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Report No: 65641-BF

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED IDA GRANT

IN THE AMOUNT OF SDR 18.3 MILLION
(US$ 28.9 MILLION EQUIVALENT)

AND A

PROPOSED GRANT FROM THE

MULTI-DONOR HEALTH RESULTS INNOVATION TRUST FUND

IN THE AMOUNT OF US$ 12.7 MILLION

TO

BURKINA FASO

FOR A

REPRODUCTIVE HEALTH PROJECT

November 22, 2011

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CURRENCY EQUIVALENTS

(Exchange Rate Effective October 31st, 2011)

Currency Unit	=	CFAF
CFAF 482	=	US$1
US$ 1.58	=	SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

BCC	Behavior Change Communication
CAS	Country Assistance Strategy
CADSS	Cellule d'appui à la Décentralisation du Ministère de la Santé/Technical Direction for Decentralization of the Ministry of Health
CBO	Community-Based Organization
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CFAF	Communauté Financière Africaine Franc
CIFE	Circuit Intégré des Financements Extérieurs/Integrated External Financing System
CM	Centre Médical / Medical Center
CMA	Centre Médical avec Antenne/Medical Center with surgical unit
COGES	Comité de Gestion (sanitaire)/Local Health Management Committee
CONAPO	Coordination nationale pour la population
CPR	Contraceptive Prevalence Rate
CSPS	Centre de Santé et de Promotion Sociale/Health and Social Promotion Center
CYP	Couple Years Protection
DA	Designated Account
DEP	Direction d'Etudes et de Planification/Directorate of Research and Planning within MoH
DGSF	Direction Générale de Santé Familiale/ General Directorate for Family Health
DHS	Demographic and Health Survey
DLI	Disbursement-Linked Indicator
EmONC	Emergency Obstetric and Neonatal Care/Soins Obstétricaux et néonataux d'urgence (SONU)
ENSP	Ecole Nationale de Santé Publique/National Public Health School
ERR	Economic Rate of Return
ESMF	Environmental and Social Management Framework
ETAT	Emergency Triage Assessment and Treatment
FA	Financing Agreement
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
HDT	Health District team
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HIS	Health Information System

HMIS	Health Management Information System
HNP	Health Nutrition and Population
HRITF	Multi-Donor Trust Fund for Health Results Innovation
IDA	International Development Association
IE	Impact Evaluation
IEC	Information, Education and Communication
IFR	Interim Financial Report
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
INSD	*L' Institut national de la statistique et de la Démographie/*National Institute for Statistics and Demography
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goal
MOH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
MTR	Mid-Term Review
MWMP	Medical Waste Management Plan
NGO	Non-Government Organization
NPV	Net Present Value
OHADA	Organization for The Harmonization of Business Law In Africa
OBD	Output-based Disbursement
OPCS	Operations Policy and Country Services
ORAF	Operational Risk Assessment Framework
PADS	Programme d'Appui du Développement Sanitaire/Support Program for Health Development
PBHS	Package of Basic Health Services
PDO	Project Development Objective
PEFA	Public Expenditure and Financial Accountability
PFM	Public Sector Financial Management
PMTCT	Prevention of Mother-to-Child Transmission
PNDS	Plan National de Développement Sanitaire/National Health Development Plan
PRGED	Programme de Renforcement de la Gestion de l'Economie et du Développement/Program to Strengthen Economic Management and Development
PRSC	Poverty Reduction Strategy Credit
PRSP	Poverty Reduction Strategy Paper
RBF	Results-Based Financing
RH	Reproductive Health
SCADD	Stratégie de Croissance Accélérée et du Développement Durable/Strategy for Accelerated Growth and Sustainable Development
SDR	Special Drawing Rights
SRFP	Stratégie de Renforcement des Finances Publiques/Public Finance Strengthening Strategy
STI	Sexually-Transmitted Infection
SRH	Sexual and Reproductive Health
TA	Technical Assistance

TBA	Traditional Birth Attendant
UK	United Kingdom
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Regional Vice President:	Obiageli K. Ezekwesili
Country Director:	Madani M. Tall
Sector Director:	Ritva S. Reinikka
Sector Manager:	Jean-Jacques de St. Antoine
Task Team Leader:	Haidara Ousmane Diadié

BURKINA FASO

REPRODUCTIVE HEALTH PROJECT

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PAD DATA SHEET

Burkina Faso

Reproductive Health Project

PROJECT APPRAISAL DOCUMENT

Region: AFR

Sector Unit: AFTHE

Basic Information			
Date:	November 22, 2011	Sectors:	Health (100%)
Country Director:	Madani M. Tall	Themes:	Population and Reproductive Health (35%); child health (35%); health system performance (20%); and other communicable diseases (10%).
Sector Manager/Director:	J-J de St. Antoine / Ritva Reinikka	EA Category:	B – Partial Assessment
Project ID:	P119917		
Lending Instrument:	SIL		
Team Leader(s):	Haidara Ousmane Diadie		
Does the project include any CDD component? Yes			
Joint IFC:			

Borrower: Burkina Faso			
Responsible Agency: Ministry of Health			
Contact:	Mr. Adama Traoré,	Title:	Minister of Health
Telephone No.:	(226) 50 30 2316	Email:	adma_traore@hotmail.com

Project Implementation Period:	Start Date: December 20th, 2011	End Date: December 31st, 2016
Expected Effectiveness Date:	April 20th, 2012	
Expected Closing Date:	December 31st, 2016	

Project Financing Data(US$M)		
[ ] Loan	[X] Grant standard IDA grant terms	[ ] Other
[ ] Credit	[ ] Guarantee	

For Loans/Credits/Others

Total Project Cost :	US $41.6 million	Total Bank	US$28.9 million

Financing :	
Total Co-financing:	US$12.7 million
Financing Gap :	0

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Financing Source	Amount(US$M)
BORROWER/RECIPIENT	
IBRD	
IDA: New	28.9
IDA: Recommitted	
Others HRI TF	12.7
Financing Gap	0
Total	41.6

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Expected Disbursements (in USD Million)

Fiscal Year	2012	2013	2014	2015	2016	2017			
Annual	3.0	8.0	8.0	12.0	10.6	0.0			
Cumulative	3.0	11.0	19.0	31.0	41.6	41.6			

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Project Development Objective(s)

To improve the utilization and quality of reproductive health services in the Recipient's territory, with a particular focus on selected regions of Burkina Faso.

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Components

Component Name	Cost (USD Millions)
Improving the delivery and quality of a Reproductive Health Service Package through Result-Based Financing;	22.3
Supporting critical inputs for reproductive and family planning services.	19.3

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Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]

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Does the project require any exceptions from Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ] n/a
Is approval for any policy exception sought from the Board?	Yes [ ]	No [ ] n/a
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

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

Legal Covenants (References are to the IDA Financing Agreement (FA) or TF Grant Agreement (GA).)

Name	Recurrent	Due Date	Frequency
FA, Section 4.01; Schedule 2, Section I.B	-	Effectiveness	Unit prices included in the PIM to be reviewed annually by March 1.-

Description of Covenant: (a) The GA has been executed and delivered and all conditions precedent to its effectiveness (except the effectiveness of the FA) have been met;[1] and (b) the Recipient has adopted the Project Implementation Manual, approved by IDA which includes the RBF framework (including, inter alia, elaboration of PBHS, methodology for calculating unit prices for PBHS packages designed to ensure that they do not exceed the reasonable cost of the services to be provided including the quality of the service delivered, do not include costs financed from sources other than the PBHS Sub-grants; initial unit prices; designation of local verification teams for each targeted district; procedures for annual review of unit prices; procedures for approval and M&E of Sub-grants)..

Name	Recurrent	Due Date	Frequency
FA, Section 4.01; Schedule 2, Section I.A.2	-	Effectiveness for the PCU and coordinator; 3 months after effectiveness for the other staff	-

Description of Covenant: The Recipient has: (a) established the Project Coordination Unit (PCU) and appointed its coordinator with terms of reference and qualifications and experience satisfactory to IDA; and (b) employed for the PCU: (i) two public health economists; (ii) two public health doctors; and (iii) two monitoring and evaluation experts, all with qualifications and experience satisfactory to IDA.

Name	Recurrent	Due Date	Frequency
FA, Schedule 2, Section I.D	-	December 15	Annually

Description of Covenant: The Recipient shall prepare and furnish to IDA for prior approval, Annual Work Programs of activities proposed for inclusion in the Project.

Name	Recurrent	Due Date	Frequency
FA, Schedule 2, Section I.E.5(b)	-	May 15, 2012, and in any event prior to award of the first PBHS	Once only

[1] A similar condition is included in the TF Grant Agreement.

		Sub-grant	
Description of Covenant: The Recipient has engaged an independent expert, whose terms of reference, qualifications and experience are satisfactory to IDA, to conduct independent verifications of the delivery of services under PBHS Sub-projects.			
Name	**Recurrent**	**Due Date**	**Frequency**
FA, Schedule 2, Section E	-	-	Ongoing
Description of Covenant The Recipient shall make PHBS Sub-grants for PHBS Sub-projects in accordance with eligibility criteria and procedures and on terms and conditions acceptable to IDA, including, inter alia: (a) aggregate amount of all PBHS Sub-grants made in a given calendar year to Health Service Providers in a Targeted District not to exceed the equivalent of $300,000; (b) prior review by IDA of the first 3 Sub-grants and each Sub-grant for an amount equivalent to $30,000 or more; (c) prior internal verification of services delivery under the Sub-project; (d) training of staff of a health center prior to award of a Sub-grant to such center.			

Team Composition

Bank Staff

Name	Title	Specialization	Unit	UPI
Ousmane Diadie Haidara	Health Specialist/TTL	Public Health	AFTHE	322783
Begnadehi Claude Bationo	Operations Officer	Social et Development Economics	AFMBF	327226
Ousmane Kolie Megnan	Sr Financial Management Specialist	Financial Management	AFTFM	333964
Nicolette K. DeWitt	Lead Counsel	Law	LEGAF	14500
Boubacar Diallo	Procurement Specialist	Procurement	AFTPC	400630
Amadou Konaré	Senior Environmental Specialist	Environment	AFTEN	177368
Dominic S. Haazen	Lead Health Policy Specialist	Health Care Services	AFTHE	161710
Amy Ba	Program Assistant	Program Assistant	AFTHE	82349
Bintou Sogodogo	Program Assistant	Program Assistant	AFMBF	71866
Aissatou Diallo	Sr. Finance Officer	Financial Management	CTRLA	241610
Bronwyn Grieve	Governance Specialist	Governance	AFTPR	329831

Non Bank Staff

Name	Title	Office Phone	City

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

PROJECT APPRAISAL DOCUMENT

BURKINA FASO

REPRODUCTIVE HEALTH PROJECT

I. STRATEGIC CONTEXT

A. Country Context

1. Burkina Faso is a landlocked country south of the Sahara. It covers an area of 274,200 square kilometers and has a population estimated in mid-2010 at 15.2 million, which has been growing at 3.4 percent per annum. The vast majority of the population (77%) lives in rural areas and is affected by illiteracy (71% in 2007). Burkina Faso remains one of the poorest countries in Africa with a per capita income of US$510 in 2009 (Atlas method). The 2010 UNDP Human Development Index ranks it 181st among 187 countries with comparable data. The poverty headcount ratio at national poverty line was estimated at 47.44% of the total population in 2009 (Source: L' Institut national de la statistique et de la Démographie - INSD).

B. Sectoral and Institutional Context

2. Burkina Faso remains off track to meet the Millennium Development Goals (MDGs) 4 (reducing child mortality) and 5 (reducing maternal mortality). A major constraint to their achievement has been the rapid population growth rate, especially with respect to fertility. Burkina Faso's total fertility rate remains very high. The average woman births at least six children over the course of her lifetime. Despite major efforts in the education sector, the country has not been able to enroll all its children in primary school, not to mention the secondary and tertiary levels of education where attainments and quality have been poor. The rapid population increase also has far-reaching consequences for the economy in the areas of dependency ratios, labor productivity, savings, growth, living standards, the demand for public services, and poverty reduction.

3. In order to harness Burkina Faso's economic potential to complete its demographic transition, it will be important to improve reproductive health (RH) outcomes, including child survival. The average age at first pregnancy has remained 19 years over the last two decades and that the adolescents 15-19 years contribute to fecundity for 11% (DHS 2010). The contraceptive prevalence rate (CPR) for modern methods remains very low at 15% (DHS IV 2010). Burkina Faso is one of the Sub-Saharan countries with the highest unmet need: 33% of married women express a desire to use contraception. While 89% of women know at least one modern contraceptive method for limiting or spacing births, fewer than 10% of them are using a long-term family planning (FP) method. One of the reasons for the high desired fertility is the poor child survival rate that makes families want to have more children in case some do not survive. Maternal health outcomes must be improved, as only 16.9% (Annuaire Statistique 2009) of pregnant women complete four prenatal care visits; and postpartum care is insufficient, covering

only 43.1% of women who gave birth. The proportion of deliveries by skilled attendants is 67.1% (DHS 2010), and the maternal mortality ratio is high at 307.3 per 100,000 (RGPH 2006). One in five children does not reach the age of five.

4. Access to health services remains inadequate, with the population living at an average distance of 7.5 km from a health center, more than an hour walk. There are large variations in access to services and health outcomes between urban and rural areas, and between the wealthiest 20% and the poorest 20% of the population. Doctors and midwives remain disproportionately concentrated in urban areas, and service quality is undermined by the inadequate motivation of public sector health workers due to low salaries, poorly developed career structures, and limited accountability for performance.

5. An evaluation of needs in emergency obstetric and neonatal care was conducted by the Bank, UNFPA, UNICEF, and WHO in 2011[2]. It shows that the quality of care is highly variable. Many health facilities are characterized by a poor welcome of patients, a lack of organization of personnel leading to long waiting lines, insufficient equipment and drugs, and a lack of skills of health staff. This results in poor health outcomes, and, as mentioned, a high maternal mortality ratio. The main factors leading to maternal deaths are the late arrival of women at a health facility because of the difficulty of recognizing risky pregnancies at the community level (53%), the late evacuation to a health facility because of the lack of transport (31%), the lack of close observation of pregnant women by health staff, the late attendance of patients by health personnel, and delays in diagnosis.

6. The lack of skills of the Ministry of Health (MOH) personnel for basic and emergency care is analyzed in detail by the above report. It points to the importance of in-service training to update the knowledge and improve the skills of the personnel. The analysis also shows the specific areas where the MOH personnel have the least knowledge, and allows designing training courses directly tailored to their needs.

7. Seventy five percent of the private sector is concentrated in Ouagadougou and Bobo Dioulasso. That sector represents an additional 33% of the health services in terms of infrastructure (512 private sector facilities compared to 1566 public sector facilities). Of these, 70% are at the primary level of care, 11% at the secondary level, and 19% are specialized services such as laboratories, dentists or radio services. This potential could be harnessed by the MOH, through contracting, to help meet public health goals.

8. In 2009, the government's health budget represented 15% of the total government budget translating into US$11.9 per capita, a level that should bring better health outcomes. The health budget covered the following categories of expenditures: infrastructure and equipment (40%), salaries (26%), and operating costs (34%). However, 39% of total health costs are paid out of pocket, thus reducing access to services and efficiency of spending.

[2] World Bank, UNFPA, UNICEF, and WHO (2011), Evaluation of Needs in Emergency Obstetric and Neo-natal Care, together with a geographical analysis of supply of services in Burkina Faso.

9. The allocative efficiency of the government health budget is limited, and the quality of public expenditure management needs to be improved. Existing plans and budgets are still not evidence-based. They focus on expenditures that do not have a direct relation with MDGs. These plans and budget mostly comprise training programs for central and regional MOH officials, investments in building construction and rehabilitation, purchase of equipment and so forth. Budgets are not clearly related to the plans. Furthermore, plans and budgets are not comprehensive. For instance, several directorates or vertical programs within the MOH still prepare and implement their own plans, without these plans being produced through the national planning process.

10. The government has demonstrated its commitment to improving the efficiency and effectiveness of health care spending. In recent years, it introduced a "common basket" (*panier commun)*, or minimum package, of health services into its Health Development Support Program - *Programme d'Appui du Développement Sanitaire* (PADS). PADS is a project coordination unit, well-integrated within the Directorate of Planning and Research of the MOH. It manages the funds put in a common pool by donors, and operates by contracting with health districts and Non-Government Organizations (NGOs). The government has also acquired political consensus to introduce Results-Based Financing (RBF) in the health sector using a phased-in approach.

C. Higher Level Objectives to which the Project Contributes

11. The project would contribute to the World Bank's Africa Strategy as follows: In the medium to long term, it would contribute to Pillar 1 – Competitiveness and Employment – as family planning would help space births and reduce population growth. As a result, the country would benefit from a higher Gross Domestic Product (GDP) per capita which would result in increased opportunities for employment. It would also contribute directly to Pillar 2 – Vulnerability and Resilience – by helping to improve female reproductive health and reducing maternal mortality, the "neglected MDG". The project would help improve access to assisted birth attendants, and to higher-end care in the case of complications. A voucher scheme would be introduced to help mothers with complications be quickly transferred to a hospital. Cultural factors affecting the decision of women to seek care or use contraception would be addressed through Behavior Change Communication (BCC) interventions. Finally, the project would contribute to Pillar 3 – Governance and Public-Sector Capacity – by introducing RBF which would strengthen accountability at the central and decentralized level in the health sector. On the supply side, the project would build the capacity of key actors so that decision-makers can be held accountable.

12. The government's renewed interest in demographic and reproductive health issues was taken into consideration during the preparation of the 2010-2012 Country Assistance Strategy (CAS), which was completed on August 10, 2009. The project is aligned with the CAS' Strategic Theme 2: "Promoting shared growth through improved social service delivery" and is consistent with the CAS priorities and goals: to better serve the needs of the poor; increase access to services; strengthen institutional capacity; upgrade quality and effectiveness of services delivery; enhance the role of the private sector in achieving important public health goals; and decentralize through enhanced participation of the local bodies and the community". The third Poverty Reduction Strategy Paper (PRSP) for Burkina Faso (2011-2015), also known as the

Stratégie de Croissance Accélérée et du Développement Durable (SCADD), emphasizes demographic issues. Finally, the proposed project is fully consistent with the Bank's HNP strategy (2007), and the Bank's Reproductive Health Action Plan (2010-2015) which commits the Bank to improving access to quality family planning and reproductive health services.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

13. The development objective is to improve the utilization and quality of reproductive health services in the recipient's territory, with a particular focus on selected regions of Burkina Faso.

Project Beneficiaries

14. The direct beneficiaries of the project are adolescents, women of reproductive age and their young children who will have a better knowledge of and improved access to reproductive and child health services. The indirect beneficiaries include the 2.7 million inhabitants in the five regions participating in the project's RBF component (Center North, Center West, North, South West, and Boucle du Mouhoun). From an institutional perspective, health personnel, notably midwives, nurses, and community health agents, will benefit from training in family planning and reproductive health. The development of the RBF instrument by the MOH could potentially benefit other sectors.

PDO Level Results Indicators

15. The key results of the project would be to increase: (i) the contraceptive prevalence rate; (ii) the proportion of births assisted by skilled personnel; (iii) the proportion of women attending post-natal consultations; and (iv) the number of children immunized.

III. PROJECT DESCRIPTION

A. Project Components

16. The proposed project will have the following components. A detailed project description is presented in Annex 2.

17. ***Component 1:*** **Improving the delivery and quality of a Reproductive Health Service Package through Result-Based Financing (US$22.3 million).** This component would be jointly financed by IDA (US$9.6 million) and the HRI TF ($12.7 million). It would have two subcomponents.

18. The project will be implemented in five selected regions out of the 13 which currently exist. Three criteria have been used to select these regions, and they were chosen with a geographical balance that will provide implementation experience in different contexts, and allow broad capacity building that will be useful for a future expansion of RBF. Out of the 5 regions, 4 have health indicators below the national median. The fifth has better health

indicators, which will allow testing RBF in a higher capacity setting and contribute to overall learning.

19. The project will build partnerships with UNICEF and UNFPA, and other agencies which are present in the same regions. There is no duplication with any other similar intervention financed by other donors.

20. Within each region, two districts were chosen which had the lowest of a combination of four indicators: (i) contraceptive prevalence rate: (ii) assisted deliveries; (iii) antenatal consultations and (iv) post-natal consultations. The 10 selected districts are listed in Annex 7.

