potential Development Policy Operation (DPO) on Equity and Sustainability in the pipeline for FY21-24, and interventions from other health partners in Senegal.

C. Relevance to Higher Level Objectives

27. **Through strengthening availability of quality health services, improving adolescent health and women's empowerment and improving financial protection, the proposed project will directly address some of the binding constraints identified in the SCD, especially the inequity of social public policies and expenditures.** As indicated in the SCD, lagging outcomes in child, maternal and reproductive health undermine Senegal's ability to build a strong and inclusive human capital base for its long-term development.

28. **Building on the SCD, the interventions under the project remain consistent with, and aligned to, the emerging framework of the Country Partnership Framework (FY19-FY23) (currently under development)**, which focuses on: (i) Building up Human Capital throughout the life cycle, (ii) optimizing social development and (iii) creating an ecosystem for innovation. More particularly, under the first focus area related to building human capital throughout the life cycle, this project will support the Bank approach on providing universal access to healthcare, increasing resilience among the poorest households (through health insurance and financial protection) and reducing dependency ratio to leverage the demographic dividend (by improving access to quality health care, especially reproductive health and family planning and nutrition services).

29. **The proposed project is also fully in line with the World Bank Group's (WBG) twin objectives of reducing poverty and promoting shared prosperity and with the Sustainable Development Goals (SDG), in particular Goal 3: Ensure healthy lives and promote well-being for all at all ages.** Goal 3 of the SDGs has several targets for 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 Universal Health Coverage (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 achievement of *Goal 1*: End poverty in all its forms everywhere through its links with social safety nets programs and improved financial protection from health expenditures among the poor and vulnerable; and *Goal 2:* End hunger, achieve food security and improved nutrition and promote sustainable agriculture, through its activities related to supporting high impact nutrition interventions.

30. **The project is also fully aligned with the Human Capital Project**, with a view to contribute to improving the three health ultimate outcomes indicators (probability of survival to age 5, stunting and

adult survival rate to age 60) included in the World Bank Human Capital Index. Senegal is one of the sixty trailblazer countries for the Human Capital Project.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The proposed Project Development Objective (PDO) is to improve utilization of essential RMNCAH-N (Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition) services meeting quality standards[6] in priority regions.

Key Results

31. The proposed PDO indicators are the following:

i. The following indicators will be used to measure increased **utilization of RMNCAH-N services** in the targeted regions:

1. Utilization of health services by patients covered by an insurance mechanism;
2. Percentage of children under 5 suffering from childhood stunting;
3. Utilization rate of modern contraceptive methods by adolescent girls, aged 15-19.

ii. The following indicators will be used to measure achievements of **quality healthcare services** in the targeted regions:

4. Quality index of health services (percentage)
5. Percentage of pregnant women having 4 antenatal care visits at standard quality.

D. Project Description

32. **The proposed 5- years project would cover the regions with the poorest health outcomes (and very high levels of poverty) with interventions to address major bottlenecks (availability and quality of basic maternal, child and nutrition services, financial access to health services, cultural and social norms) to improve health outcomes and support key governance reforms.** The Project is aligned with the priority interventions identified in the GFF investment case to improve maternal, child and adolescent health and will be focused on six priority regions (five priority regions defined through an in-depth prioritization exercise: Kédougou, Kolda, Kaffrine, Tambacounda and Sédhiou, as well as the region of Ziguinchor). Building on lessons learned from the existing portfolio (Health and Nutrition Financing Project to close in June 2019) and analytical work, international and regional experience (SWEDD project), the proposed Project will:

[6]Quality standards are defined as compliance with the official WHO quality standards of clinical care for RMNCAH-N services that Senegal has adopted. WHO standards have been defined through a series of published guidelines including: (a) Standards for improving quality of maternal and newborn care in health facilities https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/; (b) Standards for improving the quality of care for children and young adolescents in health facilities : https://www.who.int/maternal_child_adolescent/documents/quality-standards-child-adolescent/en/. In Senegal, the SPA survey allows a regular monitoring (every year) of compliance to those standards of quality of clinical care.

- Scale-up successful interventions to improve maternal and child health and nutrition (community nutrition platform, health insurance for the poorest, cash transfer for poor pregnant women, ensure availability of critical maternal and child health inputs);

- Pilot (for 2 years) with technical assistance, evaluate and scale-up innovative approaches (on adolescent health and quality of care). A significant learning agenda will also be integrated in the operation.

33. The project intends to achieve its objective through interventions at the community, primary, regional and central level that are organized into three complementary components addressing the major bottlenecks in the sector: 1) Improving availability of quality RMNACH and nutrition services (US$ 60 million); 2) Promoting adolescent health and women's empowerment(US$ 25 million); 3) Supporting reforms to strengthen governance, equity and financing sustainability in the health sector(US$ 65 million);. A fourth component for this project consists of a Contingency Emergency Response Component (CERC) which will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis. Results Chain on section D provides an overview on the impact expected from the Project's interventions on major bottlenecks.

Component 1: Improve availability of RMNACH and nutrition services of adequate quality (US$ 60 million: IDA US$ 55 million and GFF TF US$5 million)

This component will support key interventions to overcome bottlenecks identified as major constraints for health system performance and effective delivery of RMNCAH-N services in the six targeted regions.

