1. Country and Sector Background

Although recovery has been slow compared to other post-conflict countries, Burundi has made significant economic progress since 2005. Yet poverty continues to be widespread, especially in rural areas, and there are signs that poverty may actually have worsened in recent years.

Burundi’s high population growth rate – at 2.4 to 2.8 percent annually, one of the highest in Sub-Saharan Africa – is a major reason for the poor progress in addressing the high poverty rate, in a country with the third highest population density in the continent (after Rwanda and Comoros). The urgent need to address the high population growth rate is recognized in key strategic documents on the country, such as the latest Poverty Reduction Strategy Paper (PRSP). Given current trends, Burundi’s population is projected to double by around 2050. This – together with high population density, low agricultural productivity, ongoing environmental degradation and economic growth rates that are decent but still sub-standard by recent Sub-Saharan African and regional standards – is not compatible with any kind of meaningful fall in the poverty rate.

The high population growth rate is due largely to the fact that each woman has on average 6.4 children according to the 2010 Demographic and Health Survey (DHS) – by far one of the highest fertility rates in the world. Only four countries in the world had higher fertility rates than this in 2010, according to the World Development Indicators.
The stubbornly high fertility rate – the rate of 6.4 found in the 2010 DHS is little changed from the rate of 6.8 found in 2005 – is a major risk to the possibility of capturing the “demographic dividend” and moving to higher-income status. The very high fertility rate in Burundi has immediate adverse effects on health outcomes and on female empowerment. The high fertility rate is, in turn, linked to the low use of contraceptives. Only about 18% of women who are married or in stable unions use modern contraceptive methods, according to the 2010 DHS – this contraceptive prevalence rate (CPR) is low even by African (and certainly by regional East African) standards.

To reduce the high fertility rate and increase the CPR, there is an opportunity to gain some quick wins by working on the contraceptive supply side to address the substantial unmet demand for contraceptives. About 49% of women who are married or in stable unions have unmet need for contraception, according to a study conducted in 2009 (with nationwide coverage) on knowledge, attitudes and practices regarding family planning by the Ministry of Health and Fight Against HIV/AIDS, the United Nations Fund for Population and KfW (the German Bank for Development). This is higher than usual even by the standards of lower-income Sub-Saharan Africa. The CPR would likely be raised substantially by increasing supply in the right areas of the country of the right types of contraceptives.

Another key developmental challenge for the country is that human productivity is lagging, and this is in turn probably linked in part to the severe problem of malnutrition in the country. The 2010 DHS shows that child malnutrition rates in Burundi are very high, even by Sub-Saharan African standards, and this has irreversible negative implications for human and economic productivity. The DHS survey found that 58% of children under five are stunted (i.e. have low height-for-age\(^1\)), and 29% of children under five are underweight (low weight-for-age\(^2\)). The stunting rate, in particular, is one of the highest in Sub-Saharan Africa. Global evidence shows that stunting and low weight-for-age at a young age largely irreversible later on. They have permanent deleterious effects on educational achievements and productivity later in life, imposing substantial economic losses (see previous section on the likely link to poor educational quality outcomes in Burundi). Interventions against malnutrition – which are not currently in the package of services in the national RBF program – have been shown to be among the most cost-effective and with the highest impact (per dollar spent) globally among all potential interventions in developing countries, according to the Copenhagen Consensus.\(^3\)

From 2006 onwards, in an effort to improve a health care system that was poorly performing along several dimensions, some key reforms were made in Burundi’s health sector – starting with a policy of providing Free Health Care (FHC) for basic services to pregnant women and under-five children. The FHC policy, which started in 2006, mandated that pregnant women and under-five children should receive basic health care for free, and that health facilities should be

---

\(^1\) More specifically, this is the percentage of under-five children with height-for-age less than 2 standard deviations below the mean of a standard reference population, using WHO standards.

\(^2\) This is the percentage of under-five children with weight-for-age less than 2 standard deviations below the mean of a standard reference population, using WHO standards.

\(^3\) The Copenhagen Consensus is the result of work done by a panel of eight top economists, including five Nobel prize-winners, who examined a range of different interventions in developing countries.
reimbursed by the Government for their foregone user fee revenues as a result of this policy. But until recently, the impact of the FHC policy was constrained by a number of implementation difficulties.

Another major reform was the introduction, initially on a small-scale pilot basis, of Results-Based Financing (RBF) initiatives in several parts of the country. These pilots were implemented by NGOs. The first ones were introduced in 2006, and others were started later, with about half the country covered at the start of 2010. Yet despite good results achieved by the RBF pilots, they had some limitations. There were often large differences between the different RBF pilot schemes in terms of methodological approaches and parameters, and these schemes operated independently of the public system and the FHC financing mechanism. Furthermore, for some services in the RBF pilot areas, health facilities were being paid twice: by the Government through the reimbursement mechanism for the FHC policy, and at the same time by donors financing the RBF pilot schemes.

In April 2010, the RBF pilots were scaled up throughout the country with the help of co-financing from the parent project (the Health Sector Development Support Project or HSDSP), and Burundi became only the 2nd country in Africa – after Rwanda – to implement RBF in the health sector nationwide. All public and most private, nonprofit health facilities in the country – health centers and hospitals – are covered by the national program.