21. *Sub-component (i) - Delivery of Packages of Basic Health Care (PBHS) (US$16.8 million-IDA 8m and HRITF 8.8m).* In the 5 selected regions, the MOH will make PBHS Sub-grants to selected health care facilities for PBHS Sub-projects consisting of the provision of packages of basic health services (PBHS). The possibility of making Sub-grants to private sector providers would also be contemplated at a later stage. PBHS Sub-grant agreements concluded between the MOH and the health center will define the PBHS to be provided, and the indicators and targets to be reached in delivering these services. The results achieved against these targets will then be assessed by external reviewers every three months. Based on these verified results, each PBHS Sub-grant recipient will receive payments in partial reimbursement for the PBHS delivered. The payments will be based on unit prices developed under the RBF model for each PBHS, based on a number of factors designed to achieve the desired results, including basic cost of the inputs required (and not financed elsewhere) for services to be rendered, adjusted for quality of the service. In no case will the amounts paid under the PBHS Sub-grant exceed the reasonable cost of the services provided, nor will they pay for costs financed by other sources[3]. The unit price paid for each PBHS will be reviewed not later than March 1 each year to ensure their continued compliance with these criteria. The general principles for these payments for PBHS are presented in Annex 7 and will be detailed in the Project Implementation Manual. The Manual will describe the implementation details for the RBF model, including: (i) institutional arrangements; (ii) details of the different PBHS to be provided; (iii) eligible expenditures and unit prices for each PBHS, as well as the methodology for calculating the unit prices, consistent with the above criteria, and procedures for annual reviews of the unit prices; (iv) procedures for approval and monitoring and evaluation of PBHS Sub-project, and granting of PBHS Sub-grants; (v) assignment of roles and responsibilities for the verification and control of results for payment and auditing purposes, including designation of the verification team for each Targeted District; (vi) consequences for fraud in the amount billed; (vii) management and data collection tools; and (viii) rules for the use of reimbursements for PBHS delivered. Details on the RBF design and procedures are provided in Annex 6.

22. *RBF indicators have a large focus on maternal and neonatal health, but they also include non-maternal services (i.e.* child visits, immunizations etc.), adolescent services, tuberculosis, and malaria, to ensure that health care facilities do not neglect other services. Two sets of RBF indicators have been defined with the government. A first group of indicators will measure the *quantity* of services provided. The second group of indicators is about *quality*.

[3] For exmple, inputs financed under component 2 and regular salaries paid by MOH would be excluded from the costs reimbursed.

23. RBF will be an important tool to attract pregnant women to health facilities, both for ante-natal consultations and deliveries. The reimbursements made under PBHS Sub-grants to a health facility will be used by health personnel to increase both the demand for and the supply of reproductive health services. The experience of Rwanda and Burundi shows that health facilities have subcontracted traditional birth attendants (TBAs) who have brought pregnant women to health facilities for ante-natal control and delivery, and shared the RBF incentives with them. When a facility was paid a certain amount for each delivery, they gave 20-40% of it to a TBA who accompanied a pregnant woman.

24. To strengthen the capacity of the MOH, an international firm will be contracted by the government under subcomponent (ii) to: (i) verify independently the achieved results in the delivery of the services by the health centers; (ii) recruit and place in each region external reviewers which will help health facilities to better strengthen their routine data collection and results reporting system (and therefore their reimbursements for PBHS). Every three months, these reviewers will use routine data and random surveys to check the accuracy of the reported routine data. In addition, community-based organizations (CBOs) will be contracted by the international firm to conduct targeted household surveys.

25. *Subcomponent (ii) - Support to RBF implementation and supervision* (US$5.5 million-IDA1.6 million and HRITF 3.9 million). To ensure the successful implementation of the RBF component (subcomponent (i)), an international firm will be recruited at the beginning of the implementation of the project to provide technical support and external monitoring. The RBF component will be managed by the MOH, especially in the areas of setting RBF indicators and targets, procurement[4] and disbursements under PBHS Sub-grants. The international firm will provide technical assistance at central level and at district or commune level ("district controllers"). It will: (i) assist DEP (*Direction d'Etudes et de Planification*/Directorate of Research and Planning within MoH) in the design, development and implementation of RBF tools (Testing of the tools); and follow up on RBF training at all levels ; (ii) assist in the verification of quantity and quality of PBHS delivered at facility level and help strengthen the M&E system (through national HMIS); (iii) oversee the assessment made by local health verification teams who will verify the extent to which each health facility achieves its quantitative and qualitative performance targets; (iv) assist in the process of small household verifications by sub-contracting local organizations (procurement, training and monitoring). This will allow the *Direction d'Etudes et de Planification* to authorize reimbursements under PBHS Sub-grants by the payer (PADS) to health facilities (the funds flow details are presented in Annex 3); and finally (v) review the performance of CSOs contracted to carry out consistency checks between facilities records and exit surveys of patients. The project will also train stakeholders (commune local government, local health verification teams, traditional birth attendants and other community-based agents) in the districts and municipalities in the principles of the RBF and its implementation. The specific role of each stakeholder group will be explained to stakeholders to ensure their understanding and adherence to the RBF approach.

[4] Procurement will be undertaken at various levels. For example, the procurement of the international firm for RBF verification, as well as procurement of inputs under component 2 to be delivered to local health centers, will be conducted by the central-level MOH while, procurement under PBHS Subprojects will be procured by individual facilities that are part of the MOH.

26. Finally, this component will include a study which will be carried out to expand the delivery of PBHS beyond the Targeted Districts to other districts in Burkina Faso. This component will finance goods, consultant services, non-consulting services, training, and operating costs. Detailed information on the architecture and mechanisms of RBF implementation is presented in Annex 6.

27. **Component 2. Supporting critical inputs for reproductive and family planning services (US$19.3 million)**. This component, to be financed entirely by the IDA Grant, will be implemented at the national level. It will have three subcomponents: (i) training of nurses, skilled birth attendants and doctors; (ii) provision of drugs and equipment to improve obstetric and neo-natal services; and (iii) strengthening demand for family planning and reproductive health services.

28. *Subcomponent (i) - Training of nurses, skilled birth attendants and doctors (US$ 2.3 million).* Given that the limited number of skilled health professionals impairs access to reproductive health services, the 2010 Emergency Obstetric and Neonatal Care (EmONC) Survey recommended increasing their numbers and quality. To contribute to this effort, the project will support the pre-service training of about 60 skilled birth attendants and 60 general nurses. They will undertake three years of training at the National Public Health School (*Ecole Nationale de Santé Publique – ENSP)* or in private schools contracted by the MOH. Their training will benefit the project only as from the beginning of year 4, but it is an important contribution to medium-term capacity building, to which the government attributes much importance.

29. *The project will also provide in-service training to improve the knowledge and skills of about* 360 general nurses and 360 skilled birth attendants, as well as doctors, in emergency obstetric and neo-natal care, family planning, prevention of mother-to-child transmission (PMTCT) of HIV/AIDS, integrated management of child illnesses (IMCI), emergency obstetric and neo-natal care, emergency triage assessment and treatment, and management of health services. In-service training consists of a two-week course and will benefit the project r*ight away as from year 1. The project will* also finance teaching equipment and supplies for the National Public Health School. Finally, the project will finance the supervision of emergency obstetric and neo-natal care and family planning interventions. This subcomponent will finance goods, services, training, and operating costs.

30. *Subcomponent (ii) - Provision of drugs and equipment to improve obstetrical and neo-natal services (US$8.5 million).* This subcomponent will provide ambulances, motorcycles and vehicles, equipment and emergency delivery kits for about 52 health centers, drugs, contraceptives, supplies for diagnostic tests, equipment and training for waste management, small refurbishing (including painting) of health centers. This subcomponent will finance goods, services and training.

31. *Subcomponent* (iii) - *Strengthening demand for family planning and reproductive health services (US$8.5 million).* The project will strengthen the demand for family planning and reproductive health and increase financial access of women to services. It will help increase the number of women of reproductive age that seek family planning services and begin to utilize

modern methods for birth spacing or control. This subcomponent will support information, education and communication (IEC) and behavior change communication (BCC) strategies at the community level carried out by specialized NGOs who will be contracted during the first year of the project to scale up successful RH approaches. To increase the coverage and quality of services, NGOs will work in partnership with local Community-based Organizations to present innovative proposals. At the community level, the communication strategy will be to undertake social marketing and BCC with the objective of expanding family planning services and reducing delays in recognizing and managing complications of pregnancy and delivery. The project will also help increase the demand for youth health services, particularly among young girls. The MOH will call for NGO proposals and the NGOs will be selected in accordance with the Bank Selection of Consultants Guidelines. The cycle of calls for proposals, submission, review, approval, evaluation and payments will be included in the Project Implementation Manual.

B. Project Financing

32. **Lending Instrument:** The lending instrument will be a Specific Investment Loan (SIL) financed with (a) a Grant on standard IDA terms and (b) a Grant under the HRI TF. Project Cost and Financing will be as follows[5].

Project Components	Project cost (US$ million)	IBRD or IDA Financing	% Financing
1. Improving the delivery and quality of a Reproductive Health Service Package through Result-Based Financing	22.3	9.6 (HRITF 12.7)	29% (IDA)/71% (HRITF)
2. Supporting critical inputs for reproductive and family planning services	19.3	19.3	100% (IDA)
Total Baseline Costs			
Physical contingencies			
Price contingencies			
Total Project Costs	41.6		
Interest During Implementation			
Front-End Fees			
Total Financing Required	**41.6**		

C. Lessons Learned and Reflected in the Project Design

33. The following lessons learned on RBF were derived from the design and implementation of Bank operations in Africa and around the world, and found useful in the design of the project.

34. *The success of RBF has been well documented*. Experience indicates that RBF approaches can be successful in rapidly increasing the use of cost-effective health interventions. Studies of RBF in Cambodia, Haiti, and Afghanistan and a randomized controlled study in Rwanda have demonstrated the effectiveness of RBF. Besides providing an obvious performance-based motivation for health workers, RBF has a number of advantages: (i) it is a

[5] The unallocated amount (US$ 1.7 million) in the Financing Agreement has been entirely allocated to Component 2.

clear signal to health workers about the priorities of the government and ensures that facilities give importance to preventive and pro-poor interventions; (ii) it ensures that projects focus on producing tangible results and on strengthening M&E systems; and (iii) it decentralizes decision-making to managers who are much closer to the community than those in the center.

35. *Gradual scale-up.* No country has successfully introduced RBF without first starting gradually. Lessons learned during the initial phase are crucial to a successful expansion.

36. *What Services are to be paid for?* RBF is simplest when facilities are paid for services that can be easily measured. Vaccinating a child can be easily measured and paid for, whereas behavior change is much more difficult to measure.

37. *Ensuring transparency and independent verification*. Robust, independent and technically sound mechanisms are needed to verify the accuracy of reported results. There are typically two types of verification. First, ex-ante checking before payment is made to a facility that involves the review of registers and the checking of quality. This is often done by a district administrative structure and involves invoices submitted by health facilities. Second, ex-post verification is often done by independent groups or organizations and uses different techniques to detect "gaming", including the sampling of patients listed in registers to see whether they exist and whether they received the services listed. It is important to specify what sanctions will be imposed on facilities found to be misrepresenting their performance.

38. *Who Receives RBF Payments?* In most RBF schemes, it has been individual health facilities that receive the payment. This is the best way of ensuring that providers see the benefits of RBF. It often brings up the issue of how much autonomy health facilities have, and can become an important aspect of the policy dialogue.

39. *Approving Payment.* It needs to be clear who approves the invoice submitted by the health facility and what procedures they will use to: (i) check the calculations: (ii) verify that services were actually delivered; and (iii) that appropriate adjustments for quality and equity are applied. A good practice is to establish a decentralized governance mechanism for this (a "district RBF Steering Committee") with powers to decide on payments. Usually MOH officials, local government officials, and civil society representatives sit in formal meetings. After approval, the district invoice is sent to the purchaser.

40. *Manual of Procedures.* A clear and concise manual of procedures that includes all the forms and information needed to implement the RBF scheme is important. Being explicit about policies will facilitate the dialogue with stakeholders and is an essential part of training providers and managers.

41. *Training of Health Workers and Supervisors.* RBF usually involves important changes in a health care system and new procedures that need to be explained to providers and supervisors. Conducting high-quality training is an important challenge that will require a critical mass of people who are thoroughly familiar with the manual of procedures and RBF implementation.

42. *Resources to facilitate the supervision of health facilities.* One of the major contributions of RBF is to make supervision more systematic and frequent. Ensuring that supervisors have the adequate resources to carry out frequent field visits will be important for success.

43. *Measuring results.* The Rwanda RBF demonstrated improvements in the quality of health care through a rigorous impact evaluation. For this reason, an impact evaluation is programmed at mid-term to assess this project's performance.

44. The following lessons learned on reproductive health were used for the project design.

45. *A review of best practices* (well documented in the Bank's Reproductive Health Action Plan) shows that the best ways to improve reproductive health are to: (i) reduce unplanned and poorly-timed pregnancies; (ii) make sure that contraceptive products are available; (iii) reduce maternal mortality and morbidity by improving prenatal and delivery care and managing obstetric emergencies; (iv) increase the number of skilled providers; and (v) reduce the risks of STI and HIV infections.

46. *Incentives for family planning should be part of a broader package of services.* An incentive system too narrowly focused on family planning could result in health workers' excessive zeal in encouraging family planning. This could negatively affect couples' choices in achieving their desired family size. To avoid this, RBF incentives for family planning in the project will be part of a broader incentive package for maternal and child health services.

47. *Lessons from South Asia* highlight the need for decentralized approaches and implementation strategies (e.g. at district level) as well as public-private partnerships. They also show the key role of NGOs and communities. Projects in that region have also shown that traditional societies are adaptable and can experience social change and embrace new attitudes and methods, provided that IEC and BCC campaigns are carefully crafted and backed by strong leadership commitment.

48. Finally, *lessons from Egypt and Yemen* point to the importance of demand creation for family planning.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

49. The project will be implemented by the DEP with support from the PADS (*Programme d'Appui au Développement Sanitaire*, the project implementing unit established under the Bank-financed Health Sector Support and AIDS Project (P093987), for procurement and financial management, and international firm for capacity building and independent evaluation of RBF. The PADS is staffed by a multidisciplinary team including a Coordinator, a Financial Management Specialist, an Accountant, a Procurement Specialist, and an NGO Specialist who follows up contracts with NGOs and their performance, and administrative assistants. They have the skills and experience for fiduciary management which they have developed through the implementation of the Health Sector Support and AIDS Project, which has benefited from additional financing on two occasions. The PADS has also been managing other large programs

supported by the Global Alliance for Vaccination and Immunization, the Global Fund, the Dutch Cooperation, UNICEF, and others. The government will, as conditions of effectiveness, establish a Project Coordination Unit (PCU) for this project, and will appoint a coordinator of the PCU for this Project with terms of reference and qualifications and experience acceptable to the Bank. The Government will further strengthen the PCU by employing and assigning to the PCU not later than three (3) months after the Effective Date: (i) two public health economists; (ii) two public health doctors; and (iii) two monitoring and evaluation experts, all of whose qualifications and experience shall be acceptable to IDA. The project will be overseen by the Steering Committee created for the Health Sector Support and AIDS Project and is chaired by the General Secretary of the Ministry of Health, and includes Directors of all major departments, donors[6] and technical assistance partners.

50. The Recipient will be required to engage the international verification firm not later than May 15, 2012, and in any event prior to the award of the first PBHS Sub-grant. The project policies and procedures will be incorporated in the Implementation Manual. A more detailed description of the implementing arrangements is presented in Annex 3. The Recipient will be required to prepare and furnish to the Bank by December 15 in each year for the Bank's approval a proposed annual work program including all activities proposed to be included in the Project during the following calendar year (and related financing plan and timetable for their implementation).

51. The Recipient will conduct a mid-term review (MTR) expected by June 30, 2014. The MTR will assess the project status, its strengths and weaknesses, and the need for changes or specific actions to ensure the efficiency and quality of implementation. The MTR will benefit from an impact evaluation (IE) of component 1 to be carried out separately from this Project by the Bank and financed under a separate source of financing from HRITF. The IE will compare the results of the project in terms of quantity and quality of services in districts benefiting from RBF with those of control districts. The details of the design of the IE are presented in Annex 1.

52. The analysis resulting from the MTR and the impact evaluation will be discussed with the government and partners and will be useful for the government to prepare a geographical expansion of PBHS, beyond the Targeted Districts to other districts of the Recipient's territory including projected cost and financing plan.

B. Results Monitoring and Evaluation

53. In addition to the accountability function of evaluation, the Results Framework emphasizes the learning aspect of evaluation. To the extent possible, it uses existing indicators and data to measure the progress of the project and its contribution to the national program, not only for efficiency, but also to build on and strengthen existing data collection mechanisms. The indicators and methods of measurement have been designed to rely on pre-existent information systems and data sets, whenever possible. The results of the RBF component of the project will be assessed through a full Impact Evaluation (IE) carried out separately by the Bank (see Annex

[6] The Bank will not be represented on the Steering Committee so as to avoid the conflict of interest that would arise if the Bank were both financing and overseeing the implementation of the Project.

1). Under the Project, the Recipient will prepare and furnish Project reports to the Bank on a semestrial basis, not later than one month after the end of the semester concerned.

C. Sustainability

54. *Technical sustainability will be ensured by knowledge transfer activities throughout the Project.* Sustainability in terms of capacity to manage the RBF tool will be ensured in two ways: (i) the inclusion of capacity transfer in the contract of the international institution to be contracted; and (ii) learning by doing. The TORs of the international firm will include specific capacity transfer requirements whereby the firm will be required to: (i) assist in the design, development and implementation of RBF tools (Testing of the tools); assist DEP and DGS in the preparation, organization, evaluation and follow up the RBF training at all levels; (ii) assist in the verification of quantity and quality at facility level and help strengthen the M&E system (through national HMIS); (iii) oversee the assessment made by local health verification teams who will verify the extent to which each health facility achieves its quantitative and qualitative performance indicators; (iv) support all the process of households surveys by sub-contracting local organizations (CSOs) (procurement, training and monitoring); (v) review the performance of CSOs contracted to carry out consistency checks between facilities records and exit surveys of patients.

55. In parallel, the MOH will benefit from learning by doing. The DEP team in charge of RBF implementation will directly learn from the day-to-day implementation of RBF. The experience of Rwanda, Burundi and Sierra Leone shows that the learning process is fast, and that by the end of the project only limited support will be needed.

56. Financial sustainability of RBF can be reasonably achieved, given the limited cost of this mechanism and the growing interest of other donors for it. The project will help improve the efficiency of health spending by improving the outcomes obtained from the current spending of US$12 per capita. During the implementation of the on-going Health Sector Support and AIDS Project, which supports a sector-wide approach, and the PRSC series, the Bank will encourage the government to increase the proportion of the MOH budget channeled through the RBF mechanism.

57. However, as in most Sub-Saharan countries, the relatively low levels of GDP per capita will require donor support to Burkina Faso for many years to come. Because of its direct focus on results, the support for the RBF methodology has been popular with a wide array of donors and is likely to remain so in the medium term. The financial impact will be reflected in the national budget through the MOH's Medium-Term Expenditure Framework and the intra-sectoral budget at year 3.

58. Political commitment is strong, as all project components are fully aligned with national priorities. Burkina Faso has distinguished itself by acquiring political consensus on RBF in record time. In September 2009, the country organized a series of four RBF workshops that mobilized over 100 stakeholders from the government, NGOs and the private sector and the donor community, all senior policymakers from the MOH, hospitals, training institutions, Regional Directorates and Districts Managers. The Ministry of Economy and Finance and the

Ministry of Civil Service and Administration Modernization also participated. Finally, Burkina Faso sent staff to Rwanda for training in RBF. The necessary reforms (in the health system, decentralization and at the Ministry of Finance level) will be supported through the PRSC series. These reforms will sustain the gains of the RBF methods in the overall country system.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Stakeholder Risk	**Substantial**
Implementing Agency Risk	
- Capacity	**High**
- Governance	**Substantial**
Project Risk	
- Design	**Substantial**
- Social and Environmental	**Low**
- Program and Donor	**Low**
- Delivery Monitoring and Sustainability	**High**
Overall Implementation Risk	**Substantial**

B. Overall Risk Rating Explanation

98. The overall risk associated with the project is rated Substantial. The government has shown strong commitment to the project, so the main risk is related to the introduction of a new mechanism, the RBF, in a relatively low-capacity setting, especially at the local level. Other, more specific risks, include the potential for providers to emphasize quantity over the quality of services, the potential for increasing inequities between geographic regions, and the potential for providers to concentrate unduly on specific services which hare being compensated as part of the RBF payment. Experience from other countries shows that this can be successfully mitigated through a gradual scale-up, TA and training. These have already started and will continue during project implementation.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analyses

69. The economic analysis of the project justifies the economic viability of the project. The activities to be carried out under the project are expected to generate direct and indirect benefits to beneficiaries by increasing the contraceptive prevalence rate in Burkina Faso, which would lead to the prevention of a substantial number of unwanted pregnancies. Indirect benefits include the impact of improved reproductive health services on society's overall well-being,

since lower maternal and infant mortality and morbidity should result in fewer social problems and family upheavals. The project would help reduce family size, and enable parents to devote more time and resources for child care. An analysis of costs and benefits to be generated by the project's inputs and outputs provides a positive net present value (NPV) of US$10.2 million and an economic rate of return (EER) of 35% (details in Annex 8).