Sub-component 1.1: Supporting the availability and distribution of human resources and other key inputs in priority regions (IDA US$ 30 million)

34. This subcomponent will include investment to support the government in improving the availability of qualified health care professionals as well as ensuring the availability and efficient distribution of key health inputs (drugs, equipment, emergency and maternal and child health equipment) in the regions targeted by the project. The aim of this subcomponent is to increase availability and improve the quality and efficiency of the supply of health care services. Annex 2 provides details on the situation of HRH in the six regions and proposed strategies.

35. **Availability and distribution of qualified health workers.** Under this subcomponent, the project will help overcome the staffing gaps identified in the Healthcare Mapping Strategy (Care Sanitaire 2017-2021) for the 6 priority regions. In order to do so, the project will finance contracts with skilled personnel in marginalized areas. Priority personnel to be recruited include: medical specialists (gynecologists-obstetricians, pediatricians, anesthesiologists), midwives, nurses, pharmacists, nutritionists, maintenance specialists and technicians. Furthermore, the project will support the Human Resources Directorate of the Ministry of Health in the development of an incentive program that aims at retaining skilled personnel (medical specialists) in marginalized and difficult areas. The project will also involve the private sector within this subcomponent, by promoting increased partnership between the Ministry of Health and the

private sector to improve access to quality care, through the recruitment and distribution of unemployed midwives and health care workers. The Project will finance the recruitment and retention of health care professionals for the first three years of the Project. The government will then integrate them on MoHSA payroll, and finance the cost for years 4 and 5 of the Project in order to ensure the long-term sustainability of the investment (commitment letter to be signed by Ministry of Health, as it was done successfully in the past for other qualified health workers contracted by Projects then integrated in the national payroll)..

36. **To improve the availability of qualified human resources, this subcomponent will also finance the implementation and scaling-up of the strategy for mobile midwives** (*Stratégie des Sages-Femmes itinérantes* or SAFI). The strategy is to increase the availability of qualified health workers in health posts. Certified midwives (called SAFIs) devote more of their work time to reach the most remote populations at community sites and public gathering places (weekly markets ....). The tasks of the SAFIs are to deliver quality curative, preventive and promotional services and plan outreach in collaboration with the community. The SAFI strategy has proven successful in the past in Senegal in the regions of Matam and Sedhiou to help increase the recruitment of midwives, but also their availability in outposts. The initiative will finance investments such as motorcycles and small clinical equipment to ensure that midwives are mobile and can connect with the populations that are the most remote, at a community level.

37. **Under this subcomponent the project will support the availability of key drugs, commodities and equipment for maternal and child health,** as the weakness of the drugs supply chain was identified as one of the key health system bottlenecks during the development of the GFF investment case. Following a pilot approach funded by partners, the Government of Senegal chose the Informed Pushed Model as its national strategy for supply chain management. The National Pharmacy Agency (PNA) is in the process of scaling up the push model approach. PNA transports supplies to the district level and contracts private operators for last mile delivery to provide medicines to health facilities. The PNA has done extensive financial analysis of the budget and cost recovery involved in scaling up IPM and foresees that it will be self-sustaining after a transition period. The Project will support the PNA to ensure the transition and the sustainability of the approach, for example in financing the contracts of the private operators in priority regions.

38. **Additionally, the Project will procure key equipment for maternal and neonatal health services (for Emergency Obstetric Care Services and emergency pediatric services)** that are essential to avoid maternal and neonatal deaths. Specific trainings to use this equipment will also be provided. Investments will also ensure the quality of medical products delivered at facility level and will ensure the availability of blood products, which is critical to save lives of mothers and children during emergency birth deliveries. The Project will also ensure the availability and distribution of micronutrients and other inputs required to improve nutrition services. Finally, the Project will support the procurement of equipment improving accessibility of healthcare services for disabled persons.

39. **Finally, this sub-component will also support the electrification with solar panels of health facilities which are not connected or have interrupted electricity access in the six regions.** Costs of solar panels for the health facilities in need have been estimated to US$ 1.8 million. Maintenance of electricity and water equipment as well as consumption payments will also be supported by the Project during the first three years of the project and transitioned to government for years 4 and 5 of the project, and it will be monitored as part of the local quality scorecards.

Sub-component 1.2: Strengthening clinical competence and capacity of healthcare professionals and regional planning services to deliver quality care to mothers, children and adolescents (US$ 15 million: IDA US$ 10 million and GFF TF US$5 million)

40. **To improve the clinical quality of healthcare services at the community and primary health care levels, it is proposed to implement a multi-pronged strategy addressing gaps in the quality of care.** This is critical to improve clinical and health outcomes for mothers, children and adolescents. Under this sub-component, the Project will fund: (i) in-service trainings of healthcare professionals and regional planners, workshops, consultants, and communication strategies related to quality of care (US$ 4 million); (ii) efforts to strengthen the capacity of medical regions to manage and organize integrated networks of quality health services (US$ 5 million), (iii) the development and pilot of an accreditation process in two pilot regions with the view to scale up after the pilot has been evaluated (US$ 2 million) and (iv) interventions to strengthen local accountability for better quality of care for example through the release of local quality scorecards about maternal, child and adolescent health and nutrition services (US$ 4 million).

41. **Training programs will be supported to help improve current care competency levels with a focus on antenatal care (including detection and management of anemia), family planning and sick child care** and ensure that staff that are in the field have received adequate training and support. In service training programs focus on quality of clinical care and inter-relational quality including patient experience and include training for better management of antenatal care, neonatal care management, pediatric emergencies, integrated management of childcare diseases, family planning and better care of disabled persons. Core training on capacity for continuous quality improvement and care integration will also be delivered. To strengthen pre-service training, the project will also support the collaboration between the Minister of Health, the University and the Centre of Excellence for Mother and Child Health. Trainings will also support the scale up of antenatal group consultations to the priority regions.