From the time it began in April 2010, the national RBF program has been used as a mechanism to implement the Government’s policy of FHC for pregnant women and under-five children. Government funding allocated for paying health facilities for their costs incurred due to the FHC policy is now channeled to health facilities on an RBF basis, with facilities paid based on their performance vis-à-vis delivery of basic health care services to pregnant women and under-five children. The payments made under the FHC policy to the health facilities are now executed as part of the new national RBF program, with much lower transaction costs and simpler invoicing, but with several layers of verification of the accuracy of the reported levels of services.

Accordingly, the Project Development Objective (PDO) of the ongoing HSDSP focuses on the goals of the Free Health Care (FHC) policy which applies only to pregnant women and under-five children. The PDO of the ongoing HSDSP, in accordance with the FHC policy, is to increase the use of a defined package of health services by pregnant women and children under the age of five.

The essence of the RBF system in Burundi is that health facilities enter into contractual arrangements whereby they are paid based on predetermined performance indicators. These indicators measure both the quantity of services produced as well as the quality of care provided. Several layers of both “ex-ante” and “ex-post” verification are in place to ensure that the levels achieved of the performance indicators are measured and reported accurately. An “ex-ante” verification process takes place every month for each health facility with the help of an independent verification team working full-time, and an invoice is subsequently generated. Payment based on this invoice is then made, and the funds are deposited directly into the bank account of each health facility in a timely manner.
The ongoing Health Sector Development Support Project (HSDSP) mostly finances the national Results Based Financing (RBF) program in Burundi’s health sector, which has seen rapid progress in key indicators – more than initially expected – since it began in April 2010. These results account for the Highly Satisfactory Project Development Objective (PDO) rating of HSDSP, which also has Satisfactory project ratings for other areas – including for overall implementation progress, project management, Monitoring and Evaluation (M&E), financial management, procurement and safeguards. All legal covenants have been complied with. The project benefits from competent financial management, procurement and safeguards experts hired from project financing. Audit reports and financial reports have consistently been unqualified and submitted on time.

The Government has strong ownership of the national RBF program, and is the largest of several contributors to the program. The bulk of the total RBF payments to health facilities comes from the Government at present. The rest comes from several different partners, with HSDSP being the second largest financing source after the Government.

Approval of the original parent project – providing a total of SDR 16.8 million (US$25 million equivalent) and fully financed by IDA – was followed by approval of the first Additional Financing (AF) providing $14.8 million from an initial HRITF Trust Fund grant (without IDA funds). The IDA original grant (H-488-BI) was approved by the Board in June, 2009. The first AF was approved by the Regional Vice-Presidency in June 2012. The Project Development Objective (PDO) was not changed when this first AF was approved.

2. Objectives

The Project Development Objective (PDO) of the parent project is “to increase the use of a defined package of health services by pregnant women and children under the age of five”. The Project Development Objective under the proposed second Additional Financing (AF) will be revised to the following: to increase the use of a defined package of health services by pregnant women, children under the age of five and couples of reproductive age. The difference between the PDO proposed under the second AF and the PDO of the ongoing project is that the target group will now be larger than under the ongoing project, since couples of reproductive age will now be added to the target group. The PDO of the ongoing project focuses only on utilization of defined health services by pregnant women and under-five children.

3. Rationale for Bank Involvement

The rationale for the proposed second AF, in accordance with the Bank’s operational guidelines for AF (OP/BP 13.20), is as follows: The second AF will finance activities scaling up the ongoing project’s impact and development effectiveness, since: (i) the second AF would entail an expansion of the scope of services of the package covered by the RBF program (certain additional critical items to enhance the provision of RBF services will also be financed – see Section III), and (ii) the second AF will enable the financing of the ongoing project’s activities for a longer period, permitting a later closing date.
4. Description

This proposed Additional Financing (AF) will provide additional funds for the ongoing Health Sector Development Support Project (HSDSP), as follows:

**Additional Financing for Subcomponent 1A ($20 million):** AF will be provided towards the supplementation, through an RBF mechanism, of the government’s own resources to fund payments to health facilities for provision of a defined package of services. The current basic package of services – which is focused on services covered by the Free Health Care policy for pregnant women and under-five children – will be expanded to also include contraceptive provision and nutrition-related services. AF will also be provided for RBF payments to selected supervisory units involved in the national RBF program.

**Additional Financing for Subcomponent 1B ($1 million):** Additional financing will be provided for the same types of activities as are ongoing under the original project, for this sub-component – activities to increase service demand, promote healthy behavior, and help particularly vulnerable groups to access health services. These activities will include capacity building of community actors (such as local health committees, community-based organizations, community health workers, and technical promoters of health) by community mobilization entities (called facilitating agencies), as well as the use of media and various types of communication activities.