70. An analysis of health sector financing shows the predominance of donor funding, particularly for investment expenditures, and limited funding for reproductive health. Trends in the composition of recurrent expenditures, from 2008 to 2010, favor salaries and wages. This underlines the importance of policy dialogue during project implementation to encourage the government to increase spending (especially for reproductive health equipment, materials, drugs and supplies, and training) to ensure the sustainability of reproductive health services after project completion. Additionally, an adequate maintenance of the health infrastructure will be crucial to improving access to quality health/reproductive health services in Burkina Faso.

B. Technical

71. The project supports a package of reproductive health interventions aimed principally at reducing child and maternal mortality in the five selected regions. Child care and maternal care interventions are supported by a body of evidence, notably in a series of Lancet[7] articles published in 2003, 2006, and 2008 as well as Cochrane collaboration reviews[8] on interventions to reduce maternal mortality.

72. The design of RBF arrangements follows the best practices observed in other successful RBF projects. For instance, external entities (such as CBOs) are strongly involved in monitoring RBF results. Similarly, the mechanism to determine RBF grants is a "fee-for-service conditional on quality" system. Such a system ensures that: (i) the RBF mechanism is clear and can be easily understood by health workers and communities; and (ii) the increase in the quantity of care is not detrimental to quality.

C. Financial Management

73. The financial management arrangements of the project have been reviewed to determine whether they are acceptable to the Bank. The project will use the existing financial management and disbursements arrangements that are currently in place at the MOH and used for the on-going Bank-financed Health Sector Support and AIDS Project. The fiduciary aspects of this operation will be implemented by PADS (*Programme d'Appui du Développement Sanitaire)* whose capacity will be reinforced. The financial management performance of PADS was rated

[7] The Lancet, founded in 1823, is one of the oldest peer-reviewed medical journals in the world, published weekly in England. The Lancet is considered to be one of the core general medical journals. The Cochrane Collaboration, founded in 1993, was developed in response to Archie Cochrane's call for up-to-date, systematic reviews of all relevant randomized controlled trials of health care. A group of over 6,000 specialists in health care review biomedical trials and results of other research. [7] Burkina Faso: Country Systems review for project Financial Management**,** *Next Steps and Ways to move forward,* April 2010.

[8] The Cochrane Collaboration, founded in 1993, was developed in response to Archie Cochrane's call for up-to-date, systematic reviews of all relevant randomized controlled trials of health care. A group of over 6,000 specialists in health care review biomedical trials and results of other research.

moderately satisfactory following the recent supervision mission that agreed with the government on the need to: (i) reinforce the fiduciary team with additional staff; and (ii) improve the reporting by NGOs which are new executing entities. PADS has no overdue audit reports. The country Public Sector Financial Management (PFM) system will be used as per the modalities described in the Bank Economic Sector Work on Burkina PFM system[9].

74. The overall financial management risk is considered **Moderate**. The proposed financial management arrangements for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.02. PADS existing budget, accounting, internal control, internal and external audits, and reporting procedures will be amended to include the RBF specifics, including: (i) PBHS to be financed and unit prices to be paid per package: (ii) the revision of the chart of accounts; (iii) a simplified reporting system to track the PBHS and their costs; (iv) the management of the PBHS Sub-grants; and (v) the verification of unit prices. The finalization of the RBF framework (to be included in the Project Implementation Manual) will be critical in that regard. IFRs will be required to be furnished to the Bank semestrially, no later than 90 days after the end of the semester.

75. To facilitate disbursements, two Designated Accounts (DAs) will be opened at the Central Bank in Ouagadougou. DA – "RBF", a pooled account, will be used for the RBF subcomponent jointly financed by both IDA Grant and the trust fund grant; and DA – "Other" will be used for the remaining components of the Project, financed by the IDA grant. Under each DA, a Transactions Account will be opened in a reputable commercial bank. Upon effectiveness, the project will use report-based disbursements since PADS is well experienced with this method. However, the RBF subcomponent will be disbursed on the basis certified Statement of Expenditures under PBHS Subprojects. The role of the different entities in charge of sets of controls (the international firm providing independent control, the RBF Unit located in the DEP, and the PADS internal audit unit) will complement the mitigation measures with the aim to address the risk of fraud and corruption in the use of the RBF mechanism. In addition, reimbursements to health facilities under PBHS Sub-grants will be published on a quarterly basis. Lastly, a mechanism of sanctions of fraudulent cases will be developed and made publicly available.

D. Procurement

76. Procurement will be carried out in accordance with the Bank's "Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011, and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011, and the provisions stipulated in the Financing Agreement. "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006 and revised in January 2011 will apply.

[9] Burkina Faso: Country Systems review for project Financial Management**,** *Next Steps and Ways to move forward,* April 2010.

77. Procurement activities at the central level will be implemented by the PADS which has substantial experience in the implementation of Bank projects. At the decentralized level, each health district will be responsible for the procurement of small items estimated at less than US$40,000 per contract. The PADS will be directly in charge of all consultant selection, all procurement of large, complex and pooled procurement across beneficiaries.

78. During the preparation phase of the recent Additional Financing for the Health Sector Support and AIDS project, a procurement assessment was carried out by the Bank. It reviewed the organizational structure for implementing the project, the institutional arrangements and the capacity of project staff responsible for procurement. It concluded that the PADS procurement department, headed by a Procurement Specialist, is well experienced with Bank procedures.

79. Risk mitigation measures have been discussed and confirmed with the PADS, and the residual risk is rated moderate. A draft procurement plan for the project dated November 16, 2011 has been prepared and found acceptable. The Procurement Plan will be updated annually or as required to reflect project implementation needs and improvements in institutional capacity. Details on the procurement capacity assessment and project procurement arrangements are provided in Annex 3.

E. Social (including Safeguards)

80. Local socio-cultural behavioral conditions influence health outcomes. Studies have shown that even when knowledge is high, this may not be translated into behavior change, as evidenced by the under utilization of health services. Common misconceptions compromise the exclusivity and maintenance of breastfeeding. Bed nets are not used because people believe they are too warm. Many women are not aware of danger signs in pregnancy and delivery or in sick children and the need for timely intervention. In this regard, a strong IEC program is essential for changing behavior, and will be supported under the project. RBF may be used to introduce demand-side incentives, which attempt to address demand-side constraints to the utilization of services.

81. The project is expected to have a positive social impact by improving access to health care services for the poorest households. Component 1 (through the RBF mechanism) will provide incentives for health facilities to reduce staff absenteeism, to improve staff responsiveness with patients, and to provide more and better care for the poorest patients.

82. The project will also enhance community ownership for monitoring the quality of basic health services. CBOs will be identified and strengthened so that they can be involved in monitoring health facilities. The project will build on similar experiences in Burkina Faso (including Bank-financed projects) to select these CBOs.

83. The preparation of the project has been highly participatory, with extensive work and consultation among the key stakeholders: selected line ministry representatives, representatives of NGOs and health workers. To avoid opposition to RBF, a strong emphasis was put very early in project preparation to explain the project stakeholders. The monitoring and evaluation system has been designed to ensure the adequate targeting of project activities, including their social impact.

84. No social safeguards policies will be triggered by project.

F. Environment (including Safeguards)

85. Health facilities use medical equipment which might entail an increased production of medical waste. Consequently, the project has been classified as Category B for environmental screening purposes given the risks associated with the handling and disposal of medical and general health waste. This project is not expected to generate any major adverse environmental impact. Possible environmental risks include the inappropriate handling and disposal of hazardous medical waste, including sharp needles, and especially the inadequate management of disposal sites in urban or peri-urban areas, where domestic and medical waste may be mixed, and where scavenging is common. The project will help minimize the danger of poor segregation and disposal of health care waste through the training of health providers.

86. Because the project is classified as Category B for environmental purposes, an Environmental Assessment Report including a Medical Waste Management Plan was prepared, during preparation and disclosed in-country on March 3, 2011, sent to InfoShop on March 12, 2011, and is being implemented. There will be no new construction works under the project, although there will be minor refurbishing and painting of health facilities, such as the painting of windows, the replacement of some fixtures, and minor interior repairs, none of which would trigger a resettlement safeguard policy.

Annex 1: Results Framework and Monitoring

BURKINA FASO: Reproductive Health Project

Project Development Objective (PDO): to improve the utilization and quality of reproductive health services, with a particular focus on selected regions of Burkina Faso												
PDO Level Results Indicators*	**Core**	**Unit of Measure**	**Baseline**	**Cumulative Target Values****					**Frequency**	**Data Source/ Methodology**	**Responsibility for Data Collection**	**Description (indicator definition etc.)**
				YR 1	**YR 2**	**YR3**	**YR 4**	**YR5**				
PDO #1: Contraceptive prevalence rate	☐	%	15% (DHS 2010)	16.5%	17.5%	19%	22%	24%	a. Every 2 years or according to IE methodology b. 5 years	a. Representative sample household survey b.DHS 2010, and 2016/17	MOH Health Information System (HIS)/INSD	Number of women reporting use of modern contraceptive method / Total number of women of reproductive age Household survey to cover the RBF regions.
PDO #2: Proportion of births assisted by skilled personnel	☐	%	67% (DHS 2010)	69%	71%	73%	76%	80%	Annual	Routine HMIS - Facility records	DHS and HIS	Number of births assisted by a midwife, *maïeuticien d'Etat,* qualified nurse or *sage femme* / Total number of expected births
PDO #3: Proportion of women attending postnatal consultations	☐	%	46% (MOH Annuaire 2010)	48%	50%	53%	55%	58%	Annual	Routine HMIS – Facility reports	MOH (Annuaire)	Number of postnatal consultations recorded / Total number of assisted births
PDO#4: Children fully immunized[10]	☒	#	81% (DHS 2010)	84%	88%	92%	96%	96%	Annual	Routine HMIS – Facility reports	MOH (Annuaire)	Cumulative number of children completely immunized.
Intermediate Results Indicators: (Component 1) Improving the delivery and quality of a Reproductive Health Service Package through Result-Based Financing												
Intermediate Level Results Indicators*	**Core**	**Unit of Measure**	**Baseline**	**YR 1**	**YR 2**	**YR3**	**YR 4**	**YR5**	**Frequency**	**Data Source/ Methodology**	**Responsibility for Data Collection**	**Description (indicator definition etc.)**
IOI #1: Percentage of pregnant women receiving at least 2 doses of anti-tetanus immunization		%	92.3% (Annuaire statistic 2010)	94.5	96%	98%	98%	98%	Annual	Routine HMIS – Facility reports	MOH (Annuaire)	Number of pregnant women who received at least 2 doses/Total number of expected pregnancies
IOI #2: Percentage of facilities that received RBF credits on time	☐	%	0	50%	60%	70%	75%	80%	Annual	RBF payment records	Annual internal audit (by MOH inspectorate)	Number of facilities that received RBF within 30 days of sending performance report / Total number of facilities in

[10] Baseline and target figures are currently expressed as percentages. For monitoring purposes, they will be converted into absolute numbers in line with IDA 16 core indicator instructions

												districts selected for RBF. Standard for timeliness is to be agreed with MOH and defined in the RBF manual
IOI #3: Pregnant women receiving antenatal care during a visit to a health provider[11]	☒	%	94.9 (DHS 2010)	96%	97%	98%	99%	100%	Annual	Routine HMIS –	MOH (Annuaire)	This indicator measures the cumulative number of pregnant women receiving antenatal care during a visit to a skilled health provider (specialist or non-specialist doctor, or other persons with midwifery skills who can diagnose obstetric complications) for reasons related to pregnancy. Trained TBAs are excluded. The aggregation of visits will necessarily combine visits that vary in duration, types of examinations performed, and other qualitative aspects.
IOI #4: Couple years protection (CYP)	☐	#	529272	650000	750000	875000	995000	1100000	Annual	Routine HMIS	MOH (Annuaire)	The estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a standard conversion factor (which estimates the duration of contraceptive protection provided per unit of that method) to yield an estimate of the duration of protection provided by that method. CYP for each method is then summed for all methods to obtain a total CYP figure.
IOI #5: Percentage of Cesarian-sections	☐	%	1,3% (Annuaire statistic 2010)	1.5%	2.0%%	2.5%	3.5%%	4.5%	Annual	Routine HMIS data	MOH (Annuaire)	Number of C-sections/Number of deliveries
IOI #6: Percentage of women of reproductive age that are satisfied with the quality of RH care and services provided in public sector facilities.	☐	%	IE baseline	35%	40%	50%	60%	70%	Annual (aggregated from quarterly quality check)	RBF verification – Community-based questionnaire used to establish quality scores for RBF payments	Independent third party	Number of women of reproductive age who use health services and rank the facility in their community with a score of 75% or better / Total number of women interviewed. Data on respondents to be disaggregated by age (to distinguish 15-19 year olds). Questionnaire to be developed as part of RBF Manual.

[11] See footnote 10.

Intermediate Result (Component 2): Supporting critical inputs for reproductive and family planning services												
Intermediate Level Results Indicators*	**Core**	**Unit of Measure**	**Baseline**	**YR 1**	**YR 2**	**YR3**	**YR 4**	**YR5**	**Frequency**	**Data Source/ Methodology**	**Responsibility for Data Collection**	**Description (indicator definition etc.)**
IOI#7: Health personnel receiving training [cumulative]	☒	#	0	100	200	300	400	500	Annual	Project records	MOH/ENSP	This indicator measures the cumulative number of health personnel receiving training. It includes all types of health workers (doctors, nurses, midwives, and laboratory staff) and health administrators/managers who receive either pre-service or in-service training.
IOI #8: Number of CEmONC public sector health facilities	☐	#	4 (Survey 2011)	10	16	36	46	56	Annual	Routine HMIS	MOH	Number of facilities that provide all 9 emergency obstetric procedures.[12]
IOI#9: Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT (number)[13]	☒	%	52% (HMIS) (SP/CNLS2011)	54%	59%	64%	69%	73%	Annual	Routine HMIS	MOH	Pregnant women HIV+ receiving treatment/total pregnant women HIV+ in country.
IOI#10: Percentage of facilities with no contraceptive stock-outs in last three months	☐	%	71,10%	81%	91%	100%	100%	100%	Annual	Routine HMIS	MOH	Number of facilities with all 6 methods available: male condoms, female condoms, pill, injectable, implant, and IUD for at least 25 days per month / Total number of facilities offering FP
IOI #11: Percentage of women aged 15-19 who know of at least one modern family planning method	☐	%	83%[14]	-	**85%**	-	87%	90%	Every 5 years or through biannual survey	DHS 2010 and 2016/17		Percentage of women aged 15-19 who know at least one modern contraceptive method

*Please indicate whether the indicator is a Core Sector Indicator.
**Target values should be entered for the years data will be available, not necessarily annually.

[12] A basic EmONC facility performs the following 7 critical lifesaving procedures: Administration of parenteral antibiotics, paterental oxytocics (uterotonic drugs), parenteral anticonvulsants for pre-eclampsia/eclampsia; Manual removal of placenta; Removal of retained products of conception (manual vacuum aspiration [MVA] or dilatation and curettage [D&C]); assisted vaginal delivery (vacuum extraction or forceps delivery); and basic neonatal resuscitation (bag and mask). Additionally, a comprehensive EmONC facility offers blood transfusion and cesarean delivery.

[13] See footnote 10.

[14] DHS 2003. Results from the DHS 2010 (data collected 05/2010 through 01/2011) should soon be available.

87. *The Results Framework* for this project is informed by the advances in M&E thinking in the Bank,[15] and in particular by regarding M&E in HNP.[16] The Results Framework focuses on accountability for results, i.e., it moves beyond the usual tracking of inputs and outputs, and places emphasis on intermediate outcomes. In addition to the accountability function of evaluation, the Results Framework emphasizes the learning function of evaluation. To the extent possible, it uses existing indicators and data to measure the progress of the project and its contribution to the national program, not only for efficiency, but also to build on and strengthen existing data collection mechanisms.

88. The indicators and methods of measurement have been designed to rely on pre-existent information systems and data sets, whenever possible. For example, routine monthly and quarterly data collected from the Burkina Faso Health Management Information System (HMIS) will aggregated for the project's annual indicators so as to reinforce the national system and avoid creating a parallel one. The Demographic and Health Surveys (DHS) will be used for population-level indicators because the survey rounds coincide with the 5-year project cycle.

89. The RBF component will take place in five pilot districts and five control districts (within five regions). As such, an independent third party will be hired by the MOH to conduct quality checks and independently assess implementation performance for the RBF verification in Component 1. This third party will help the government determine the RBF payments to be made each quarter.

90. The project monitoring system will include:

- Identification and consolidation of M&E indicators;
- Training and capacity building initiatives at the national, regional and local level, as needed;
- Standardized methods and tools to facilitate consistent collection, consolidation and sharing of information;
- A computerized information system at the national and regional levels to integrate data collected from the MOH;
- An independent review led by an external technical consultants;
- Annual program evaluations and strategic planning exercises for each component.

91. **Impact Evaluation.** The results of the RBF component of the project will be assessed through a full Impact Evaluation (IE) to be carried out by the Bank. To conclude that the project has an impact, the IE will have three features: (i) it will be prospective, (ii) it will be controlled, and (iii) it will be randomized.

92. The Impact of the RBF mechanism will be measured prospectively. In other words, the indicators will be measured before and after the implementation of RBF, through a baseline

[15] QAG, 2009a,b; IEG, 2009a.

[16] In support of the 2009 IEG HNP Evaluation, a background paper on M and E quality in HNP investment operations raised concerns about: (i) the poor quality of results frameworks, (ii) the absence of baseline data; (iii) poor or failure to collect baseline data or within first year of the project approval; (iii) unrealistic indicator targets; and (iv) poor data quality.

study. This study will start in March 2012. Three follow-up assessments are planned in mid-2013, mid-2014 and mid-2015.

93. The IE design will include a "treatment" group and a "control group", following random assignment. A certain number of health districts will be selected. Out of these facilities in these health districts, a certain proportion will be randomly assigned the RBF "treatment". They will benefit from the full RBF mechanism. The other health facilities will form the "control" group. They will receive a similar amount of money, but the payment will not be linked to results. The purpose of this design is to make sure that the RBF impact is not confounded with the "additional resources" effect. This issue has made the evaluation of some previous IE of RBF mechanisms more difficult, given that, in these experiments, selected RBF districts were receiving much more resources than the control districts. It was therefore difficult to determine if their improved performance was related to an enhanced focus on performance or simply to more funding. The proposed design will solve this issue.

94. The indicators to be measured through the IE are the same as found in the results framework. Data collection will be carried out by a third party. Funding of this IE is provided by the Health Results Innovation Trust Fund.

95. This Impact Evaluation will be supervised by a Principal Investigator.

96. The impact evaluation will involve an international firm as well as the participation of the National Institute of Public Health who will thus acquire experience in RBF evaluation and have its capacity strengthened.

Annex 2: Detailed Project Description

BURKINA FASO: Reproductive Health Project

97. The development objective of the proposed project is to improve the utilization of reproductive health services in the recipient's territory, with a particular focus on selected regions of Burkina Faso. The project would have the following components:

98. The proposed project will have the following components.

99. **Component 1: Improving the delivery and quality of a Reproductive Health Service Package through Result-Based Financing (US$22.3 million).** This component would be jointly financed by IDA (US$9.6 million) and the Health Results Innovation Trust Fund ($12.7 million). It would have two subcomponents.

100. The project will be implemented in five selected regions out of the 13 which currently exist. Three criteria have been used to select these regions, and they were chosen with a geographical balance that will provide implementation experience in different contexts, and allow broad capacity building that will be useful for a future expansion of RBF. Out of the 5 regions, 4 have health indicators below the national median. The fifth has better health indicators, which will allow testing RBF in a higher capacity setting and contribute to overall learning.

101. The project will build partnerships with UNICEF and UNFPA, and other agencies which are present in the same regions. There is no duplication with any other similar intervention financed by other donors.