42. **The Project will support medical regions to organize and manage integrated networks of quality health services** with the development and implementation of quality improvement plans at regional and health facilities levels (financial transfers for quality improvement activities, including medical waste management), and set-up quality assurance mechanisms for drugs and integrated supervision.

43. **The Project will finance the development of standards of care for maternal, child and adolescent care and will pilot the implementation of an accreditation process in two pilot regions.** The Project will also evaluate the effectiveness of introducing accreditation of facilities as well as its impact, with a view to scale up accreditation in other parts of the country. The accreditation standards and process will be developed in year 1, piloted in years 2-3, evaluated in year 4 and ready for roll out by end of the project to the entire country

44. **Local accountability for better quality of care will be strengthened by implementing local scorecards** for maternal, child and adolescent health including quality of care indicators, by engaging the community in the design of provider plans of continuous quality improvement, and by training community volunteers in quality of care and equipping them with processes and instruments to share complaints with health care providers and districts. Innovative models of community engagement related to quality of

care will be tested such as the model of health defenders successfully implemented in Guatemala[7]. The project will ensure that reliable information about quality of care including clinical quality and effective coverage is available throughout the duration of the project.

Sub-component 1.3: Supporting nutrition services at community, health centers and hospital levels (IDA US$ 15 million)

45. **Community Nutrition.** The Project will support the community-based interventions of the *Cellule de Lutte contre la Malnutrition (CLM)* to enhance demand for nutrition services. This sub-component will support the CLM to carry on the demand-side activities of the current successful nutrition program in Senegal. As currently done, local NGOs (called *"Agences d'Exécution Communautaire" - AEC)* are contracted by the CLM to implement the different community-based nutrition services. One "AEC" is covering approximately one health district. AECs work closely with local councils to implement the package of nutrition services and activities at the community level. Three kinds of activities would be implemented: (i) growth promotion and monitoring for children between 0 and 24 months in communities; (ii) Behavioral Change Communication (BCC) activities; and (iii) detection and community care of malnutrition. Thus, contracts with local NGOs to implement these activities will be funded. Community nutrition Interventions will be complementary (geographically) to the interventions supported by the Early Years Project which became effective in April 2019, and benefit from the interventions developed under this Project to remain efficient. Targeted regions under the ISMEA project regarding the nutrition package will be focused exclusively on Kolda, Sedhiou and Zinguichor as the Early Years Project will intervene in the remaining regions (Kaffrine, Kolda, Tambacounda, Diourbel, Fatick, Kaolack and Matam).

46. **Supporting health posts, health centers and district hospital to better promote nutrition activities and the management of malnutrition**. To strengthen links between community and health posts/centers and hospitals levels on nutrition management, the Project will support improvement in management of malnutrition cases as well as nutrition promotion for pregnant mothers, adolescents and children.

Component 2: Promote adolescent health and women's empowerment (IDA US$ 25 million)

47. **Investing in adolescent health is at the heart of the potential for demographic dividend and increased population well-being in Senegal.** Indeed, one of the contributors to high fertility rates is the early age at which women start their reproductive life. Younger age at childbirth for women is associated

[7] Community defenders are volunteers elected by their own communities to implement monitoring and evaluation of public policies and healthcare services. They also collect complaints and evidence of right to health violations in their communities and translate it to corresponding authorities. Community defenders also engage in strategic advocacy with municipal, provincial and national government with explicit demands to eliminate barriers to access and the discrimination experienced by rural indigenous families when seeking healthcare.

with negative outcomes for both women and their children, such as higher risk of complications at birth, poorer health, lower educational attainment and poverty.

48. **Component 2 of the Project aims to alleviate barriers due to social and cultural norms that limit women's and adolescent girls' access to health and nutrition services.** Indeed, beyond the constraints related to the availability and quality of health and nutrition services (which are supported under Component 1) and the financial constraints (which are targeted by interventions funded under Component 3), certain social and cultural norms, as well as low levels of women's empowerment impact negatively adolescent girls and women's health. This component will therefore finance interventions (i) promoting behavioral change through awareness and communication, community mobilization and (ii) empowering adolescent girls and women including through pilot cash transfers initiatives. Interventions under this component are multi-sectoral and address different groups of the Senegalese population. The overall objective through this component is to (i) increase the demand for and use of quality RMNCHN services; (ii) improve sexual and reproductive health knowledge and practices; (iii) enhance women and girls' autonomy and decision power and (iv) delay marriage and pregnancy. Operational research will also support implementation, by including insights from behavioral science in the design and evaluation of selected multisectoral interventions to empower adolescent girls and improve their reproductive health. Lessons learnt, and evidence produced by the Sahel Women Empowerment and Demographic Dividend (SWEDD) Project will also be integrated in the design of the proposed interventions.