**Additional Financing for Component 2 ($5 million):** As under the ongoing project, various types of capacity building activities for MPH will be financed under the proposed second AF – covering various areas including Monitoring and Evaluation (M&E), financial management and procurement. Project financial audits and surveys, as well as verification activities for the national RBF program, will be financed. Financing will also be provided for: (i) selected nutritional products, especially micronutrient and mineral products; (ii) selected equipment to be provided to selected health facilities; and (iii) small-scale low-cost incinerators for hospitals for the treatment of medical waste.

5. Financing

<table>
<thead>
<tr>
<th>Source:</th>
<th>($m.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BORROWER/RECIPIENT</td>
<td>0</td>
</tr>
<tr>
<td>International Development Association (IDA)</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

6. Implementation

The implementation arrangements for the proposed AF would be the same as for the original project. As is the case for the original project, the proposed AF would be implemented by the Ministry of Public Health and Fight Against HIV/AIDS through its relevant directorates and services, in particular the General Directorate of Health Services and Fight Against HIV/AIDS (GDHF), the General Directorate of Resources (GDR) and the Directorate for Health Promotion, Hygiene, and Sanitation (DHPHS).
The GDHF will continue to be responsible for overall coordination and technical supervision of the project and AF activities (including service use, sector issues, the population’s health status, and any epidemic trends) as well as for recommending ways to improve overall project implementation. The GDR will carry out all procurement and disbursements related to the project in accordance with World Bank-approved procedures. It will manage the designated accounts for the project and AF and submit withdrawal applications to the World Bank, and will be in charge of financial management activities. The DPHHS will be responsible for safeguards activities. The Ministry’s General Directorate of Planning will be in charge of overall M&E aspects.

The implementation arrangements for the existing national RBF program will continue to be in place, overseeing the RBF activities for the ongoing program including those financed by the AF. This includes: (i) the National RBF Technical Cell consisting of public officials dedicated to the implementation of the national RBF program, supported by contracted personnel providing technical assistance; as well as (ii) the Provincial Verification and Validation Committees (PVVCs) and the structures for internal and external verification as described above.

7. Sustainability

Given current projections, the expected level of Government contribution to the national RBF program every year (1.4% of the total Government budget – a legal condition for the ongoing project and the proposed second AF) would ensure that the proportion of the total payments for the expanded RBF package paid for by the Government rises every year, hence assuring sustainability. This is because: (i) the total Government budget is projected to rise by about 9% on average every year over the period 2012-2015 (based on the macroeconomic framework of the Government’s PRSP), and at a marginally lower annual rate afterwards; (ii) the Government’s contribution to the national RBF program will also rise by a similar percentage every year, since it will be a fixed percentage of the total Government budget (unless this percentage is changed after a joint review); and (iii) the total cost of the national RBF program – which is determined largely by utilization levels and tariffs set in local currency terms – will rise by much less than 9% every year, based on latest projections.

8. Lessons Learned from Past Operations in the Country/Sector

Before the national RBF program was started in April 2020, with co-financing from the parent IDA HSDSP project, RBF pilots were undertaken in several parts of the country. The design of the project and of the national RBF program are based on lessons learned from the implementation of these pilots and the Free Health Care policy in Burundi, as well as experience elsewhere on RBF and on other interventions. Among these lessons are: (i) RBF approaches can be very successful in rapidly increasing the use of cost-effective health interventions, but (ii) RBF involves some potential risks that have to be addressed. The parent project as well as the proposed first and second Additional Financing incorporate significant measures to address these potential risks. Lessons learned in other post-conflict settings have also been incorporated into the design of the parent project as well as the proposed Additional Financing.
9. Safeguard Policies (including public consultation)

No new safeguard policies are triggered under the proposed AF and thus the environmental category of the project including the AF will not change. The original project’s social and environmental category is currently rated ‘B’, as a result of triggering the Environmental Assessment (OP/BP 4.01) and Indigenous Peoples (OP/BP 4.10) safeguards policies due mainly to the fact that the health care centers targeted through this operation generate health care waste which contains infectious and hazardous material. The proposed operation performance framework actually includes indicators related to the health care waste management which justifies that particular efforts are exerted to help health care facilities address this issue. In addition the project will include specific actions for insuring that poor and most vulnerable groups, including Indigenous Peoples such as the Batwa population have access to basic health care and that there are not discriminated against.

The same initial safeguards instruments, namely the Medical Waste Management Plan (MWMP) and the Indigenous Peoples Plan (IPP), are applicable and relevant to the AF and have been updated to reflect the latest situation on the ground. The MWMP and IPP have been reviewed and found satisfactory to the Bank. Consequently, they both have been disclosed in-country and at the World Bank InfoShop on August 1, 2012 respectively prior to appraisal.

10. List of Factual Technical Documents
N/A

11. Contact point

Contact: Andrew Sunil Rajkumar
Title: Sr Economist (Health)
Tel: (202) 458-1904
Fax: 
Email: Arajkumar@worldbank.org

12. For more information contact:
   The InfoShop
   The World Bank
   1818 H Street, NW
   Washington, D.C. 20433
   Telephone: (202) 458-4500
   Fax: (202) 522-1500
   Email: pic@worldbank.org
   Web: http://www.worldbank.org/infoshop