102. Within each region, two districts were chosen which had the lowest of a combination of four indicators: (i) contraceptive prevalence rate: (ii) assisted deliveries; (iii) antenatal consultations and (iv) post-natal consultations. In the Boucle du Mouhoun region, Segenega district was excluded because an NGO is currently supporting an RBF pilot operation, which would be a confounding factor. The 10 selected districts are listed in Annex 7.

103. Sub-component (i) - Delivery of Packages of Basic Health Care (PBHS) (US$16.8 million-IDA 8m and HRITF 8.8m). In the 5 selected regions, the MOH will make PBHS Sub-grants to selected health care facilities for PBHS Sub-projects consisting of the provision of packages of basic health services (PBHS). The possibility of making Sub-grants to private sector providers would also be contemplated at a later stage. PBHS Sub-grant agreements concluded between the MOH and the health center will define the PBHS to be provided, and the indicators and targets to be reached in delivering these services. The results achieved against these targets will then be assessed by external reviewers every three months. Based on these verified results, each PBHS Sub-grant recipient will receive payments in partial reimbursement for the PBHS delivered. The payments will be based on unit prices developed under the RBF model for each PBHS, based on a number of factors designed to achieve the desired results, including basic cost of the inputs required (and not financed elsewhere) for services to be rendered, adjusted for quality of the service. In no case will the amounts paid under the PBHS Sub-grant exceed the

reasonable cost of the services provided, nor will they pay for costs financed by other sources[17]. The unit price paid for each PBHS will be reviewed not later than March 1 each year to ensure their continued compliance with these criteria. The general principles for these payments for PBHS are presented in Annex 7 and will be detailed in the Project Implementation Manual. The Manual will describe the implementation details for the RBF model, including: (i) institutional arrangements; (ii) details of the different PBHS to be provided; (iii) eligible expenditures and unit prices for each PBHS, as well as the methodology for calculating the unit prices, consistent with the above criteria, and procedures for annual reviews of the unit prices; (iv) procedures for approval and monitoring and evaluation of PBHS Sub-project, and granting of PBHS Sub-grants; (v) assignment of roles and responsibilities for the verification and control of results for payment and auditing purposes, including designation of the verification team for each Targeted District; (vi) consequences for fraud in the amount billed; (vii) management and data collection tools; and (viii) rules for the use of reimbursements for PBHS delivered. Details on the RBF design and procedures are provided in annex 7.

104. *RBF indicators have a large focus on maternal and neonatal health, but they also include non-maternal services (i.e*. child visits, immunizations etc.), adolescent services, tuberculosis, and malaria, to ensure that health care facilities do not neglect other services. Two sets of RBF indicators have been defined with the government. A first group of indicators will measure the *quantity* of services provided. The second group of indicators is about *quality*.

105. RBF will be an important tool to attract pregnant women to health facilities, both for ante-natal consultations and deliveries. The reimbursements made under PBHS Sub-grants to a health facility will be used by health personnel to increase both the demand for and the supply of reproductive health services. The experience of Rwanda and Burundi shows that health facilities have subcontracted traditional birth attendants (TBAs) who have brought pregnant women to health facilities for ante-natal control and delivery, and shared the RBF incentives with them. When a facility was paid a certain amount for each delivery, they gave 20-40% of it to a TBA who accompanied a pregnant woman.

106. To avoid the "numbers game", an international firm will be contracted by the government under subcomponent (ii) to verify independently the achieved results in the delivery of the services by the health centers. To limit risk that health facilities might manipulate their routine data to artificially inflate their results (and therefore their reimbursements for PBHS), external reviewers ("district controllers") will be recruited (through a subcontract with the international firm, and placed in each of the regions. Every three months, these reviewers will use routine data and random surveys to check the accuracy of the reported routine data. In addition, community-based organizations (CBOs) will be contracted by the international firm to conduct targeted household surveys.

107. *Subcomponent (ii) - Support to RBF implementation and supervision* (US$5.5 million-IDA1.6 million and HRITF 3.9 million). To ensure the successful implementation of the RBF component (subcomponent (i)), an international firm will be recruited at the beginning of the implementation of the project to provide technical support and external monitoring. The RBF

[17] For example, inputs financed under component 2 and regular salaries paid by MOH would be excluded from the costs reimbursed.

component will be managed by the MOH, especially in the areas of setting RBF indicators and targets, procurement[18] and disbursements under PBHS Sub-grants. The international firm will provide technical assistance at central level and at district or commune level ("district controllers"). It will: (i) assist DEP in the design, development and implementation of RBF tools (Testing of the tools); and follow up on RBF training at all levels ; (ii) assist in the verification of quantity and quality of PBHS delivered at facility level and help strengthen the M&E system (through national HMIS); (iii) oversee the assessment made by local health verification teams who will verify the extent to which each health facility achieves its quantitative and qualitative performance targets; (iv) assist in the process of household surveys by sub-contracting local organizations (procurement, training and monitoring). This will allow the *Direction d'Etudes et de Planification*, Directorate of Research and Planning (DEP within the MOH) to authorize reimbursements under PBHS Sub-grants by the payer (PADS) to health facilities (the funds flow details are presented in Annex 3); and finally (iv) review the performance of CSOs contracted to carry out consistency checks between facilities records and exit surveys of patients.

108. The project will also train stakeholders (commune local government, local health verification teams, traditional birth attendants and other community-based agents) in the districts and municipalities in the principles of the RBF and its implementation. The specific role of each stakeholder group will be explained to stakeholders to ensure their understanding and adherence to the RBF approach. Finally, this component will include a study which will be carried out to expand the delivery of PBHS beyond the Targeted Districts to other districts in Burkina Faso. This component will finance goods, consultant and non-consulting services, training, and operating costs. Detailed information on the architecture and mechanisms of RBF implementation is presented in Annex 6.

109. **Component 2. Supporting critical inputs for reproductive and family planning services (US$19.3 million)**. This component, to be financed entirely by the IDA Grant, will be implemented at the national level. It will have three subcomponents: (i) training of nurses, skilled birth attendants and doctors; (ii) provision of drugs and equipment to improve obstetric and neo-natal services; and (iii) strengthening demand for family planning and reproductive health services.

110. *Subcomponent (i) - Training of nurses, skilled birth attendants and doctors (US$ 2.3 million).* Given that the limited number of skilled health professionals impairs access to reproductive health services, the 2010 Emergency Obstetric and Neonatal Care (EmONC) Survey recommended increasing their numbers and quality. To contribute to this effort, the project will support the pre-service training of about 60 skilled birth attendants and 60 general nurses. They will undertake three years of training at the National Public Health School (*Ecole Nationale de Santé Publique – ENSP)* or in private schools contracted by the MOH. Their training will benefit the project only as from the beginning of year 4, but it is an important

18 Procurement will be undertaken at various levels. For example, the procurement of the international firm for RBF verification, as well as procurement of inputs under component 2 to be delivered to local health centers, will be conducted by the central-level MOH while, procurement under PBHS Subprojects will be procured by individual facilities that are part of the MOH.

contribution to medium-term capacity building, to which the government attributes much importance.

111. The project will also provide in-service training to improve the knowledge and skills of about 360 general nurses and 360 skilled birth attendants, as well as doctors, in emergency obstetric and neo-natal care, family planning, prevention of mother-to-child transmission (PMTCT) of HIV/AIDS, integrated management of child illnesses (IMCI), emergency obstetric and neo-natal care, emergency triage assessment and treatment, and management of health services. In-service training consists of a two-week course and will benefit the project right away as from year 1. The project will also finance teaching equipment and supplies for the National Public Health School.

112. Finally, the project will finance the supervision of emergency obstetric and neo-natal care and family planning interventions.

113. This subcomponent will finance goods, services, training, and operating costs.

114. *Subcomponent (ii) - Provision of drugs and equipment to improve obstetrical and neo-natal services (US$8.5 million).* This subcomponent will provide ambulances, motorcycles and vehicles, equipment and emergency delivery kits for about 52 health centers, drugs, contraceptives, supplies for diagnostic tests, equipment and training for waste management, small refurbishing (including painting) of health centers.

115. This subcomponent will finance goods, services and training.

116. *Subcomponent* (iii) - *Strengthening demand for family planning and reproductive health services (US$8.5 million).* The project will strengthen the demand for family planning and reproductive health and increase financial access of women to services. It will help increase the number of women of reproductive age that seek family planning services and begin to utilize modern methods for birth spacing or control. This subcomponent will support information, education and communication (IEC) and behavior change communication (BCC) strategies at the community level carried out by specialized NGOs who will be contracted during the first year of the project to scale up successful RH approaches. Larger NGOs will be encouraged to present innovative proposals and to associate themselves with smaller NGOs, allowing them to increase the coverage and quality of services. At the community level, the communication strategy will be to undertake social marketing and BCC with the objective of expanding family planning services and reducing delays in recognizing and managing complications of pregnancy and delivery. The project will also help increase the demand for youth health services, particularly among young girls. The MOH will call for NGO proposals and the NGOs will be selected in accordance with the Bank Selection of Consultants Guidelines. The cycle of calls for proposals, submission, review, approval, evaluation and payments will be included in the Project Implementation Manual. The detailed project cost would be as follows.

Table 1 - Project Costs

Components 1	Cost (US$)	Financing (US$)	
Component 1: Improving the use and quality of a "Reproductive Health Service Package" through Result-Based Financing		**IDA**	**HRITF**
Strengthening of M&E System	800,000	800,000	
Payments under PBHS sub-grant	16,800,000	8,000,000	8,800,000
Technical Assistance for Verification/Management of PBHS, training of Local Health Personnel in RBF	3,900,000	600,000	3, 300,000
Study to Prepare country harmonization of RBF/ CBHI	800,000	200,000	600,000
Subtotal Component 1	**22,300,000**	**9,600,000**	**12,700,000**

[13]UNFPA, USAID, PADS (and Government DAF), also fund the provision of drugs and equipment under separate projects, not financed under this project.

Components 2	Cost (US$)	Financing (US$)	
Component 2. Supporting critical inputs for family planning and reproductive health services		**IDA**	**HRITF**
Subcomponent (i)			
Training of Trainers, In-service training in obstetric and neonatal care	246,000	246,000	
Pre-service Training of 120 nurses, and skilled birth attendants	654,000	654,000	
In-service Training of Nurses , medical doctors and Midwives in Obstetric and Neonatal Care	1,873,000	1,873,000	
Subcomponent (ii)			
Ambulances, Motorcycles, other vehicles, Delivery kits, Contraceptive Products, Drugs and waste management equipments.	8,500,000	8,500,000	
Subcomponent (iii)			
Training Equipment	1,000,000	1,000,000	
Strengthening demand for RH services through Population strategic Plan and the Ministry of women's promotion.	1,167,000	1,167,000	
Contracting of NGOs for Social Marketing of Family Planning	4,260,000	4,260,000	
Unallocated	1,600,000	1,600,000	
Subtotal Component 2	19,300,000	19,300,000	
Total Project Cost	**41,600,000**	**28,900,000**	**12,700,000**

Annex 3: Implementation Arrangements

BURKINA FASO: Reproductive Health Projet

117. The project will be implemented by the DEP with support from (a) the PADS (*Programme d'Appui au Développement Sanitaire* , the project implementing unit established under the Bank-financed Health Sector Support and AIDS Project (P093987), for procurement and financial management, and (b) an international firm, for capacity building and independent evaluation of RBF.

Project administration mechanisms

118. The PADS is staffed by a multidisciplinary team including a Coordinator, a Financial Management Specialist, an Accountant, a Procurement Specialist, and an NGO Specialist who follows up contracts with NGOs and their performance, and administrative assistants. They have the skills and experience for fiduciary management which they have developed through the implementation of the Health Sector Support and AIDS Project, which has benefited from IDA additional financing on two occasions. The PADS has also been managing other large programs supported by the Global Alliance for Vaccination and Immunization, the Global Fund, the Dutch Cooperation, UNICEF, and others. The government will, as conditions of effectiveness, establish a Project Coordination Unit and appoint a coordinator with terms of reference, qualifications and experience satisfactory to the Bank. To this end, the terms of reference of the PADS will be expanded to provide technical support to the DEP. The Government will further strengthen the PCU by employing and assigning to the PCU not later than three months after the Effective Date: (i) two public health economists; (ii) two public health doctors; and (iii) two monitoring and evaluation experts, all with qualifications and experience acceptable to IDA.

119. The project will be overseen by the existing Steering Committee established for the Health Sector Support and AIDS Project, which is chaired by the General Secretary of the Ministry of Health, and includes Directors of all major departments, donors (excluding the World Bank) and technical assistant partners.

120. The project policies and procedures will be incorporated in an Implementation Manual, the adoption of which by the MOH is a condition of effectiveness.

Financial Management, Disbursements and Procurement

Financial Management

121. **Country PFM situation and Use of Country System**. Overall, the Bank considers implementation performance of the PFM reform program (*Stratégie de Renforcement des Finances Publiques or SRFP*) to date and the government's commitment to PFM improvements as exemplary. As a result, the Bank is preparing its 11th budget support operation. SRFP is supported by a wide range of donors providing budgetary support, and donors commit to it through a Memorandum of Understanding for budget support. To assess the progress made after four years of SRFP implementation, the government has undertaken a second Public Expenditure and Financial Accountability (PEFA). This PEFA, completed in June 2010, confirmed the

progress made so far by Burkina Faso in the PFM area. Improvements were noted in budget credibility (indicators 1-4), and it was confirmed that the arrangements for the remaining indicators (comprehensiveness and transparency, policy based budgeting and predictability and control in budget execution) were adequate. Improvements remain necessary in the areas of mobilization of fiscal revenue, control over payroll, and scope of the internal and external control. To complement the national PEFA, a sub-national PEFA for the Ouagadougou municipality was also completed in June 2010 with major outcomes similar to the national PEFA. Meanwhile, the Ministry of Economy and Finance has been working on several initiatives in the PFM area: (i) a new sector strategy (*Stratégie Sectorielle du Ministère de l'Economie et des Finance*) aiming at merging SRFP and PRGED (*Programme de Renforcement de la Gestion de l'Economie et du Développemen*t) and ensuring a smooth transition towards the implementation of the PFM Directives recently issued by the West African Economic and Monetary Union; and (ii) the new Integrated Circuit for Donors-financed Projects (*Circuit Intégré des Financements Extérieurs*, CIFE).

122. CIFE involvement started on April 1, 2011, following the approval by the Council of Ministers on March 2, 2011. It is built on a computerized system that aims at applying the country PFM system at the project level by involving key players in project monitoring (Directorate of Budget, Directorate of Finance Control, and Directorate of Public Treasury, notably). CIFE has six modules, of which two have been in use since 2010. They relate to project identification and financing agreement monitoring. The four remaining cover budget monitoring as well as internal controls and accounting arrangements in line with the national PFM system. All modules are interfaced with the country Integrated Financial Management Information Systems. As it is currently, CIFE is only opened at central level not yet decentralized at projects level. The proposed project will be channeled through CIFE as per the recommendations of the Bank analytical work on the Burkina PFM system. However, during an interim period of one year, the project will maintain its own accounting software. Upon satisfactory reconciliation of the financial data and decentralization of CIFE at projects level, the decision will be made to fully rely on CIFE. To this end, policy dialogue will be pursued with the aim to render CIFE fully operational at projects level.

123. **Staffing and Training**. PADS is staffed with a Finance Manager and five accountants at the central level and has thirteen accountants at the decentralized level (one for each region) all well experienced in the implementation of Bank-financed projects. The team has been recently reinforced with the recruitment of an additional accountant at the central level. At local health facility and COGES level, the FM staffs consist of a treasurer and external controller. The existing accountants at decentralized level will provide technical support to the COGES FM staff that has different levels of qualifications and experience.

124. **Budgeting.** PADS current budgeting arrangements which are well aligned with the national budget at formulation stage, not execution, will be amended to integrate RBF specifics (credit allocation, creation of new budget codes, etc.). With CIFE implementation, budget execution will be also aligned with the national budget execution process.

125. **Accounting Policies and Procedures.** PADS will use its current platform (accounting software multi projects and multi sites) to maintain the books and accounts of the project

activities and ensure that the annual financial statements are produced in a timely manner in accordance with OHADA (*Organisation pour l'Harmonisation en Afrique du Droit des Affaires*) accounting principles which calls for double entries system. The existing accounting manual and chart of accounts will be amended to include the accounting procedures related to the RBF. The simplified accounting tool already developed by PADS will be amended for the COGES. As per CIFE procedures, the project's accounting transactions will be reflected by the Directorate of Public Accounting after control by the Directorate of Financial Control into the national financial statements. This will improve the reliability of the national financial statements.

126. **Internal Control and Internal Auditing.** The current manual of procedures will be amended to include a new delegation of authority (specifying the signatories at both central level and local health management community level) and the different types of key controls meant to be performed by the stakeholders (independent controller, RBF Unit and payer) with the aim to ensure that the results have been actually produced, and reimbursements under RBF Sub-grants have been received and spent on eligible expenditures. Ex ante control and control over delivery (*contrôle du service fait*) of procurement contracts above the national thresholds will be performed by the D**i**rectorate of Financial Control. The PADS internal audit unit will continue to perform its internal audit mission jointly with the Inspectorate of Ministry of Health and make use of the risk map developed in this Ministry. The risk map will be revised to include the RBF.

127. **Funds Flow and Disbursement Arrangements**: One pooled account and one segregated Designated Accounts (DAs) will be opened at the Central Bank in Ouagadougou. DA – "RBF", a pooled account, will be used for the RBF component jointly financed by both IDA Grant and the HRI TF grant; and DA – "Other" will be used for the other component of the project and financed by the IDA grant. As DA-"RBF" is a pooled designated account, its ceiling is apportioned between the two financing sources (i.e., the IDA Grant and the HRTF Grant) in the amounts of CFAF 625 million and CFAF 529 million, respectively. The ceiling of DA "Other" will be equivalent to the cash forecast for two quarters as shown in the Interim Financial Report, which will be furnished 90 days after the end of each calendar semester. Under each DA a Transaction Account will be opened at a reputable commercial bank. All accounts will be held in CFAF. Each local health authority will open an account at a commercial bank. These accounts will be replenished through the Transactions Accounts (from DA – "RBF" and DA – "Other"). The replenishment of the Transactions Accounts will be made on a monthly basis and based on the cash needed. Direct payments will be made to service providers if need be. As for the RBF component, disbursements to the health authorities will be made pari passu from IDA and the HRITF, through the pooled designated account, and for services already rendered based on pre-determined unit prices which takes into account inter alia, quality and cost (adjusted for quality). Table 2 below shows the disbursements from the IDA Grant.