49. The proposed interventions are based on promising local experience and international evidence, and complementarity with other partners (UNFPA, Whish program funded by DFID, etc..), some are summarized in the table below (details in Annex 3):

Table 1: Global evidence and Senegal experience to improve adolescent health and women's empowerment

Type of interventions	Promising experience in Senegal	Global evidence
Mass media approaches	TV show *" C'est la vie"* promote through entertainment knowledge on reproductive health, personal skills, etc..	Evaluations in number of countries (Ethiopia, Mali, the Gambia, etc..) has shown increased knowledge and improved attitudes about family planning, approval of family planning, and use of reproductive health services
Social and behavior change at community level	*Tostan* program in Senegal focuses on community education and mobilization, and engages communities to pledge public declarations against harmful practices such as early marriage Safe spaces for women's leadership in Senegal (UNFPA). To improve school performance and keep girls in school, the program establishes safe spaces for girls in school and community space	Rigorous evaluations of programs in Bangladesh and India indicate that community-based approaches have been effective and have resulted in increases in use of modern family planning methods, discussions with husbands about family planning and continuation of method use.

Life skills[8] and jobs skills training	Life skills training have been implemented by DGPSN as part of the Yok Kom Kom program. Results of the Impact Evaluation will be available early 2020.	Life skills and livelihoods trainings help to decline child marriage and increase engagement in income-generating activities. The BALIKA (Bangladeshi Association for Like skills, Income and Knowledge for adolescents) program targeted girls age 12-18 with safe spaces, education support with tutoring, life skills; Livelihoods training in generic skills and exposure to a variety of income-earning activities. The program helps reducing child marriage (by 23% for the girls involved in the livelihoods activities) and increase engagement in income-generating activities (35%).
Cash transfers for adolescent girls (to keep them in schools or back to schools/vocational training)	No experience in Senegal targeting adolescent girls	In Malawi, the ZCTP (Zomba Cash Transfer Program) gave incentives (school fees and cash transfers) to keep girls in school and to encourage them to return to school. Through an impact evaluation, results showed that the likelihood of ever being pregnant or married was reduced by 27% and 44% respectively[9]

Sub-component 2.1 Supporting behavioral change through communication, community and individual interventions (IDA US$ 7 million)

50. **Strong social and behavioral change communication (SBCC) is a critical part of community mobilization which is necessary to address social norms, attitudes and practices, especially for sustainability of results.** The objective is to increase sociocultural acceptability and behavior change through an inclusive process, that involves all relevant stakeholders and to change perception on adolescent reproductive health issues by focusing on its overall benefits and by putting the accent on health, well-being, and capacity to engage in schooling or productive activities to help lift their families out of poverty rather than just sexual and reproductive health. Several types of social and behavioral change interventions will be financed by the Project targeting different groups (religious and traditional leaders, health workers and teachers, youth counsellors and young leaders, adolescent girls and boys, men and husbands) and at different levels (national, community, individual), making them complementary approaches to support the development of positive behaviors towards adolescents and women. Boys will also be targeted as they play a key role in women and girls' empowerment.

51. **At national level, the Project will fund national mass media campaigns, promoting on television, radio and social networks messages regarding gender issues and adolescent health**. The content would be locally generated with support from experts, involving religious leaders and civil society representatives so as to be most relevant and culturally appropriate. At community level, the Project will

[8] These interventions are designed to teach a broad set of social and behavioral skills including decision-making, community living, and personal awareness and management with the aim of developing young peoples' abilities and motivations
[9] Baird, Sarah, Berk Ozler et al. (2010, forthcoming)

scale-up several successful interventions such as creating community forums with religious and community leaders to foster dialogue between parents and adolescents and also promoting intergenerational and intragenerational dialogue platforms. The Project will also contribute to improve existing health promotion activities linked to adolescent health such as Counseling Centers (*Centre Conseil Adolescent*) managed by the Ministry for the Youth.

52. **To promote an enabling environment for adolescent health and women's empowerment, "champions" (such as young leaders, youth associations representatives, journalists, teachers, bloggers, etc…) will benefit from activities to strengthen their advocacy capacities**. Training and discussions among peers with religious and community leaders (SWEDD approach and manual), as well as traditional *"communicators"* and teachers would also be supported on adolescent health and women's empowerment. Finally health workers' s capacities will be strengthened on interpersonal communication, women's and adolescents' rights, building self-confidence, etc.. in order to create a more positive environment at health facilities for adolescents.

Sub-component 2.2 Strengthening adolescent and women' s empowerment (IDA US$ 18 million)

53. **Several factors are drivers of teenage pregnancies and early marriage, including persistence of traditional social norms, religious beliefs, economic incentives, education, socioeconomic background, tradition of child marriage and inadequate sexual health service provision.** This sub-component of the Project will fund interventions to address issues related to economics incentives and education, as the sub-component 2.1 is supporting alleviation of traditional social norms and religious beliefs. Indeed, low level of empowerment of adolescent girls and women prevents them from effectively achieving their desired fertility and also impacts their health (constraints on access to information, disempowered within the household on health seeking decisions and interactions with health providers) and their children development (health and education), thus hindering Senegal Human Capital improvement. Addressing these gender gaps early on is crucial as adolescent outcomes can have long-term effects throughout the life cycle and it is key to reach young women before they have children to break the inter-generational transmission of poverty and its associated outcomes.

54. **Levels of education and poverty both play a significant role in adolescent pregnancies and early marriage in Senegal**. Low levels of school enrollment for girls (especially at secondary level and in rural areas) and low bargaining power to make informed decisions about fertility and contraception within the household, explained partially by the low economic power of women, are major gender issues affecting adolescent and women's health. To address these issues, the project will support the implementation of strategies to (i) enhanced access of girls to secondary school and (ii) improved economic empowerment of women (including out-of-school girls) while strengthening multisectoral coordination mechanisms to ensure effectiveness and sustainability of these strategies.