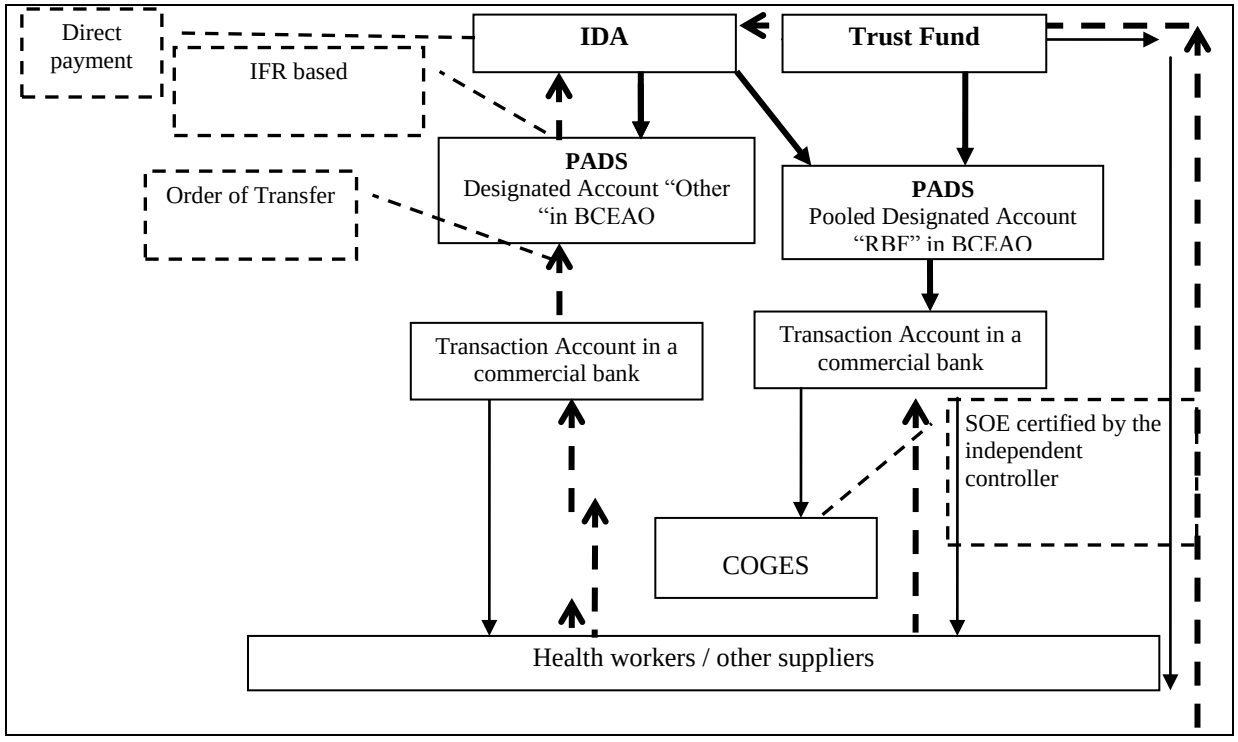
Table 2 – Grant Disbursements by Category

Category	Amount of the Financing Allocated (US$)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Goods, non-consulting services, consultants' services, Training and Operating Costs required for each PBHS provided under a PBHS Sub-project and to be financed out of a PBHS Sub-grant under Part A (1) of the Project and paid at the Unit Price for said PBHS	7,730,000	48% of amounts paid by the Recipient under the PBHS Sub-grant
(2) Goods, non-consulting services, consultants services, Training and Operating Costs for:		
(a) Parts A(2) and A(3) of the Project; and	1,550,000	29%
(b) Part B of the Project	17,320,000	100%
(3) Unallocated	1,700,000	
TOTAL AMOUNT	28,300,000	

Disbursements

128. The RBF component will be disbursed on the basis of certified Statements of expenditures while the other component will follow the report-based disbursements since PADS has been using this disbursement method for almost five years. The quarterly Interim Financial Report (source of funds and use of funds per category) will be supplemented by: (i) bank reconciliation statements of the designated and the operational accounts; (ii) cash flow forecast for the following quarterly; and (iii) the list of payments against contracts that are subject to Bank prior review. Disbursements between PADS and the COGES for the RBF subcomponent will be made against certified statement of expenditures for PBHS delivered under the relevant Sub-project and to be paid out of the relevant Sub-grant. The certified SOEs will include unit prices, PBHS delivered and amount reimbursed to the COGES. The SOE will be signed by the PADS certifying that amounts were reimbursed in line with legal agreements and the manual.

Table 3 - Disbursement arrangements for IDA and HRITF



Legend	*Transfers of funds* *Flow of documents* *Payment to suppliers*	

Procurement

129. **General.** Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits & Grants By World Bank Borrowers" dated January 2011 and "Guidelines: Selection and Employment of Consultants Under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011, and the provisions stipulated in the Financing Agreement.

130. **Prior-Review Thresholds**. Prior-review and procurement method thresholds for the project are shown in the following table.

Table 4 - Procurement and selection review thresholds

Expenditure Category	Contract Value (US$) (Threshold)	Procurement Method	Contract Subject to Prior Review
1. Goods	≥ 500,000	ICB	All contracts
	< 500,000	NCB	Review of the first 2 contracts from all entities in charge of procurement
	< 50,000	Shopping	
	No threshold	Direct contracting	All contracts
2. Consultants **Firms**	No threshold	QCBS; LCS; FBS	All contracts of US$200,000 and more and the first 2 contracts below US$200,000
	< 100,000	CQ	Review of the first 2 contracts from all entities in charge of procurement
Individuals	No threshold	IC (at least 3 CVs)	All contract of US$50,000 and more
	No threshold	Single Source (Selection Firms & Individuals)	All contracts
3. Training and workshops	No threshold	On basis of detailed and approved annual plan (with indication of venue, number of participants, duration and exhaustive budget, etc.)	

131. **Procurement implementation arrangements** Procurement activities at central level will be implemented by the Coordination Unit of the PADS who has experience of implementation of projects financed by the World Bank. At decentralized level, each health district will be responsible for procurement of small items estimated less than US$ 40,000 per contract. The PADS management unit will have directly in charge of all consultant selection, all procurement of large, complex and/or pooled procurement across beneficiaries.

132. Frequency of procurement reviews and supervision: Bank's prior and post reviews will be carried out on the basis of review thresholds indicated in Table 10. The Bank will conduct six-month supervision mission and annual Post Procurement Review (PPR); the ratio of post review is at least 1 to 5 contracts. The Bank could also conduct an Independent Procurement Review (IPR) at any time until two years after the closing date of the Project.

133. Risks and mitigation measures: In view of the experience of the PCU in carrying out procurement activities for the PADS, the overall Project procurement risk has been rated as moderate. The following measures are planned upon to mitigate the remaining risks:

Table 5 - Project Action Plan

Task	Completion	Intermediate milestones	Responsibility
1. Submit to the Bank the first's 18 month procurement plan	Completed		Project preparation team
2. Organize a procurement workshop focusing on shopping for Health districts benefit	By June2012 (not a covenant)		PMU
3. Prepare the procurement section of operational manual/ procurement section of project's procedures Manual (all included in the Project Implementation Manual)	Before effectiveness	Selection of consultant by November 15, 2011	PMU/Bank team

134. **Procurement plan.** All procurement activities will be carried out in accordance with the original or formally updated agreed procurement plan. The PCU will be responsible for the preparation and updating of procurement plan. The Procurement Plans will be updated at least annually or as required to reflect the actual project implementation needs and capacity improvements. An 18 months draft procurement plan has been prepared and found acceptable by IDA (November 16th,2011), with specific entries for: (a) goods, (b) Consultancy Assignments with Selection Methods and Time Schedule and (c) Capacity Building Activities with Time Schedule.

135. **Procurement of Goods.** Goods procured under this Project would include: vehicles, drugs and contraceptives, reproductive health equipments, delivery kits and waste management equipment, teaching materials (small midwifery laboratory for teaching schools**)**, etc... Goods procurement will be done using the Bank's SBD for all ICB and National SBD agreed with the Bank for National Competitive Bidding (NCB).

136. **International Competitive Bidding (ICB).** Each goods contract package estimated to cost US$500,000 equivalent and more per bid package would be procured through International Competitive Bidding.

137. **National Competitive Bidding (NCB).** For the supply of goods contract estimated to cost less than US$500,000 equivalent and locally available at commercial price would be procured through National Competitive Bidding (NCB) procedures acceptable to IDA.

138. **Shopping**. Procurement for readily available off-the-shelf goods that cannot be grouped, or standard specification commodities for individual contracts of less than US$50,000 equivalent, may be procured under shopping procedures as detailed in paragraph 3.5 of the "*Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits & Grants By World Bank Borrowers "* dated January 2011. The requests of solicitation will specify that offers should be submitted sealed and opened at a public opening session.

139. **Procurement from United Nations Agencies**: Contracts for vehicles may be procured from the Inter Agency Procurement Services Office of the United Nations, whose procedures have been found acceptable to the Bank.

140. **Community Participation in Procurement**: Activities related to social marketing of family planning and other similar activities carried out under PBHS Sub-projects may be executed through community participation procedures set out in the Project Implementation Manual.

141. **Direct contracting for Goods** may be only used on an exceptional basis and with the prior approval of the Bank in accordance with the provisions of paragraph 3.8 and 5.6of the Procurement Guidelines.

142. The **Selection of Consultants** would be as follows.

143. **Firms.** Consultancy services will be selected using Request for Expressions of Interest, short-lists and the Bank's Standard Requests for Proposal, where required by the Bank's Guidelines. The selection method would include Quality and Cost Based Selection (QCBS) whenever possible, Quality Based Selection (QBS), Fixed Budget (FBS), Least Cost Selection (LCS), Single Source Selection (SSS) as appropriate; all consultancy services contracts estimated to cost less than US$100,000 equivalent for firms could be awarded through Consultant's Qualifications (CQ).

144. **Individual Consultants (IC)**. Specialized advisory services would be provided by individual consultants selected by comparison of qualifications of at least three candidates and hired in accordance with the provisions of Section V of the Consultant Guidelines.

145. Short-lists of Firms for services estimated to cost less than US$100,000 equivalent per contract may be composed entirely of the national consultants in accordance with the provisions of paragraphs 2.7 through 2.8 of the Consultant Guidelines.

146. **Single Source Selection (SSS**). Single Source Selection may be used exceptionally in accordance with paragraph 3.8 to 5.6 of the Consultant Guidelines.

147. **Workshops, Seminars and Conferences.** Selection of consulting firms for training services estimated to cost US$100,000 equivalent or more shall be procured on basis of QCBS or QBS as appropriate. Training services estimated to cost less than US$100,000 equivalent per contract may be procured through CQS method. When appropriate, training may also be procured on the basis of Direct Contracting subject to review and approval by the Bank. The training (including training material and support), workshops, conference attendance and study tours will be carried out on the basis of approved annual programs that will identify the general framework of training activities for the year, including: (i) the type of training or workshop; (ii) the personnel to be trained (or criteria for selection if not yet known); (iii) the selection methods of institutions or individuals conducting such training; (iv) the institutions which will conduct the training (if known) (v) the justification for the training, how it will lead to effective performance and implementation of the project and or sector; and (vi) the duration of the proposed training;

(vii) the cost estimate of the training. Report by the trainee upon completion of training would be mandatory.

148. **Operating costs.** incremental expenses incurred on account of Project implementation, consisting of reasonable expenditures for vehicle operation and maintenance, communication and insurance costs, banking charges, rental expenses, office (and office equipment) maintenance, utilities, document duplication/printing, consumables, travel cost and *per diem* for Project staff for travel linked to the implementation of the Project, salaries of contractual staff for the Project and payments for overtime services performed by staff under PBHS Sub-projects (but excluding regular salaries of officials of the Recipient's civil service), with prior clearance from IDA. Operating costs financed by the project which involve procurable items will be procured in accordance with the Bank's procurement guidelines.

149. **Assessment of the Agency's Capacity to Implement Procurement.** Procurement activities and overall fiduciary responsibility will be carried out by the Coordination Unit of the PADS which is a structure depending of the Ministry of Health. During preparation phase of the PADS, a procurement assessment was carried out by the Bank. This assessment revealed that the Coordination Unit of the PADS was well staffed by a procurement specialist.

150. The assessment reviewed the organizational structure for implementing the project, the institutional arrangement and the capacity of project staff responsible for procurement. The assessment found that the PADS procurement department is composed by one staff who is very experienced with the Bank procedures. In the favor of the new procurement law and the decentralization of public financial expenditure, a Regional Commission was set in 2008 to handle procurement activities and award contracts. This commission will work for procurement at decentralized level through Health districts, but it presents weak capacities and lake of experience in Bank procurement procedures.

151. **Overall Procurement Risk Assessment.**

High	
Moderate	**X**
Low	

152. **Fraud, Coercion, and corruption.** All procuring entities, as well as bidders, suppliers, and contractors shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraphs 1.15 & 1.16 of the Procurement Guidelines and paragraphs 1.23 & 1.24 of the Consultants Guidelines.

153. **The details of procurement arrangement involving International Competition** are presented below.

Goods and Non Consulting Services:

Table 6: List of contract packages which will be procured following ICB

Ref. No.	Contract Description	Estimated Cost (US$ million equi valent)	Procurement Method	Prequalification (yes/no)	Domestic Preference (yes/no)	Review by Bank (Prior / Post)	Expected Bid-Opening date
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
	Reproductive health equipments, delivery kits and Waste management equipments	2,000,000	ICB	No	No	Prior	July 2012
	Teaching material (small midwifery laboratory for teaching schools**)**	1,000,000	**ICB**	**No**	No	Prior	October 2012
	Ambulances, Motorcycles	2,000,000	**ICB**	No	No	**Prior**	February 2013
	Contraceptive Products, and Drugs	3,000,000	**ICB**		No	**Prior**	July 2013

Consulting Services:

Table 7: List of Consulting Assignments with short-list of international firms.

1	2	3	4	5	6	7	8
Ref No	**DESCRIPTION**	**Amount ESTIMAT.**	**Selection Method**	**Prior and Post Review**	**Estimated Bid Opening Date**	**Estimated contract signing date**	**Comments**
1B-C1	Recruit a firm for Capacity building and monitoring services in RBF3,975,000	$3,900,000	QCBS	Prior	April 2012	July 2012	
1B-C1	Recruit a consultant (bureau d'etude) to provide local technical assistance for 3 years	$50,000	QCBS	prior	July 2012	October 2012	
1B-C1	Contracting of NGOs for Social Marketing of Family Planning	$3,960,000	QC	Prior	July 2012	October 2012	
	Recruitment of a consultant for the extension of RBF	$1,000,000	CI	Prior	February 2012	July 2012	
	RBF Training and workshop (1,000,000) and surveys (200,000)	$1,200,000	CI	Prior	February 2012	October 2012	

Environmental and Social (including safeguards)

154. Health facilities use medical equipment which might entail an increased production of medical waste. Consequently, the project has been classified as Category B for environmental screening purposes given the risks associated with the handling and disposal of medical and general health waste. This project is not expected to generate any major adverse environmental impact. Possible environmental risks include the inappropriate handling and disposal of hazardous medical waste, including sharp needles, and especially the inadequate management of disposal sites in urban or peri-urban areas, where domestic and medical waste may be mixed, and where scavenging is common. The project will help minimize the danger of poor segregation and disposal of health care waste through the training of health providers.

155. Because the project is classified as Category B for environmental purposes, an Environmental Assessment Report including a Medical Waste Management Plan was prepared, during preparation and disclosed in-country on March 3, 2011, sent to InfoShop on March 12, 2011, and is being implemented. There will be no new construction works under the project, although there will be minor refurbishing and painting of health facilities, such as the painting of windows, the replacement of some fixtures, and minor interior repairs, none of which would trigger a resettlement safeguard policy.

Monitoring & Evaluation

156. Project processes will be monitored by the Operations Officer, based in Ouagadougou. During the early stages of project implementation, progress monitoring will focus on procurement activities against the agreed procurement plan, implementation of the agreed action plan and Environmental and Social Management Framework (ESMF).

Annex 4: Operational Risk Assessment Framework (ORAF)

BURKINA FASO Reproductive Health Project

Stage: Board

Project Stakeholder Risks	**Rating:**	**Substantial**		
Description: Marginal risk of competing influence by oppositional local leaders (in particular cultural and religious leaders / religious followings). The utilization of FP services is constrained by socio-cultural barriers and the resistance of religious leaders, spouses and mothers in law. There is a high desire among men (and women) to have many children, but a relatively low decision making power of women. The opposition of religious leaders could influence couples' decision and reverse their support for FP activities.	**Risk Management:** The project objective is closely aligned with the Government's forthcoming PRSP, National Population Policy and the Ministry of Health's strategy to introduce a nationwide RBF system. The project will support communication activities to sensitize community leaders and communities and to empower them to demand 'results' in service delivery. Existing Bank-financed technical assistance for the promotion of population control by CONAPO will strengthen stakeholder buy-in. Regular workshops hosted by the National Directorate for Population support will be held with key stakeholders - political, religious, traditional leaders. These workshops would promote an environment supportive to reproductive health women's rights.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** On-going
	Risk Management: The recently published World Bank Action Plan on Reproductive Health and the sub-Saharan Africa-specific Strategic Plan for Population and Reproductive Health will reinforce the linkages between reproductive health and the Bank's poverty mandate thereby mitigating any public perception risk that the objective of the project falls beyond the Bank's mandate			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
	Risk Management: Activities contracted through International and local NGOs would help improve access to FP information and develop friendly youth and adolescent health services in health facilities, schools and villages. It'll also help strengthen the capacity of Ministry of health in implementing the result based financing component of the project.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
	Risk Management: Unmet needs of women for contraception are high in Mali, and the RBF mechanism would provide incentives to encourage health service providers to promote RH and FP services and commodities.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
Implementing Agency Risks (including fiduciary)				
Capacity	**Rating:**	**High**		
Description: As RBF is new to the country, limited implementation capacity of the MOH could lead to delays in project implementation. Capacity relatively well developed at the central level, but gaps were identified at regional and districts levels, but were more acute in	**Risk Management:** International TA will be provided to help implement the RBF pilot, with a timeline for knowledge transfer. On the technical side, the project will train doctors, nurses, and midwives in RBF, FP, RH, and obstetric care.			
	Resp: Client	**Stage:** Implementation	**Due Date:** October 2012	**Status:** Not yet due
	Risk Management: The project will strengthen the MOH procurement, financial management and internal audit capacity at district and community level. The PADS' internal audit unit will continue to perform its internal audit mission jointly with the Inspectorate of Ministry of Health and make use of the risk map developed in this Ministry. The current manual of procedures will be amended to include a new delegation of authority (specifying the signatories at both central level and local health management community level). The risk map will be revised to include the RBF.			

community health centers. Limited institutional capacity of the MOH and Directorate of Population to implement population policies targeting all segments of society. The financial management performance of implementing agency PADS was rated moderately satisfactory. Despite recent efforts by the MOH, it is still very difficult to post skilled health personnel, such as midwifes in rural and remote areas.	The project will also strengthen M&E so as to improve the health information system.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
	Risk Management: Communication and coordination between the key stakeholders of population control and RH interventions will be strengthened. Civil society will play an important role in conveying beneficiary concerns within the National Coalition for Population Control. National Population Strategic plan will be assisted for implementation and advocacy.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
	Risk Management: RBF bonuses would enable health providers to maintain an adequate stock of drugs and supplies by complementing what they receive from the MOH.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
	Risk Management: Existing capacity of MOH staff will be complemented by contracting local and international NGOs to work in remote community. NGOs would develop a network of community health workers and mobile teams who would work in coordination with the MOH health staff based in health facilities. For the fiduciary capacity, need to: (i) reinforce the fiduciary team with additional staff; and (ii) improve the reporting by NGOs which are new executing entities. PADS existing budget, accounting, internal control, internal and external audits, and reporting procedures will be amended to include the RBF specifics, including: (i) PBHS to be financed and unit prices to be paid per package: (ii) the revision of the chart of accounts; (iii) a simplified reporting system to track the PBHS and their costs; (iv) the management of the PBHS Sub-grants; and (v) the verification of unit prices.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
Governance	**Rating:**	**Substantial**		
Description: Health facilities may exaggerate or falsify their records in order to obtain more funds, thereby corrupting the health management information system.	**Risk Management:** Strong internal verification systems will be complemented by regular external verification of health facilities' records and by the fact that sanctions would be imposed on any facilities found to have exaggerated their records.			
	Resp: Client	**Stage:** Implementation	**Due Date:** July 2012	**Status:** Not yet due
Project Risks				
Design	**Rating:**	**Substantial**		
Description: In order to obtain additional resources, health facilities may focus excessively on the quantity of services they provide. RBF, if not properly designed, can worsen inequities by giving more resources to facilities to which the community already has easy physical access while underfunding those in more remote areas. RBF could have the unintended consequence of over-emphasizing certain services. There's a risk that we have a lack of demand, lack of supply inputs (contraceptives or funding) and	**Risk Management:** Facilities will be dissuaded from focusing more on quantity than quality because measures of quality are incorporated into the criteria for reimbursing health facilities under RBF Sub-grants			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
	Risk Management: To address geographical equity concerns, the amount of PBHS Sub-grants would be adjusted to take into consideration higher costs of providing services in remote areas.			
	Resp: Client	**Stage:** Implementation	**Due Date:** Feb 2015	**Status:** Not yet due
	Risk Management: The unit prices associated with specific services can be adjusted so as to rebalance the package of services offered.			
	Resp: Client	**Stage:** Implementation	**Due Date:** May 2012	**Status:** Not yet due

risk that the new approach is too complex to be implemented.				
Social & Environmental	**Rating:**	**Low**		
Description: The project is classified as Category B for environmental screening purposes given the risks associated with the handling and disposal of medical and health waste.	**Risk Management:** The MOH has updated the existing Medical Waste Management Plan March. This Plan includes measures for capacity building needs, training, and awareness building to ensure its proper and effective implementation.			
	Resp: Client	**Stage:** Preparation	**Due Date:** December 2016	**Status:** Completed
Program & Donor	**Rating:**	**Low**		
Description: Many donors are involved in FP/RH funding and technical support. Difference of views between donors involved in project.	**Risk Management:** This is a small risk as it is an issue that has been present since the inception of the HRITF. IDA mitigates this risk by providing regular reporting to donors on progress in implementation and results indicators. The project would organize regular donor coordination meetings and participate actively in the PNDS RH sub-group.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** In progress
Delivery Monitoring & Sustainability	**Rating:**	**High**		
Description: have the ownership and commitment to continuing project activities and policies. Insufficient capacity to ensure timely and accurate measure of health sector performance could result in delays if new indicators and data collection methods have to be put in place.	**Risk Management:** This is a small risk, as experience from other countries shows that implementing agencies are highly motivated by the RBF approach which improves working conditions, benefits, and health outcomes. Also mitigated through training and verification measures. The MOH has a basic health information system that collects most key indicators required for the project on a routine basis. However, a few more will need to be developed. Formats from other similar projects using RBF will be used and adapted to the local context of Burkina Faso.			
	Resp: Client	**Stage:** Implementation	**Due Date:** December 2016	**Status:** Not yet due
Overall Risk Following Review				
Implementation Risk Rating:	**Substantial**			
Comments:	Comments: Despite the government's strong commitment to the project, several risks persist: (i) the limited implementation capacity for large scale population projects specially related to the introduction of a new mechanism, the RBF, in a relatively low-capacity setting and especially at the local level, and (ii) the limited fiduciary capacity of the implementing agency. Experience from other countries shows that these and the other risks identified above can be successfully mitigated through a gradual scale-up, TA and training. These mitigation measures have already started and will continue during project implementation.			

Annex 5: Implementation Support Plan

BURKINA FASO: Reproductive Health Project

Strategy and Approach for Implementation Support

157. The project will need intensive supervision given the geographic spread of the proposed operation (10 districts in 5 regions), and given implementation capacity weaknesses at the country and project level. The project will be implemented at three levels: the central MOH, regions, and districts. A budget of US$150,000 would be required for the Bank team to thoroughly supervise the project during the first 12 months of implementation.

158. The supervision by the Bank will be leveraged by the supervision carried out by the MOH and the PADS on a regular basis. The MOH will have teams visiting each district four times a year for a period of about 8 days each and will prepare action-oriented supervision reports that will be reviewed by the Bank and donors during their bi-annual supervision missions, and through desk reviews. This system will allow the MOH to distinguish between the better and lesser-performing regions and districts, and provide more assistance to the latter. Sufficient funds to that effect have been included in the project design with a total of about US$600,000 allocated for fuel and per diem over a five-year period.

159. The overall supervision of RBF implementation (75% of project cost) will be the responsibility of the health district/regional directorates and a private entity to be contracted for the verification of health services delivery and verification of health facilities reporting. The entity will verify the reported quality performance through regular data quality audits at the source, to carry out regular community client satisfaction surveys, and maintain a server with a web-enabled performance database. Bank supervision will consist in ensuring that the entity is performing its functions properly according to the terms of its contract through direct interaction with the entity, sample verification of its records, and interviews and feedback from the MOH, selected districts, and health facilities interacting directly with the entity.

160. Some of the skills required by the Bank team for supervision will be needed on a regular basis while others will be required on an ad hoc basis. It is therefore proposed to establish a core supervision group, that will emphasize financial, procurement, RBF, and operational basic needs, complemented by technical specialists, in particular those covering reproductive health, and monitoring and evaluation.

161. While regular Bank (and donors) supervision will take place twice a year, this will be leveraged by regular visits each per year by the country-based Bank health sector, procurement and financial management specialists who take advantage of their field presence to verify progress and provide ongoing assistance to the client.

162. A much more intensive than normal supervision program should be carried out during the first year of the project to put in place a sound institutional base and properly begin interventions to be undertaken by this complex operation.

163. While the MOH will benefit from the experience of the PADS staff that has a long experience in project management, there will be an incubation period during which they will plan and organize the work with regions and districts. There may also be some new MOH staff without knowledge of Bank procedures and standards and there will be a learning curve for the development of a smooth-working team and to get the supervision program under way. The priority technical specialists will provide support periodically, as required. The emphasis of the supervision missions will be in getting the project up and running, with particular stress on capacity development of provinces and municipalities.

164. The supervision team includes the following members: (i) the *Task Team Leader* with experience in health systems; (ii) a *reproductive health specialist*; (iii) a *senior implementation specialist*, to help in the critical first half year of project implementation; (iv) a RBF specialist with technical expertise in the field; (v) a *financial management specialist* who will review adherence to Bank procedures with regard to fiduciary responsibilities; and (vi) *procurement and implementation specialists*, responsible for procurement, implementation, and institutional issues; and (vii) *an environmental specialist*.

165. *Financial management*. FM implementation support missions will use a risk-based approach, and collaborate with the Task Team, including the procurement specialist. A first implementation support mission will be performed six months or earlier after effectiveness, especially for the review of RBF mechanisms. Afterwards, the missions will be scheduled by using a risk-based approach model and will include the following: (i) monitoring of the financial management arrangements at intervals determined by the risk rating assigned to the overall FM Assessment at appraisal, and subsequently during implementation; (ii) review the IFRs; (iii) review the audit reports and management letters from the external auditors and follow-up on material accountability issues by engaging with the Task Team Leader, client, and auditors. The quality of the audits (internal and external) will be monitored closely to ensure that they are comprehensive and provide enough confidence on the appropriate use of funds by the client; and (iv) physical supervision especially for the RBF mechanism; and (v) assistance to build or maintain appropriate financial management capacity.

166. The supervision team will be complemented by representatives of donors. As during the preparation process, technical partners, including UNICEF, WHO, and UNFPA, will be invited to participate in supervision missions to ensure the good quality of health interventions and project implementation, build strong partnerships, and facilitate a cross-fertilization of experiences. Areas of technical consultant support to highlight are RBF, IEC and BCC, and monitoring and evaluation (including KAP surveys).

Time	***Focus***	***Skills Needed***	***Resource Estimate***	***Partner Role***
First twelve months	*Setting up RBF and other components*	*Team Leadership, RBF, RH, FM, Procurement, implementation, environment*	*$150,000 per year*	*Technical support and policy dialogue*
12-48 months	*Operation of RBF and other components*	*As above*	*As above*	*As above*
Other				

Skills Mix Required

Skills Needed	***Number of Staff Weeks***	***Number of Trips***	***Comments***
Team Leadership	*8*	*2*	
Implementation specialist	*4*	*2*	
RBF Specialist	*4*	*2*	
RH specialist	*4*	*2*	
FM	*3*	*1*	
Procurement	*3*	*1*	
Environment	*2*	*1*	

Partners

Name	***Institution/Country***	***Role***
UNICEF, WHO, and UNFPA		*Technical support on RH issues*

ANNEX 6: RESULTS-BASED FINANCING

BURKINA FASO: Reproductive Health Project

167. **Background**. Burkina Faso has distinguished itself by acquiring political consensus on RBF in record time. In September 2009, the country organized a National RBF Workshop in Ouagadougou. In parallel, donors mobilized international experts to support the Ministry of Health (MOH). The Bank, WHO, UNICEF, and the Dutch Cooperation provided experts to work with the national team, and a series of three workshops were organized. They mobilized over 100 stakeholders from the government, NGOs and the private sector and the donor community, including all senior policy makers from the Ministry of Health, hospitals, training institutions, Regional Directorates and Districts Managers. The Ministry of Economy and Finance and the Ministry of Civil Service and Administration Modernization also participated.

168. Burkina Faso intends to introduce RBF in the health sector in a phased way so as to eventually reach nationwide coverage. Minimum inputs necessary for the sector such as personnel, drugs, contraceptives, supplies, and major equipment will continue to be purchased centrally, but under RBF the government will provide complementary financing under this Financing by making PBHS Sub-grants to health facilities, for the delivery of agreed-upon packages of basic health services (PBHS), to be partially reimbursed on the basis of predetermined unit prices for each package of services, calculated on the basis of the costs -- adjusted for quality -- of the additional inputs required to deliver the service. This changes health management dynamics from a passive one in which health facilities' personnel wait for patients to show up (e.g. for a family planning consultation) into an active one whereby health personnel develop links with the community to encourage patient visits, as the reimbursements under the PBHS Sub-grant now give them the incentive to do so. In October 2009, the MOH created a technical unit in charge of producing RBF tools and manuals.

169. **Objective**. The general objective of RBF is to change the behavior of health providers at facility level for them to deliver more quality services. The specific objectives are to:

(i) provide cash at facility level to cover the additional costs of delivering improved services and removing the need for 'informal' fees;
(ii) provide financial incentives to facilities in order to increase productivity and quality of care, especially for the identified key indicators; and
(iii) Increase the equity of distribution of resources between urban and rural areas, with funds from RBF being used to hire contractual health workers and finance outreach activities.

170. **Selection of health districts and facilities to benefit from RBF sub-grants.** In Burkina Faso, the implementation of RBF takes place within an experiment, which will enable Government to determine if RBF improves health system performance. In order to answer this question, an ideal experiment has to be randomized, controlled and prospective, as for a clinical trial.

171. RBF will be implemented in selected health districts in five regions out of the 13 existing. Three criteria have been used to select these districts. The regions were chosen with a geographical balance that will provide implementation experience in different contexts and allow broad capacity building that will be useful for a future expansion. Out of the 5 regions, 4 have health indicators below the national median. The fifth, which has better health indicators, will allow testing RBF in a higher capacity setting, hence contributing to overall learning.

172. The project will build partnerships with UNICEF and UNFPA which are present in the same regions. There is no duplication with any other similar intervention financed by other donors.

173. Within each region, two districts were chosen which had the lowest achievement of a series of 4 indicators: (i) contraceptive prevalence rate: (ii) assisted deliveries; (iii) antenatal consultations and (iv) post-natal consultations. In the Boucle du Mouhoun region, Segenega district was excluded because an NGO is currently supporting an RBF pilot operation, which would be a confounding factor.

174. The 10 selected districts are presented below. A study will be carried out to expand the delivery of PBHS beyond the Targeted Districts to other districts of the Recipient's territory.

Table 8 - Selected districts for RBF

Region	"Treatment" District	Control District
Boucle du Mouhoun	Nouna	Tougan
Central North	Boulsa	Kaya
Central West	Koudougou	Léo
North	Titao	Ouahigouya
South West	Batié	Diébougou

175. In each region, there will be one "RBF treatment" district and one "RBF control district". In the "treatment" district, health facilities will receive PBHS Sub-grants. In the "control" district, health facilities will also benefit from PBHS Sub-grants, but the amount of these Sub-grants will be capped and therefore not entirely based on performance achieved by facilities. The cap will be the average of amounts of all PBHS Sub-grants received by all "RBF treatment facilities". These facilities will be called "RBF control facilities".

176. The experiment will also be prospective, given that a baseline study will be conducted by the bank before implementation of RBF under another project (HRITF grant-impact evaluation). A follow-up survey and evaluation will be conducted at the end of year 3.

177. **Institutional arrangements.** Each of the key functions of performance-based financing - purchasing, verification, regulation, service delivery and reimbursement for services - will be performed by the existing structures of the MOH, district health management teams, and health facilities.

178. **Purchasing and verification**. The experience from other countries[19]shows that pilot RBF phases are best managed by contracted private entities, including local organizations and community-based entity. As capacity is built, countries may evolve towards a semi-public management.

179. In the case of Burkina Faso, a private entity will be contracted by the MOH. The entity will help DEP manage PBHS Sub-grants and disburse reimbursements under the Sub-grants to health facilities based on the information provided by monthly evaluation reports. The amounts transferred for recurrent costs will be based on the unit prices of services (ref annex 8) provided by the health facilities for different PBHS. A quality score will also be used to discount the amount transferred.

180. The tasks of the private entity will be to help DEP: (i) draft and negotiate PBHS Sub-grant agreements with the health facilities; (ii) verify the reported quality performance through regular data quality audits at the source; (iii) provide training, basic equipment and consulting services to DEP; (iv) carry out regular community client satisfaction surveys; (iv) maintain the server which hosts the web-enabled database and to enter the performance data in this database; and (v) build capacity at all levels (national, regional, and district) support the RBF approach.

181. **Elaboration of the RBF framework.** The RBF approach will be implemented through PBHS Sub-grant agreements between government and health facilities. Before this process begins, an RBF framework will be elaborated by the DEP and approved by the Steering Committee and the Bank. Its adoption (as part of the Project Implementation Manual) will be a condition of effectiveness. This framework will be valid for the duration of the project, but could be revised each year, subject to World Bank approval. It will include the following elements:

- The specific PBHS to be delivered
- Maximum allocation of PBHS Sub-grant amounts for each year of the project and for each district;
- Outputs to be financed by PBHS Sub-grant;
- Methodology and procedures for calculating and updating the unit prices for determining amounts to be paid under PBHS Sub-grants for each PBHS delivered (the methodology will be designed to ensure that the unit prices do not exceed the reasonable cost of the package (which cost in turn excludes the costs of inputs for the PBHS that are financed through other means – eg., equipment and supplies under component 2; civil servant salaries), and are scaled to reflect the quality of the output and conditions of the district and the need to ensure balance with other services needing to be delivered.
- Initial unit prices for each PBHS;
- A template of the PBHS Sub-grant agreement
- Procedures for approval, monitoring and evaluation of PBHS Sub-projects and for granting of PBHS Sub-grants, including the designation of the local health verification team for each targeted district to be responsible for the verification of

[19] Rwanda, Burundi, Democratic Republic of Congo, Cameroon, Central African Republic, Zambia, Indonesia and planned for Chad and Zimbabwe.

the quality and quantity of the PBHS delivered under each PBHS Sub-project to be carried out in its district; and for development and delivery of training under the Project.

- Rules for the use of reimbursements made under PBHS Sub-grants.

182. **Determination of the maximum allocation for RBF.** The maximum annual amounts allocated under PBHS Sub-grants for each district and for each facility will be set out in the Project implementation manual. However, the maximum amounts allocated to a given district per year will in any event not exceed the equivalent of $300,000.

183. During the first 3 years, 50% of the total RBF budget will be for "treatment" facilities and 50% for "control" facilities.

184. **Determination of PBHS to be delivered under PBHS Sub-projects.** Although the final list of PBHS will be confirmed (in the Project implementation manual), the tentative list for a primary health facility is so far the following.

Table 9 – List of Services (Quantitative outputs) to be included under PBHS Sub-projects

Maternal and Child Health Care Services	
1.	Antenatal care visit
2.	Assisted delivery
3.	Postnatal care visit
4.	Family planning visit
5.	Fully immunized children
6.	Childhood disease according to the IMCI approach
7.	Severe acute Malnutrition
8.	Complicated malaria /MC-RH
Other Health Care Services	
9.	Obstetric emergency: Caesarean section
10.	PMTCT to Pregnant women who are HIV positive
11.	Antenatal care visit for a woman with malaria and receiving intermittent presumptive treatment
12.	Uncomplicated malaria /HSPC
13.	ARV treatment and followed up
14.	screening for TB

185. **PBHS Sub-grant payments**. The payment under PBHS Sub-grant for each of these PBHS will be based on a unit price calculated to reflect the cost of the PBHS, adjusted for quality of care and whether any of the inputs needed for the particular PBHS are financed under other sources (e.g., any drugs/equipment financed under component 2 or civil service salaries financed by Government would be excluded from the cost of the PBHS). The methodology for determining the unit prices and the initial unit prices will be specified in the Project Implementation manual. The final list of indicators for measuring quality of care will be included in the RBF framework. A preliminary list is presented below.

Table 10 – Qualitative outputs to be reflected in determining unit prices for each PBHS

1.	Percentage of antenatal care visits complying with quality standards
2.	Percentage of family planning visits complying with quality standards
3.	Percentage of child outpatient visits complying with quality standards
4.	Follow-up of labor and deliveries complying with quality standards

5.	Percentage of postnatal care visits complying with quality standards
6.	Average availability of essential drugs in health facilities
7.	Cleanliness of health facility
8.	Average availability of health workers (one minus rate of absenteeism)

186. During appraisal unit costs of PBHS to be financed were calculated to determine the unit price to be paid for each PBHS, and will be finalized and reflected in the Project Implementation Manual. During implementation, disbursements will be made based on reported delivery of PBHS which, as with traditional projects, will be periodically verified by the task team. Thus, since reliable unit costs and unit prices will be set, once outputs are evidenced during implementation, this will provide the clear basis for disbursement. In estimating the costs of PBHS during appraisal, alternative information sources of information were taken into account, some of which were technical in nature (e.g.: universities, Ministry of Health, independent technical consultants) and some which were market based (e.g.: technical/trade associations, supplier surveys, contracted expert consultants). More than one source was used for determining costs so as to avoid a "unique source bias." According to the OPCS guideline on output based disbursement (OBD), this is important since at this stage, OBD becomes an alternative to otherwise direct procurement/bidding processes for setting cost/price parameters.

187. The unit prices to be paid for each PBHS will be re-estimated more precisely before the start of the RBF process and will be updated annually not later than March 1 in each year. The initial unit costs and unit prices approved by the Bank will be included in the Project Implementation Manual. Several specific PBHS will benefit from a higher subsidization by RBF. Conversely, other outputs will receive a lower RBF subsidization. For instance, given that immunization rates are already high in Burkina Faso, this item will have a lower RBF subsidization.

188. The cost estimates on the basis of which unit prices are determined provide preliminary evidence that through the RBF mechanism the project will ensure that PBHS delivered will be reimbursed at a level well below the additional costs of the PBHS (ie, excluding costs financed from other sources). Moreover, the unit prices will be assessed annually by March 1 and revised as needed to ensure they continue to respect these criteria. Consequently, this mechanism is compliant with the guidelines on Output-Based Disbursement Mechanisms (OPCS, April 2007).

189. **Templates for Sub-grant Agreements.** A template for PBHS Sub-grant Agreements will be elaborated in the Project Implementation Manual.

190. **Preparation and execution of RBF training.** Before launching the award of PBHS Sub-grants, decision-makers have to be extensively trained in RBF, especially at the district and health facility levels. The following training will be prepared and implemented by the MOH, with support from the international RBF firm and the districts.

Table 11 - Description of the RBF training activity

Kind of activity and population aimed	Content of the message	Modes	Responsible
RBF training for health care facility managers, district health teams, and	The whole procedures manual, with exercises.	5 whole days (for each district)	DEP

Regional Health Authorities			

191. **Negotiation of PBHS Sub-grants.** In accordance with «bottom-up planning» logic, the PBHS Sub-projects will first be discussed between health district teams and health facilities managers. The draft proposals will then be sent to the DEP for approval. When approved, the Sub-grant agreement will be negotiated by the health district officer.

192. **Eligibility criteria.** To be eligible for a PBHS Sub-grant: (a) the proposed PBHS Sub-project must be technically feasible and economically and financially viable; and in compliance with the Health Care Waste Management Plan; and (b) the proposed health service provider must be a public or a private non-profit health service provider located in a targeted district, with the organization, management, technical capacity and financial resources necessary to carry out the proposed Sub-project and have prepared a satisfactory financing plan and budget, and implementation plan for the proposed Sub-project.

193. **Maximum amount of a PBHS Sub-grant.** The maximum amount of each Sub-grant may not exceed 100% of the total estimated cost of the PBHS Sub-project (excluding the costs of other inputs required for the Subproject and to be financed out of other funds).

194. **Prior Bank approval.** The first three Sub-grants, regardless of cost; and each Sub-grant for an amount equivalent to $30,000 or more would be subject to prior Bank review.

195. **PBHS Sub-grant Agreements.** Under the PBHS Sub-grant agreement, each health service provider will be required, among other things, to (a) carry out its PBHS Sub-project in accordance with the Project Implementation Manual, the Health Care Waste Management Plan and the Anti-Corruption Guidelines; (b) procure the goods and services required for its Sub-project and to be financed out of the proceeds of the PBHS Sub-grant in accordance with the Bank's Procurement and Consultant Guidelines; (c) monitor and evaluate its Sub-project; and (d) maintain an appropriate financial management system and prepare financial statements acceptable to the Bank, adequate to reflect its operations, resources and expenditures, including those related to the Sub-project; and have these financial statements audited at the Bank's request.

196. **Communication on RBF implementation.** Once PBHS Sub-grant agreements are signed, their content will be widely disseminated, through the following communication campaigns.

Table 12- Description of the RBF training activity

Kind of activity and beneficiaries	Content of the message	Modes	Responsible
Communication on RBF to workers in health facilities.	CONTENT: Explain indicators, monitoring, evaluation and modes of RBF payment. - IMPORTANT : During the communication, a simulation of their RBF allocation should absolutely be presented to the health workers (for each category according to different levels of achieved results)	- Half-day session, in each facility, with 2 hours of presentation and 2 hours questions-answers. - Distribution of a synthetic note to participants.	DEP for preparation and implementation.