55. **Two cash transfers programs will be supported by the project: (i) one for enhancing access and retention of adolescent girls in secondary schools and (ii) one to support access of out-of-school girls in vocational training.** Girls' access to schools is hindered by cost issues: transportation and accommodation when the school is further away from home reinforce decisions to marry them early rather than sending

them to school. Based on international and regional evidence, a cash transfer program for vulnerable adolescent girls (based on the Unique Registry that is already used for targeting beneficiaries of the country's safety net program) in secondary school will be piloted then scaled-up in the six regions after two years refining the design with results from the evaluation. For the 2-year pilot, one district in each region will be selected and around 100 girls per district will benefit from cash transfers. An NGO/firm will be contracted to support the Ministry of Health, in coordination with the Ministry of Education, to implement this program and a research agenda and evaluation will be conducted. The second cash transfer program will support out-of-school adolescents to ensure their enrollment in vocational training, with a similar approach: 6 pilot departments (around 50 girls per department) and appropriate accompanying measures and evaluation before scaling-up the intervention in all six regions. The evaluation would include a baseline survey in the selected areas and control areas and an endline survey after two years. In the pilot phase, these cash transfers programs will benefit to 900 girls per year. The total adolescent girls' population (girls between 10-19) in the six poorest regions of Senegal is estimated at around 400,000 persons, and the cash transfers programs would target 10% of them each year from year 3 of the Project. **Thus, it is estimated that around 120,000 girls will benefit from cash transfers by the Project**.

56. **The Project will also support interventions to empower girls and young women with life skills and jobs skills training.** These trainings will target women and girls who never entered or have fallen out of the school system, or even girls in school whose needs the education sector alone cannot meet (for example, married girls). These trainings will be based on curricula already developed in Senegal (through the Yok Kom Kom program with DGPSN). Such trainings will include among others functional alphabetization centered on health and nutrition, development of skills on leadership, self-confidence, negotiations skills, reproductive health knowledge, etc…

Component 3: Support reforms to strengthen governance, equity, and financing sustainability in the health sector (US$ 65 million: IDA US$ 60 million and GFF TF US$5 million)

57. **Component 3 of the project aims to support the Government of Senegal in necessary reforms to strengthen governance to improve equity, efficiency and sustainability in the financing of health sector.** Indeed, some inefficiencies in the utilization of existing resources, as well as the low level of domestic resources for health and low strategic management of the sector limit improvements of health outcomes for the Senegalese population, especially for the most vulnerable. To increase equity, this component will support interventions to overcome financial barriers encountered by the most vulnerable to access essential health services, including RMNCAH-N. In doing so, it provides a strong incentive for the utilization of services improved as part of component 1 of the project. This component also aims to bring more efficiency overall: in the way health insurance for the most vulnerable is managed, in the way providers are incentivized to deliver care in an efficient manner with strategic purchasing mechanisms, and finally by improving the general governance of the health system (health information systems, stewardship, health financing reforms).

Sub-component 3.1 Improving financial protection against health risks (IDA US$ 37 million)

58. **Waiving financial barriers to access to care in order to reach a greater level of equity. These financial barriers and resulting inequity pertain to two types of costs, those directly related to care (cost of services, cost of medicines) and indirect costs (transportation to facilities especially).** These two types of costs require separate sets of interventions. As part of this subcomponent, direct financial barriers will be addressed through an enhancement of the Universal Health Insurance scheme (details on the scheme in Annex 4) and indirect barriers will be addressed through an extension of the maternal health vouchers pilot.

59. **Tackling the direct cost issue while enhancing efficiency through a support to the Universal Health Insurance (UHI). The Project will contribute to expand coverage of UHI for greater equity and to develop strategic purchasing and new institutional arrangements for greater efficiency and sustainability of UHI.** The following activities will be financed: (i) contribute to finance and promote the enrollment in Community-Based Health Insurance (CBHI), including of the poorest (as identified in the national unified registry) and more vulnerable (children under five years old), through the integration of the free healthcare scheme into the community-based health insurance scheme; (ii) support the development of strategic purchasing by the Universal Health Insurance Agency, for instance through strengthening of the information system of the Universal Health Insurance (SIGICMU- *Système d'Information de Gestion Intégré de la CMU*) and building capacities for informed-decisions to manage the health insurance (control, equalization, costs, etc..), (iii) promote greater efficiency in internal processes of the Universal Health Insurance scheme.

60. **More equity through subsidization of the enrollment in UHI contributory scheme, including of the poorest and most vulnerable populations (children under five years old),** hence resulting in the integration of the free healthcare scheme into the insurance scheme of the UHI. To improve efficiency in the management of the very fragmented set of benefits under its responsibility, the Agency plans to progressively integrate free healthcare schemes into the CBHI. The agency will therefore subsidize enrollment in the CBHI and hence access to a broader package of care, moreover with more efficiency than when reimbursing discrete interventions on a fee-for service basis with the free healthcare scheme. This integration effort is currently piloted in one district and supported over the last 8 months of the current Health and Nutrition Financing Project, through partial subsidization of the enrolment. This support is meant to continue as part of the new project, as well as to be scaled up to additional districts of intervention of the project. In doing so, the project will contribute to open access to a wider package of care[10] for the poor and the under-five years old, in intervention districts which are known for a low level of utilization of health services. In addition, while subsidizing access of the most vulnerable this financial support will also provide a steady flow of funds, which will allow the UHI to focus on additional reforms. This will for instance enable the introduction of new purchasing mechanisms to fund health services in a more strategic way, as well as testing new institutional arrangement at district and regional level. This will ultimately result in greater efficiency and sustainability of the Universal Health Insurance scheme at the end of the project (these innovations are described in the following paragraphs). The bulk of related intervention will take the form of direct subsidization by the project's funds, as a complement to domestic funding, of the enrolment of the beneficiaries of PNBSF and free healthcare scheme for a total amount of US$ 28 million.