Communication on RBF to local representatives, community representatives and private sector representatives.	- CONTENT: Explain indicators, monitoring, evaluation and modes of RBF payment. - IMPORTANT: This communication should show to population representatives that health workers are now responsible for the health care quality.	- Meeting in each district, with a presentation (1h), followed by questions and answers (1h). - Distribution of a summary note to participants.	DEP for preparation and implementation.

197. **Measurements and controls of the results.** As mentioned earlier, to measure the achieved results in each health facility and therefore to determine the amount of a PBHS Sub-grant it can receive, 22 indicators will be monitored. Fourteen (14) will be quantitative indicators, reflecting the utilization of health care facilities, while seven (8) indicators will be for quality of care. These indicators are described in the table below.

Table 13 - Indicators for PBHS delivered

Quantitative indicators	
Maternal and Child Health Care Services	
1.	# of pregnant women making two or more antenatal care visit
2.	% of assisted delivery
3.	% of postnatal care visit
4.	Percentage of women aged 15-19 who know of at least one modern family planning method
5.	% of fully immunized children
6.	% of Childhood disease screened according to the IMCI approach
7.	% of children under five with severe acute Malnutrition being treated according to the new protocol
8.	# Complicated malaria treated according to protocol
Other Health Care Services	
9.	% of Caesarean section
10.	Number of pregnant women who are HIV positive and receiving PMTCT
11.	Antenatal care visit for a woman with malaria and receiving intermittent presumptive treatment
12.	Uncomplicated malaria treated
13.	Number of persons under ARV treatment who are followed up
14.	Number of persons screened for TB
Qualitative indicators	
9.	Percentage of antenatal care visits complying with quality standards
10.	Percentage of family planning visits complying with quality standards
11.	Percentage of child outpatient visits complying with quality standards
12.	Follow-up of labor and deliveries complying with quality standards
13.	Percentage of postnatal care visits complying with quality standards
14.	Average availability of essential drugs in health facilities
15.	Cleanliness of health facility
16.	Average availability of health workers (one minus rate of absenteeism)

198. Health facilities will not all be assessed on the basis of the same set of indicators:

- for primary health centers (PHC), all indicators will be used;
- for hospitals, only the quantitative indicator for "hospital care" and the 7 qualitative indicators will be used.

199. The reason for this choice is that assigning quantitative indicators for outpatient care to hospitals would provide them with an incentive to compete with PHC on the same services (staff and equipment) as PHC have. More importantly, such an incentive could disrupt the already fragile referral system (i.e. hospitals would try to attract as many cases as possible, even those that could have been adequately treated at PHC level).

200. All indicators will be first measured by health facilities managers and then controlled by various entities (see below), including:

- District health teams;
- "District controllers", who are independent technical assistants permanently based in each district sub-contracted by the international RBF firm, to be selected at the beginning of the project);
- Community-based organizations (CBOs), which are sub-contracted by the "M&E" third party (international firm) during years 1 and 2. In subsequent years (3 and 4), they will be funded directly by the MOH, as they are expected to gradually replace "district controllers" (for the sake of sustainability).

201. The timing and responsibilities for measurement and control can be described as follows.

Table 14 - Measurement and controls for RBF indicators

	Measurement		**Control**	
	When ?	**By who?**	**When?**	**By who?**
Quantitative indicators (14)	Monthly	Health facility teams	Monthly	District health teams, "district controllers" and CBOs
Qualitative CBOs indicators (8)	Quarterly		Quarterly	

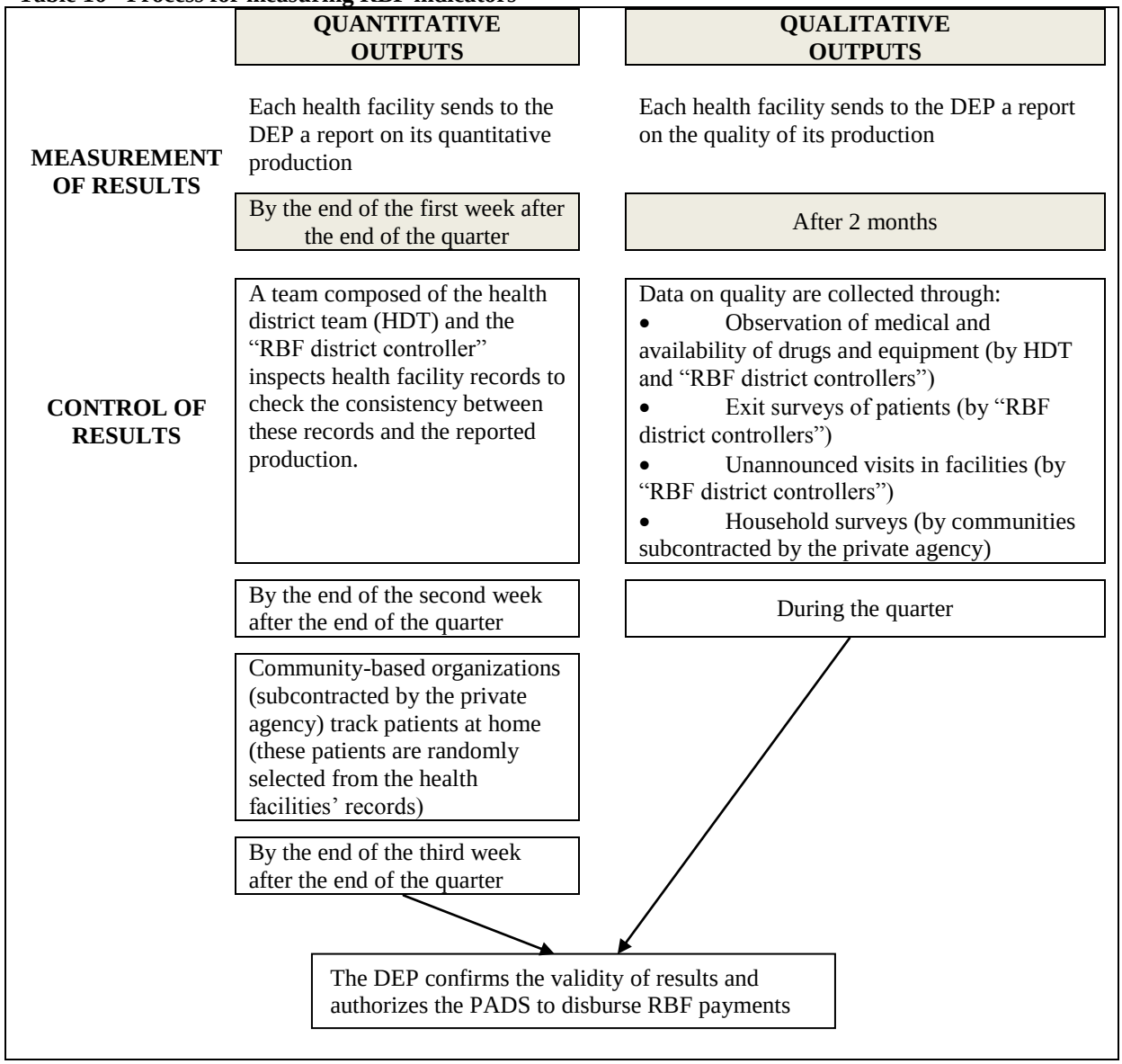
202. For control, several instruments will be used. Whenever possible, each indicator is controlled through at least 2 different sources of data. One of these sources is the local community. The instruments are presented below.

Table 15 - Instruments for measuring RBF indicators

Instrument for data control	**For which indicator (as an example)?**	**By whom?**
Consistency check between reported indicators and facilities records	Number of antenatal care visits	District health teams and "district controllers"
Survey of patients at home (these patients will have been randomly selected from the list of patients mentioned in the facilities records)	Number of antenatal care visits	Community-based organizations
Direct observations	Availability of drugs	"District controllers"
Exit patients survey	Quality of antenatal care visits	"District controllers"
Unannounced visits in health facilities	Absenteeism of staff	"District controllers"
Test of staff skills and knowledge	Staff skills and knowledge	"District controllers"

203. **The process for measuring and controlling results is presented below**.

Table 16 - Process for measuring RBF indicators



204. The results of these monitoring activities will be presented to the facilities during district meetings (every six months).

Table 17 - Detailed description of indicators

Indicator	Measurement method	Control method
Maternal and Child Health Care Services	Facilities monthly reports	Control by District Health Team and district controllers: consistency check between reported outputs and facilities
1. Antenatal care visit		
2. Assisted delivery		
3. Postnatal care visit		
4. Family planning visit		

Table 17 - Detailed description of indicators

Indicator	Measurement method	Control method
5. Fully immunized children		records
6. Childhood disease according to the IMCI approach		
7. Severe acute Malnutrition		
8. Complicated malaria		
Other Health Care Services		
6. Obstetric emergency: Caesarean section		
7. Number of pregnant women who are HIV positive and receiving PMTCT		
8. Antenatal care visit for a woman with malaria and receiving intermittent presumptive treatment		
9. Uncomplicated malaria		
10. Number of persons under ARV treatment who are followed up		
11. Number of persons screened for TB		

Table 18 - Detailed description of indicators

Indicator	Numerator	Denominator	Measurement method	Control method
QUALITATIVE INDICATORS for MATERNAL HEALTH				
1. # of pregnant women making two or more antenatal care visit complying with quality standards	Number of antenatal care visits where all 9 required exams or actions (see comments) have been performed	Number of antenatal care visits	- Facilities monthly reports	- Control by "district controllers": Exiting patients survey
Comment: The 9 exams or actions required for each antenatal care visit are: 1. Information given on obstetrical complications, 2. Weight, 3. Blood pressure, 4. Urine check, 5. Blood sample 6. Height 7. Abdominal palpation 8. Advice about diet and 9. Provision of Sulfacoxine-pyrimethamine (**SP**).				
2. Percentage of family planning visits complying with quality standards (and knowledge of FP).	Number of family planning visits complying with quality standards (see comment)	Total number of family planning visits	- Facilities monthly reports	- Control by "district controllers": Exiting patients survey
Comment: Appropriate questions to patient during physical exam and justification of family planning method recommended.				
3. Percentage of child outpatient visits complying with quality standards	Number child outpatient visits complying with quality standards (see comment)	Total number of child outpatient visits	- Facilities monthly reports	- Control by "district controllers": Exiting patients survey
Comment: Appropriate filling up of consultation register. Appropriate diagnosis and treatment prescribed.				
4. Percentage of follow-up of labor and deliveries complying with quality standards	Number of women with labor follow-up and delivery complying with quality standards (see comment)	Total number of deliveries	- Facilities monthly reports	- Control by "district controllers": Exiting patients survey
Comment: Appropriate filling up of partogram				
5. Percentage of post-natal care visits complying with quality standards	Number of post-natal care visits complying with quality standards	Total number of post-natal care visits	- Facilities monthly reports	- Control by "district controllers": Exiting patients survey
Comment: Consultation protocol appropriately followed up, including suggestion on family planning and iron and folic acid				

Table 18 - Detailed description of indicators

Indicator	Numerator	Denominator	Measurement method	Control method
supplementation when necessary.				
6. Average availability of essential drugs in health facilities	Average number of essential drugs available	N/A	- Facilities monthly reports	- Control by "district controllers": Observation on site.
7. Cleanliness of health facilities	Average number essential equipments available and functional	N/A		- Control by "district controllers": Observation on site.
8.Average availability of health workers	Number of health workers of the facility present (or not present but with clear justification such as sickness or vacation).	Number of employed health workers in the staff roster		- Control by "district controllers": Unannounced visits to facilities.

205. **Determination of PBHS Sub-grant payments in treatment facilities**. PBHS Sub-grant payments are determined as follows.

206. **Measurement of achieved quantitative results**. As explained earlier, health facilities will report their quantitative production to the DEP. A team composed of district health officers and the external "district controller" will first check the consistency of these results with the health facility records. In addition, a random sample of patients mentioned in the health facility records will be contacted at home by a community-based organization, so as to verify that these results (outpatient visits and deliveries) are not fake ones.

207. Quantitative results to be taken into account in RBF are the ones in addition to baseline level. In other words, a facility that has "produced" 20 antenatal care visits more than the baseline level will receive funding under a PBHS Sub-grant only for the 20 additional visits (and not for its total production). Baseline level will stay the same along the Project. The objective is to make sure that facilities starting at low levels of production at baseline have stronger incentives for improvements than facilities with already high production.

208. As an example, for a given health facility, the quantitative results at the end of a quarter could be the following, after the various verifications mentioned earlier:

Table 19 - Quantitative results for a quarter in a given primary health care facility (example)

PBHS Delivered		Number produced in one quarter (in addition to baseline production)
Maternal and Child Health Care Services		
1.	Antenatal care visit	98
2.	Assisted delivery	75
3.	Postnatal care visit	70
4.	Family planning visit	12
5.	Children completely immunized	10
6.	Childhood disease according to the IMCI approach	66
7.	Severe acute Malnutrition cases	7
8.	Complicated malaria managed	34
Other Health Care Services		

9. Obstetric emergency care: Caesarean section	12
10. Pregnant women who are HIV positive receiving PMTCT	2
11. Antenatal care visit for a woman with malaria and receiving intermittent presumptive	8
12. Uncomplicated malaria treated	234
13. Number of persons under ARV treatment who are followed up	4
14. Number of persons screened for TB	6

209. Measurement of achieved qualitative results. Similarly, quality of care will be measured, mostly by the "district controllers" (see further for details).

210. Again, as an example, a given health facility could have achieved the following quality results at the end of a quarter:

Table 20 - Qualitative results for a quarter in a given health facility (example)

Indicator	Weight	Raw results achieved (%)	Weighted results (%)
1. Percentage of antenatal care visits complying with quality standards	16	76%	12.2%
2. Percentage of family planning visits complying with quality standards	12	68%	8.2%
3. Percentage of child outpatient visits complying with quality standards	12	55%	6.6%
4. Follow-up of labor and deliveries complying with quality standards	15	43%	6.5%
5. Percentage of postnatal care visits complying with quality standards	8	87%	7.0%
6. Average availability of essential drugs in health facilities	8	45%	3.6%
7. Cleanliness of health facility	8	59%	4.7%
8. Average availability of health workers (one minus rate of absenteeism)	21	70%	14.7%
Total	100		63.5%

211. **Determination of the PBHS Sub-grant amounts**. The distribution of PBHS Sub-grants is based on the size of the target population of each district. The total amount allocated by income is shared among the ten districts proportionally to the relative sizes of the target population in each outcome. It is expected that each district and health facility determines according to specific criteria a key of distribution of the retribution for caregivers. The table below summarizes the grant distribution by district and based on outcomes.

Table 21 - Sub-grants distribution by district and by outcomes (in US$)

	R.1	R.2	R.3	R.4	R.5	R.6	R.7	R.8.1	R.8.2	R.9	R.10
BOUCLE du MOUHOUN											
1. District of Nouna	62 944	302 726	37 506	8 134	21 941	535 543	303 276	309 252	279 746	146 558	97 587
2. District of Tougan	49 328	237 238	29 393	6 375	17 194	419 690	237 669	242 352	219 229	114 854	76 476
CENTRAL-NORTH											
3. District of Kaya	103 854	499 478	61 883	13 421	36 201	883 611	500 386	510 246	461 562	241 812	161 012
4. District of Boulsa	76 237	366 656	45 427	9 852	26 574	648 640	367 322	374 561	338 823	177 509	118 195
CENTRAL-WEST											

5. District of Koudougou	18 116	87 130	10 795	2 341	6 315	154 139	87 288	89 008	80 516	42 182	28 087
6. District of Léo	48 960	235 469	29 173	6 327	17 066	416 561	235 897	240 545	217 594	113 997	75 906
NORTH											
7. District of Titao	32 955	158 493	19 637	4 259	11 487	280 386	158 781	161 910	146 462	76 731	51 092
8. District of Ouahigouya	15 942	76 673	9 499	2 060	5 557	135 639	76 812	78 326	70 852	37 119	24 716
SOUTH-WEST											
9. District of Batié	16 483	79 273	9 821	2 130	5 745	140 239	79 417	80 982	73 255	38 378	25 554
10. District of Diebougou	23 670	113 838	14 104	3 059	8 251	201 387	114 045	116 292	105 196	55 112	36 697
Grants/outcomes/Districts	448489	2156974	267238	57959	156330	3815833	2160893	2203474	1993234	1044253	695322

NB: This distribution gives the total amount of USD 15,000,000 to be allocated among the targeted districts. Any deduction of other expenses from that amount and therefore any change in that amount would result in the automatic change in the levels of grants allocated by outcome.

212. **RBF « control » districts**. In the "RBF control facilities", PBHS Sub-grants will also be made, with payments under the Sub-grant being made every 3 months based on the quantity of PBHS delivered. But the amount will not be adjusted to reflect the qualitative results achieved by these facilities. Each control facility will receive a Sub-grant amount which cannot be higher than the average of all PBHS Sub-grants made to the "RBF treatment facilities".

213. This quite particular scheme ensures that all the facilities (treatment and control) receive comparable financial amounts. It allows measuring the effects attributable to the RBF mechanism. This "RBF effect" will not be confounded with the "additional resources" effect. In the past, some RBF experiments have been difficult to evaluate because of this problem. "Treatment" facilities were receiving much more important financial amounts than "control" facilities did. When health outcomes improved in « treatment » facilities, it was then impossible to distinguish between the "additional resources" effect and the "RBF" one.

214. **Payments under PBHS Sub-grants.** Payment for PBHS delivered will take place every 3 months, when the DEP has defined the amount of the payment for each facility. This payment will be directly sent to the health districts through the local health authorities and facilities accounts.

215. **Utilization of PBHS Sub-grant reimbursements by the facilities.** The precise rules to be followed for using RBF reimbursement will be defined in the Project Implementation Manual. "Control" facilities will comply with the same rules. A number of key principles will be as follows:

(i) Health facilities will have to spend a minimum portion of the reimbursement on equipment, drugs, training sessions, IEC actions or outreach.
(ii) Staff recruitment to be financed with reimbursements will not be allowed.
(iii) As for how reimbursements are spent (in compliance with the above-mentioned principles), decision making will depend on the type of facility.

216. **Annual accounting audit.** Each year, a financial audit of the health facilities benefiting from PBHS Sub-grants (treatment and control districts) will be carried out by an external auditor, so as to verify that the payments under these Sub-grants have been: (i) correctly received by the health facilities and their agents and in a timely manner; and (ii) used in accordance with the

rules defined in the Project Implementation Manual and the Burkina Faso public accounting rules.

217. **Sequencing of RBF implementation.** The expected sequencing of implementation would be as follows.

Table 22 - Sequencing of RBF implementation

	Year 1	Year 2	Year 3	Year 4	Year 5
New population ("treatment")	1.34	0.00	0.00	1.34[20]	0.00
New population (control)	1.34	0.00	0.00	0.00	0.00
Cumulated population ("treatment")	1.34	1.34	1.34	2.67	2.67
Cumulated population (control)	1.34	1.34	1.34	0.00	0.00
Total cumulated population	2.67	2.67	2.67	2.67	2.67
Payments per capita (US$)	1.00[21]	2.00	2.00	2.00	2.00
Total cost of RBF (US$)	2.67	5.34	5.34	5.34	5.34
Cumulated total cost of RBF (US$)	2.67	8.01	13.35	18.69	24.03

[20] New population control now starts receiving RBF
[21] Estimated to be implemented over a 6-month instead of one year, hence $1 per capita instead of $2

ANNEX 7: UNIT PRICES TO BE PAID

For Packages of Basic Health Services (PBHS)
BURKINA FASO: Reproductive health Project

218. In estimating the costs of PBHS during appraisal, alternative information sources of information were taken into account, some of which were technical in nature (e.g.: universities, Ministry of Health, independent technical consultants) and some which were market based (e.g.: technical/trade associations, supplier surveys, contracted expert consultants). More than one source was used for determining costs so as to avoid a "unique source bias."

219. **The choice of intervention areas:** The project will provide RBF sub-grants in 10 districts in 5 regions. Half of the 10 districts will be funded based on full RBF quantitative and qualitative indicators and the other half will receive an equivalent amount based on quantitative performance but will not be directly linked to qualitative performance. This allows having a proper comparator group to undertake the impact evaluation of RBF, a requirement of the Health Results Innovation Trust Fund (HRITF). The intervention areas are presented in table 22.

Table 23 : Choice of intervention areas

Regions	Health Districts	
	Intervention Districts	Control Districts
Boucle du Mouhoun	Nouna	Tougan
Central North	Boulsa	Kaya
Central West	Koudougou	Léo
North	Titao	Ouahigouya
South West	Batié	Diébougou

220. The outputs initially selected (the list will be finalize in the PIM) for results-based financing are presented in Table 23.

Table24: Outputs and indicators

Services	Outputs	Indicators
1. PNC refocused to all pregnant women (including common diseases of the pregnant woman)	R1: Prenatal care to all pregnant women (including common diseases in pregnant women) refocused.	# of pregnant women making two or more antenatal care visit
2. Childbirths	R2: attended childbirth (using a partogram) is provided	Follow-up of labor and deliveries complying with quality standards
3. Complications related to pregnancy and childbirth	R3: the management of obstetric emergencies (Caesarean + EUP + others) is correctly done	% of Caesarean section

Table24: Outputs and indicators

Services	Outputs	Indicators
4. Post-natal consultations	R4. post-natal consultations is provided according to standards	% of postnatal care visits complying with quality standards
5. Child immunization	R5: children aged 0 to 11 months are immunized using fixed and advanced strategies	% of fully immunized children (in DPT polio 3 and/or Pentavalent and AMV before 12 months)
6. Nutrition	R6: the management of severe acute malnutrition cases is done	% of children under five with severe acute Malnutrition being treated according to the new protocol
7. Child curative care	R7: the management of sick children under 5 years according to the IMCI approach	% of Childhood disease screened according to the IMCI approach
8. Diseases of special interest (malaria)	R8: malaria cases (uncomplicated/ complicated) are managed according to national protocols	R 8.1 Number of uncomplicated malaria cases tested and treated (according to protocols/standards) R 8.2 # Complicated malaria treated according to protocol (and standards)
9. Diseases of special interest (HIV/AIDS and TB)	R9: Provide PMTCT, clinical and laboratory monitoring of HIV positive pregnant women is provided	Number of pregnant women who are HIV positive and receiving PMTCT Number of persons under ARV treatment who are followed up Number of persons screened for TB
10. Family planning	Ensure family planning care	Percentage of women aged 15-19 who know of at least one modern family planning method Number of women using modern contraceptive methods Percentage of family planning visits complying with quality standards

221. Calculation of unit price for each PBHS. These were calculated in several steps: (i) the basic unit cost of the PBHS; and (ii) the application of a coefficient for difficulty of the producing the output; (iii) application of a coefficient for the quality of the PBHS delivered; and (iv) whether other sources of funds are used to finance the inputs required for the PBHS.

222. Unit costs are the actual basic production costs of an output and were calculated, as mentioned, using various sources of information.

223. The coefficient of difficulty was calculated using a Delphi technique using a panel of twenty health sector experts who assessed the relative weights of the outcomes using the following criteria: (i) the potential of a given output to lead towards achieving the corresponding MDG; (ii) the technical difficulty of producing the output; and (iii) the time taken to produce a unit of output.

224. The details of the calculations will be included in the Project Implementation Manual.

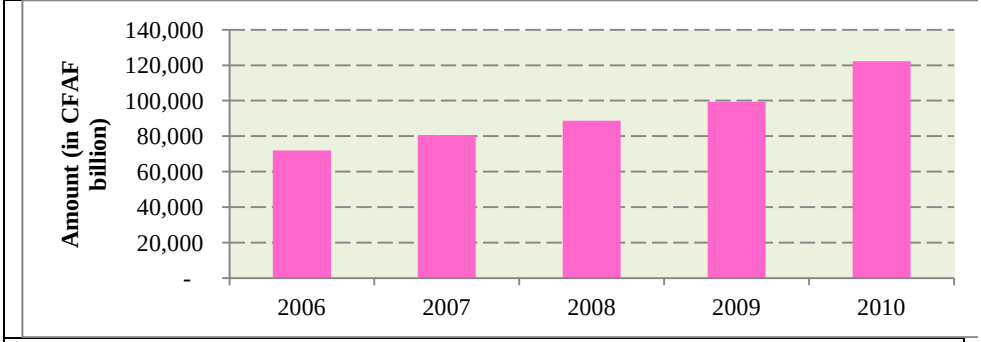
Annex 8: Economic and Financial Analysis
BURKINA FASO: Reproductive Health Project

225. **Financial analysis.** Sustainability of the benefits to be derived from the Burkina Faso's Reproductive Health Project (RHP) depends, to a greater extent, on the government's commitment to position reproductive health among priority programs, allocate significant proportion of its budget for recurrent expenditures associated with the delivery of health/reproductive health services in Burkina Faso. This section provides the analysis of health sector spending trends and resources required to sustain health/ reproductive services over the period of the project and beyond.

226. **Key macroeconomic outcomes**. Burkina Faso's macroeconomic performance has been remarkable over the past two years. Its real GDP growth increased from 3.2% in 2009 to 7.9% in 2010. Key factors that have contributed to this growth rate are the expansion in the agriculture and mining sectors, and increase in public investment. Over the same period, there has been significant improvement in revenue collections, with total revenue rising from 13.7% of GDP in 2009 to 15.6% in 2010. Total expenditures, however, accounted for 25.7% of GDP in 2010, a rise of about 1.3% from 2009 level, due mainly to a rise in investment spending. This situation resulted in an increase in overall budget deficit of 4.8% of GDP in 2009 to 5.6% of GDP in 2010 (IMF Staff Mission Statement, April 2011).

227. **Health sector financing**. In Burkina Faso, the health sector is financed from three sources: government budget, household's expenditure on health, and development partners' contributions. Public sector funding for health has increased markedly over the past five years. Available expenditure data in the national budget statements (2006-2009), and the health sector medium term expenditure framework (2010-2012), show a sustained increase in the government budgetary allocations to health. In 2006, total government expenditure, including external funding, on health amounted to CFAF 71.8 billion (US$154.2 million). Funding rose steadily to CFAF 122.2 billion (US$262.6 million) in 2010. Figure 1 shows trends in total government expenditure on health over the period 2006 to 2010.

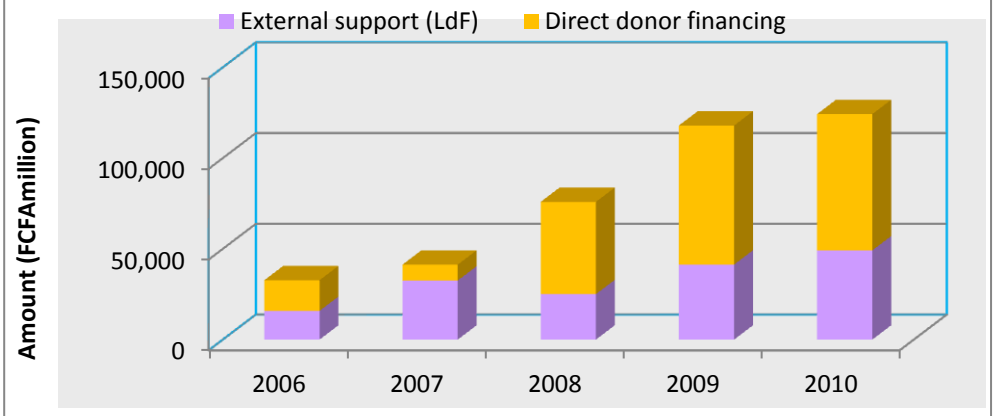
Figure 1 - Trends in health sector financing



Sources: MOF, PNDS, Health MTEF, MOH

228. **Analysis of development partners' support to health.** Development partners' support the health sector through project implementation and budget support. There are two main components of donor's contributions to the health sector: (i) external support incorporated in the budget, and (ii) direct support. Trends in these two categories of donor expenditures show that development partners contribution to health grew from CFAF 32.7 million (US$0.69million) in 2006 to CFAF124.2 million (US$2.6 million) in 2010. Figure 2 presents trends in donors' contributions to the health sector from 2006 to 2010.

Figure 2 - Trends in external funding for health



Sources: Health MTEF, PNDS (2010), MOH

229. **Macroeconomic and funding analysis.** This macroeconomic analysis was based on a review of: (i) the joint government and International Monetary Fund (IMF) recent macroeconomic projections report; (ii) the health sector Medium Term Expenditure Framework (MTEF); and (iii) the National Health Development Plan (PNDS). The review allowed developing two main scenarios (base case and high growth) that enabled to estimate the expected level of government funding for health and reproductive health. The analysis assumes an annual GDP growth rate of 7.9%. The percentage of total government expenditure to GDP was projected to increase from 26.8% in 2010 to 28.45% in 2016. The analysis also assumed constant 10.49% annual increase in total government expenditure on the health sector over the period 2010-2016; and a modest 0.012% of the health sector budget allocation to reproductive health in 2010 with an expected sustained increase in the reproductive health budget. Table 25 shows the results of the base case scenario analysis.

Table 25 - Results of base-case scenario analysis

	2010	2011	2012	2013	2014	2015	2016
Baseline Real GDP Growth	5.20	5.20	5.20	5.20	5.20	5.20	5.20
Gross Domestic Product (in billions of $US)-2010 values	8.10	8.57	9.07	9.59	10.15	10.74	11.36
Total Government Expenditure (% of GDP)	26.80	27.07	27.34	27.61	27.89	28.17	28.45
Total Government Expenditure (US$ billions)	2.17	2.32	2.48	2.65	2.83	3.02	3.23

Total Government Expenditure on Health (%)	10.49	10.49	10.49	10.49	10.49	10.49	10.49
Total Health Expenditure (US$ million)	227.72	243.33	260.02	277.85	296.91	317.27	339.03
Percentage of Health Expenditure for Reproductive Health (%)	0.012	0.013	0.014	0.016	0.017	0.018	0.019
Total Reproductive Health Expenditure (US$ million)	2.73	3.16	3.64	4.45	5.05	5.71	6.44

Sources: Projected from Government and IMF expenditure data, Health Sector MTEF

230. The results of the base case scenario analysis depict an increase in the total government expenditure from US$2.17 billion in 2010 to US$3.23 billion in 2016; this represents an increase of about 48.8% over the same period. The increased government expenditure is expected to translate into an increase in total government expenditure on health by 48.9% from US$227.20 million in 2010 to US$339.03 million in 2016. With the increase in the health sector expenditure, the reproductive health expenditure has been projected to increase from US$2.73 million in 2010 to US$6.44 million in 2016**.** It must be noted that reproductive health services have been, grossly underfunded. Available health expenditure data do not clearly state the share of the health sector budget that goes into the provision of reproductive health services.

231. The high growth scenario analysis was also based on the Burkinabe authorities and the IMF high growth projections over the period 2010 to 2016, with GDP growth rate estimated at 5.2% in 2010; and is expected to increase steadily to 8.3% in 2016. The total government expenditure as a percentage of GDP is forecast to rise from 26.8% in 2010 to 59.7% in 2016. The percentage of health expenditure to total government expenditure is estimated to rise from 11.3% in 2010 to 13.7% in 2016. The share of the health sector budget to reproductive health has been estimated to rise from US$2.70 million in 2010 to US$16.20 million in 2016.

Table 26 - Results of high growth scenario analysis

	2010	2011	2012	2013	2014	2015	2016
Baseline Real GDP Growth	5.20	5.50	5.60	6.20	7.50	7.90	8.30
Gross Domestic Product (in billions of $US)-2010 values	8.10	8.51	9.06	9.65	10.27	10.94	11.65
Total Government Expenditure (% of GDP)	26.80	38.86	40.30	47.56	51.66	56.28	59.69
Total Government Expenditure (US$ billions)	2.17	3.31	3.65	4.59	5.31	6.16	6.96
Total Government Expenditure on Health (%)	11.30	11.50	12.40	12.70	13.20	13.60	13.70
Total Health Expenditure (US$ million)	245.30	380.08	452.64	582.67	700.57	837.46	952.89
Percentage of Health Expenditure for Reproductive Health (%)	0.011	0.012	0.013	0.014	0.015	0.016	0.017

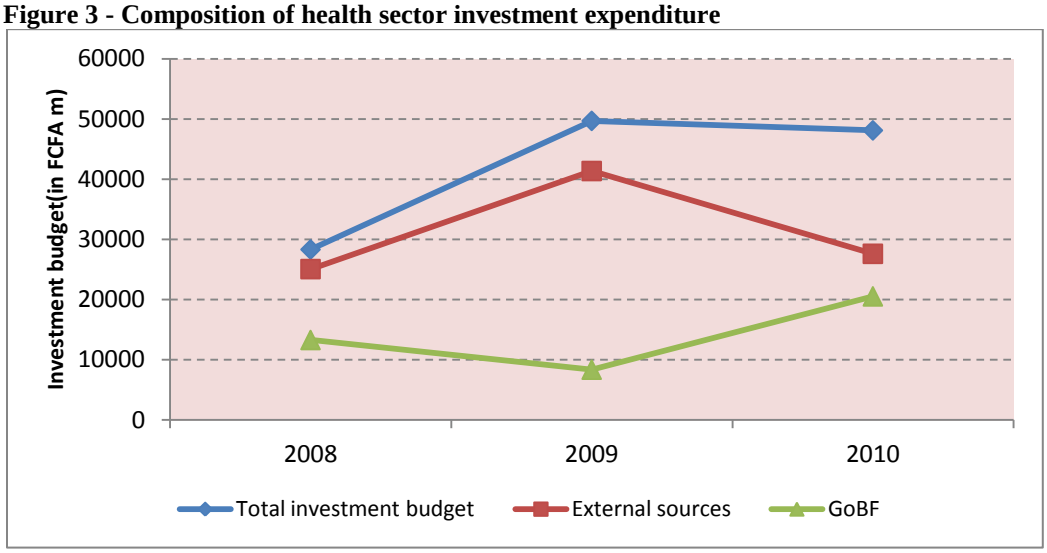
Total Reproductive Health Budget (US$ million)	2.70	4.56	5.88	8.16	10.51	13.40	16.20

Source: Projected from Burkinabe Authorities and IMF expenditure data, CDMT santé

232. The results of the high growth scenario analysis show a rise in total government expenditure from US$2.17million in 2010 to US6.96 million. The total government expenditure on health is projected to increase from US$245.30 million to US$ 952.89 million over the period 2010-2016. The share of the health sector expenditure to reproductive health is estimated to increase from US$2.70 million in 2010 to US$16.20 million in 2016.

233. **Analysis of investment and recurrent expenditures**. An analysis of the structure and trends of health sector investment expenditures shows that donor contributions outweigh government funding. For example, of the total investment budget of CFAF38.3 (US$0.82 million), donors contributed up to the tune of CFAF25.0 million (US$0.53 million) compared with CFAF13.3 million (US$0.29 million) from the GoBF in 2008. Similar trends were observed in 2009 and 2010 respectively. In 2009, the sector's total investment budget was CFAF49.7million (US$0.106.3million) of which FCAFA41.3million (US$0.88million), about 83%, came from external sources, living only CFAF 8.3million (US$0.17million) as government sources. In 2010, total investment budget decreased a bit to CFAF48.1million (US$0.10million), of this amount CFAF27.6million (US$0.59 million) constituted donor funding, and CFAF29.5 million (US$0.63million) came from the government The dominance of the donors' resources raises serious concerns about medium to long-term sustainability of investment programs in the sector. Figure 3 depicts trends in investment expenditures for health over the period 2008-2010.

Figure 3 - Composition of health sector investment expenditure



Source: MoF, CDMT Santé, PNDS

234. **Economic Analysis**. The development objective of Burkina Faso Reproductive Health Project is to: (a) improve access and quality of reproductive health services in Burkina Faso; and (ii) strengthen the institutional capacity of the Ministry of Health (MOH). The project will be implemented through two main components: (a) Component 1: Improving the use and quality of a Reproductive Health Service Package through Result-Based Financing will focus on maternal and neonatal health and certain non-maternal services such as child visits and

immunizations. Component 2 aims at increasing the supply of and demand for reproductive and family planning services through training of nurses and midwives; provision of drugs and equipment to improve obstetrical and neo-natal services; and strengthening demand for family planning and reproductive health services. The project will target three categories of beneficiaries: adolescents, women of reproductive age and their young children. These beneficiaries are expected to acquire substantial knowledge in reproductive health practices as well as have better access to reproductive and child health services.

235. **Project benefits and costs**. The implementation of the project is expected to generate two main types of benefits (direct and indirect benefits). Direct benefits are benefits that would accrue to the project target beneficiaries; they are referred to as medical benefits resulting from improved sexual and reproductive health services. For example the project aims to increase contraceptive prevalence rate in Burkina Faso, and this could lead to prevention of substantial number of unwanted pregnancies. The prevention of unwanted pregnancies constitutes a benefit. Indirect benefits include reproductive health services contribution to the society's well-being; improved reproductive health services would reduce family size, and enable parents to devote much time and resources for child care. Costs are the resources used in carrying out project activities. The direct costs of the project are the cost of training (pre and in-service training), cost of equipment, materials, and supplies, costs of vehicles and motorcycles and consultant/services costs. Indirect costs include, beneficiaries transport costs, costs associated with patients' visits etc. Due to lack of data, the analysis did not take into account indirect benefits and costs, and focused mainly on direct benefits and costs.

236. **Activities included in the analysis.** The analysis included all the project components and, subcomponents. Component 1 includes activities programmed to be implemented through PBHS Sub-projects, and implementation and supervision of RBF through provision of technical advisory services, strengthening of the M&E system, and supervision and oversight activities of local health management team. Activities to be implemented under component 2 are training of health professionals (nurses and midwives), procurement and distribution of drugs and equipment to obstetrical and neonatal services, and strengthening demand for family planning and reproductive health services.

237. **Cost benefits analysis**. To ascertain economic soundness of the project, a cost benefit analysis (CBA) was carried out. The analysis took into account the estimated incremental project's costs and benefits associated with each component of the project. A CBA is a technique of identifying, measuring and calculating a project's cost and benefits in order to ascertain the net returns [net present value (NPV) and economic rate of return (ERR)] of the project's investments.

238. **Methodology**. The input-output[22] approach to CBA was employed to generate net benefits of project components/activities. From the net benefits, the net present value (NPV) and the economic rate of return (ERR) were calculated to determine economic viability of the project. To account for uncertainties associated with the analysis, a sensitivity analysis was

[22] The input-output approach is based on the premise that implementation of every project requires a combination of basic factors of production (labor capital, equipment and material and supplies) to generate the project's benefits

conducted to determine the extent of responsiveness of the analysis. The chronology of steps to the conduction of the analysis is outlined below.

- Identify project inputs and outputs;
- Quantify project inputs and outputs based on project objectives and expected results;
- Construct value flow tables to value inputs and outputs that would generate the project's net benefits;
- Use techniques of discounting to discount project benefits and costs, and compute the net present value (NPV) and the economic rate of return (ERR) of the project to determine economic soundness of the project;
- Conduct sensitivity analysis to determine the relative responsiveness of changes in key variables used in the analysis.

239. **Key assumptions and notes**. The following are the underlying assumptions of the analysis.

1. Total population of Burkina Faso is 15.2 million (Source: MOH Annuaire, 2009).
2. Annual population growth rate is assumed to be 3.4%
3. 23.4% of the total population is considered as women of reproductive age.
4. 18% of the population is assumed to be adolescents.
5. 3.5% of women/adolescents are assumed to seek reproductive health services.
6. 5% of women are assumed to demand long-term contraceptive methods.
7. Assume 10% discount rate for computing present values of net benefits and costs.
8. It is assume that project beneficiaries would derive substantial benefits beyond the duration of the project. The period of the analysis therefore covers a ten-year period.
9. Economic project costs have been calculated by COSTAB which takes into account taxes and prices effects.

240. **Summary of results of the analysis**. On the basis of the above assumptions and taking into consideration economic project costs and benefits, the net present value (NPV) of the project has been calculated as $10.3 million. The positive NPV means that the project would generate the expected results. The economic rate of return (ERR) has also been estimated at around 35%**.** The following table provides a summary of results of the analysis.

Table 27- Results of the CBA Analysis

	Years										
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Total Net benefits	(11,149)	(22,605)	(37,086)	(55,377)	(78,478)	3,393,607	3,457,121	3,513,850	3,561,166	3,595,945	3,613,895
Present value of net benefits	(11,149)	(20,550)	(30,650)	(41,606)	(53,601)	2,107,163	1,951,455	1,803,161	1,661,310	1,525,032	1,393,313
Net present value (NPV) at 10% discount rate	10,283,878										
Economic Rate of Return (ERR)	35%										

241. **Conclusion**. From the foregone analysis, and the results in tables 4 and 5, it is clear that when the project's benefits were compared with costs the net present value depicted positive outcome. This suggests that the project investments are worthwhile. Additional analysis (sensitivity analysis) undertaken to address the uncertainties surrounding the choice of variables also resulted in a positive NPV when the discount rate was altered.