[10] UHI schemes, including population covered, modalities of subsidization and packages of care are described in annex 4.

61. **Strengthening equity even further through communication geared towards potential net contributors. Although the focus is put on the most vulnerable and their health needs, it is worth noting that in a voluntary scheme such as the Senegalese UHI, it is crucial to develop strategies to attract net contributors[11], hence enlarging the pool and countering adverse selection.** The project will support the development and implementation of a communication strategy including interventions at both national and community levels will be funded. As the voluntary nature of enrolment is a well-known factor of mid-term slowdown in the enrolment rate of CBHI, the Project may also provide technical assistance to facilitate the shift to a more mandatory approach. Support of the project to these interventions will consist in technical assistance/consultants and workshops for the preparation of the communication strategy, and communication campaigns as well as financing of community-level events and payment of broadcasting fees. Communication-related intervention will amount to US$ 1 million.

62. **More health for the money through better efficiency. As a mean to seek greater efficiency of the Universal Health Insurance scheme, the project will support institutional change and strategic purchasing[12] reforms to render the management of the Universal Health Insurance system more agile and more efficient**. This is the purpose of the planned support to the professionalization of CBHI agents and to the progressive transfer of part of the CBHI roles to the departmental and even regional levels. The Project will also provide technical assistance in such areas as alignment and improvement of packages of care currently managed by the Universal Health Insurance Agency (and especially the alignment of the benefit package with priority interventions determined in the Investment Case, to make sure that essential RMNCAH are actually free at the point of service). The project will also support the design and implementation of new purchasing mechanisms (for instance per-capita funding for PHC) in collaboration with the Ministry of Health. As a pre-requisite, for the UHI to purchase health care services strategically, it requires adequate information and the capacity to use it to inform decision-making. While the previous operation supported the design of the SIGI-CMU, this project will support it's deployment and operationalization at local and facility level, including the training of relevant staff to properly feed the system with data and interpret it to make evidence-based decisions. Aside from being essential to such tasks as claims management and control of the effectiveness of care, the system is indeed expected to feed a data warehouse which will centralize very granular (down to the individual level) information on utilization and funding flows from every CBHI, hence allowing real-time interpretation and policy adjustments. Interventions related to efficiency gains and strategic purchasing will amount to a total of US$ 5 million.

63. **Tackling inequity of access beyond direct cost of treatment. As far as indirect costs are concerned, the project will support interventions overcome barriers and hence to boost demand for maternal health services.** This sub-component will expand the maternal health vouchers pilot intervention that is currently implemented under the Health and Nutrition Financing Project by the CLM and identified in the GFF Investment Case as successful to increase demand for maternal services. Two services are incentivized through these vouchers: (i) four antenatal care (ANC) visits by poor pregnant women; and (ii) assisted deliveries at the health center level. Cash transfers to pregnant women and

[11] Net contributors are enrollees who contribute more than they receive from the insurance scheme.
[12] As defined by WHO, "Strategic purchasing means active, evidence-based engagement in defining the service-mix and volume and selecting the provider-mix to maximize societal objectives. Improving the strategic purchasing of health services is central to improving health system performance and making progress towards universal health coverage".

operational costs of local NGOs (managing the cash transfer, verification and communication) will be funded (US $ 3 million)

64. **Seeking synergies between health financing and service delivery policies. Interventions of sub-component 3.1 will be implemented in synergy with activities conducted as part of other components and sub-components.** On the one hand they will waive barriers of access to health services improved as part of component 1, and on the other they will be implemented, monitored and improved as part of the broader governance improvement led in sub-component 3.2 below. Pilot activities of sub-component 3.1 can actually be considered as proofs of concept for a future scale up of policies aiming at more equity and efficiency in health financing.

Sub-component 3.2: Improving governance of the system (US$ 28 million: IDA US$ 23 million and GFF TF US$5 million)

65. **The objective of this sub-component is overall to improve transparency and accountability in health policy implementation, with a focus on resources utilization.** This will be achieved by i) improving how financial resources for health are managed and tracked ii) Improving how health information is produced and analyzed to generate more robust evidence and iii) improving stewardship and accountability, especially through a greater role of the civil society..

66. **Improving how financial resources for health are managed and tracked.** The project will support improvement in public finance management in health. In cooperation with the WB Governance team in Senegal it will support the MoHSA to implement program budgeting, which will allow to track resources in the health sector and measure the efficiency of domestic resources. It will then allow to take corrective measures in case of misalignment between priorities and financial resources allocation as for instance revealed in a previous BOOST in the case of RMNCAH.

67. As a complement to enhancing program budgeting, **the project will also support the development of a fiduciary unit to manage resources of external partners**. Several donors (Global Fund, GAVI, USAID, World Bank) are already strengthening their partnership in support of a common workplan to build capacities of the fiduciary unit of the Ministry of Health (DAGE-*Direction de l'Administration et de la Gestion des Equipements*), at central and regional levels, to manage resources of external partners with respect to RMNCAH+N. This unique workplan aims to strengthen the alignment of partners and strengthen the capacities of the DAGE but also strengthen the internal audit function within the MoH. Moreover, it will also support the implementation of a unique workplan leading to a virtual pooling of external resources by the Ministry of Health to support the funding of the RMNCAH+N package in the long-term. The project will also continue to support the promotion of public-private partnership in the sector, on the basis of current bank support to the establishment and function of the alliance of the private health sector. Activities in support of better management and tracking of financial resources for health will amount to a total of US $ 3 million.

68. **Improving how health information is produced and analyzed.** The project aims to support the production of more timely, comprehensive and accurate data on how health services perform and how they are funded (by domestic and external resources alike). This will be achieved through the

development of an integrated HMIS (especially creating inter-operability between several information systems, including those of the MoH and of the UHI), and of a resource tracking tool on the basis of existing sources on financial flows (NHA and IFMIS). The national capacity to interpret compiled information and formulate it in policy recommendation will also be strengthened through support to dedicated units at the UHI and at the MoHSA Department of planning.. Evidence-generation activities will mostly consist in procurement of equipment, TA, training and capacity building workshops and will amount to a total of US $ 10 million.

69. **Improving stewardship and accountability.** This sub-component will support support the coordination mechanism for the implementation of the IC, including the development of implementing tools at the regional level. Civil society organizations will also be supported to play their role of monitoring and citizen participation in the health sector. Special attention will also be given to the role of civil society organizations (organized with the Civil Society Organizations for GFF) for: (i) the functionality of the civil society organization platform for the GFF; (ii) the implementation of a community scorecard for monitoring commitments and accountability of stakeholders; (iii) the development and implementation of watch and alert tools; (iv) the development and implementation of a communication plan on the GFF. Interventions under this sub-component will therefore include contracts with civil society organization and amount to a total of (US$ 10 million)

70. **Project coordination.** This includes day-to-day management of project activities including recruitment of necessary staff to ensure a smooth coordination and implementation of the Project (coordinator, financial management specialist, procurement specialist, monitoring and evaluation specialist) and related expenses. Expenses related to this sub-component will include technical assistance, consultants, equipment, workshops, formal trainings, on the job trainings, study tours, as well as coordination and communication activities (US$ 5 million).

71. **Component 4: Contingent Emergency Response (USD 0 equivalent):** A Contingency Emergency Response Component (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.

E. Implementation

Institutional and Implementation Arrangements

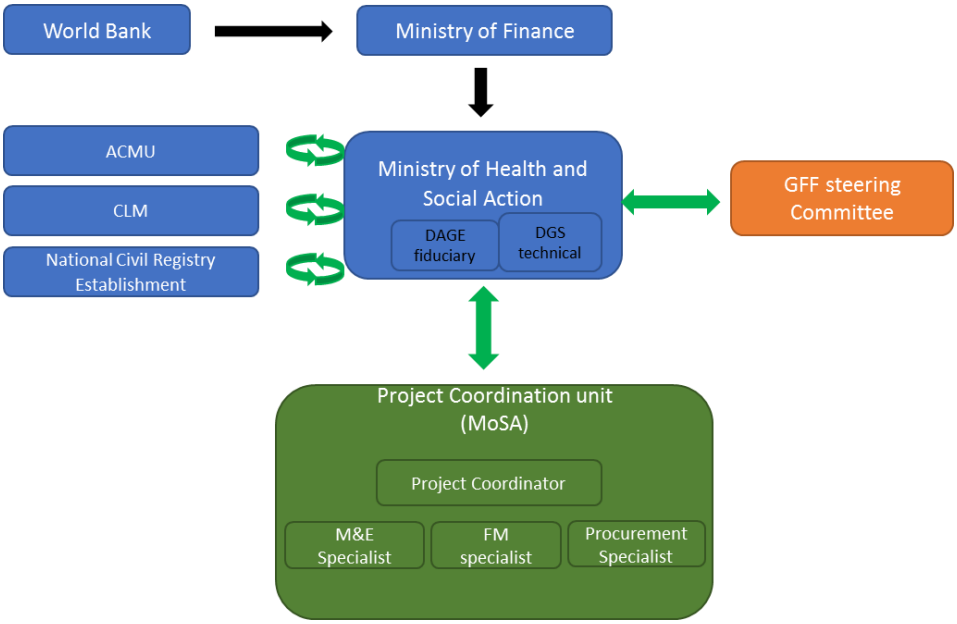
72. **The Ministry of Health and Social Action will be the implementing ministry of the project.** Under coordination from the Minister and Secretary General, technical activities will be undertaken by the relevant directorates and agencies (CLM, ACMU). The General Secretariat (SG) of the Ministry of Health will be the unit responsible for the overall technical coordination of implementation of the Project. The Directorate for Financial Management (DAGE) will have the overall fiduciary responsibility and it will rely on the existing fiduciary arrangements in place for the ongoing PFSN and REDISSE projects.

73. **Overall governance of Project will be provided by the multi-sectoral steering committee of the Global Financing Facility (*plateforme GFF*).** All entities involved in the Project's implementation will be overseen by a Steering Committee. In accordance with aid harmonization and alignment, the proposed project will be implemented by the MoHSA, in close collaboration with the Malnutrition Unit (CLM), the Universal Health Insurance Agency (ACMU). Other Ministries and institutions will also support the project and facilitate implementation (Ministry of Education, Ministry of Women, Family and Gender, Ministry of Territorial and Social Equity, General Delegation of Social Protection and national Solidarity). A technical committee will also be setup at the MoHSA to ensure a regular monitoring of implementation of the Project. It is proposed that this committee will meet once a month during the 1st year of the project, then one a quarter.

74. **A specific Project Coordination Unit (PCU) will be put in place.** A dedicated Project Coordinator (i.e. coordinating only this Project) will be appointed. Fiduciary support to the DAGE will be mutualized with support provided through the two other projects (Health Financing and Nutrition Project closing in June 2019 and REDISSE project closing in January 2023). Additional staff may be recruited within the PCU, such as an M&E specialist, technical specialist (public health), FM and procurement specialists to support the DAGE. The PCU will be responsible for the day-to-day management of the project and will: (i) coordinate the project activities; (ii) ensure the financial management of the project activities in all components under oversight of the DAGE and (iii) prepare consolidated annual work plans, budgets, monitoring and evaluation, and the implementation report of the project to be submitted to the steering committee and the World Bank. The proposed institutional arrangements are based on lessons learned from coordination and implementation of the two ongoing health Projects.

75. Through the Project, support will continue to be provided to the fiduciary directorate of the Ministry of Health and internal inspection, jointly with other partners (Global Fund, GAVI, USAID, LuxDev). The objective is to set-up a center of mutualized fiduciary management (*Centre de Gestion Mutualisée*) to manage donor financing in the mid-term. Thus, fiduciary arrangements may be revised at mid-term review of the project if this center is operational and functional.

Figure 4: Institutional arrangements



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

The project will be implemented in six priority regions in South/East of Senegal: Sedhiou, Kolda, Kedougou, Tambacounda, Ziguinchor and Kaffrine. During the course of the project, some regions could be added in agreement with the Borrower, but that will not be known by project appraisal. The project will focus on strengthening of regional capacities, in particular on supply and demand for health services and medical care. The project will not finance the construction of health centers or other physical structures (e.g. additions or expansion of existing structures).

G. Environmental and Social Safeguards Specialists on the Team

Fabienne Anne Claire Prost, Environmental Specialist
Mamadou Moustapha Ndoye, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project triggers Safeguards Policy OP/BP 4.01 (Environmental Assessment) and has been classified as category B project given the likely increase in biomedical waste due to improved coverage and quality of maternal and child health services across the regions. A Medical Waste Management Plan has been prepared. The purpose of this plan is to specify the procedures used to handle and dispose of medical waste. The MWMP proposes technically feasible, economically viable, and socially acceptable waste management systems. The potential beneficiaries (public and private), modalities of interventions, chain of management of the MWMP, sites of discharges, transport logistics, costs of the chain of values, follow-up, and evaluation system should be an integral part to align the plan with the project health vision. The document should approved and should be published in the country and on the World Bank's external website before appraisal. Subproject sites are not all identified, in particular the electrification with solar panels of health facilities, but the civil works at all sites are expected to be small-scale and very limited. These small-scale constructions will be cover by a Checklist Environmental Management Plan for any subproject where there are no unusual risk factors. The Checklist EMPs will be prepared by the Borrower and attached to the construction contracts. The implementation of a grievance redress mechanism will be put in place within the project to materialize citizen engagement. It will also address the concerns of communities and all stakeholders involved including civil society. These aspects must

		be supported by social communication about the objectives of the project, the targets as well as the mechanism put in place with the aim of raising the concerns and providing the appropriate responses. Such mechanisms should be accessible to communities, but also to other stakeholders and should be documented and monitored as part of the performance indicators. Support for a specialization in social inclusion is recommended.
Performance Standards for Private Sector Activities OP/BP 4.03	No	Non applicable
Natural Habitats OP/BP 4.04	No	The policy is not triggered as the project activities are not expected to overlap or cause adverse impacts on natural habitats.
Forests OP/BP 4.36	No	The policy is not triggered as the project activities are not expected to overlap or cause adverse impacts on forests or forestry activities.
Pest Management OP 4.09	No	This policy is not triggered as the project does not anticipate acquiring pesticides or equipment of pesticides application.
Physical Cultural Resources OP/BP 4.11	No	The scale and scope and location of subprojects makes it an unlikely possibility of chance finds of physical cultural resources in the identified project
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project areas, as defined by OP/BP 4.10.
Involuntary Resettlement OP/BP 4.12	No	The project activities will not involve land acquisition leading to the economic or physical displacement of project-affected people.
Safety of Dams OP/BP 4.37	No	The project interventions is not expected to require the construction of dams or impoundment structures, nor is it expected that they could cause impacts to existing structures as governed by this policy.
Projects on International Waterways OP/BP 7.50	No	The project interventions are not expected to cause any drainage or discharges to surface waters, nor entail any significant usage of surface water that would affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project interventions are not in any disputed areas. Therefore, this policy is not triggered.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

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

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

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

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
A Medical Waste Management Plan has been prepared. The purpose of this plan is to specify the procedures used to handle and dispose of medical waste. The MWMP proposes technically feasible, economically viable, and socially acceptable waste management systems.
If there is some civil work, they will be small-scale and very limited. Those constructions will be cover by a Checklist Environmental Management Plan for any subproject where there are no unusual risk factors. The Checklist EMPs will be prepared by the Borrower and attached to the construction contracts.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

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

"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Have costs related to safeguard policy measures been included in the project cost?

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

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APPROVAL

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