Report Number: ICRR0024694

1. Project Data

Project ID P164696	**Project Name** Health Services Reinforcement Project
Country Burkina Faso	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-D3540,TF-A7763,TF-B0496	30-Jun-2023	102,749,564.15
Bank Approval Date	**Closing Date (Actual)**	
06-Jul-2018	28-Jun-2024	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	100,000,000.00	30,000,000.00
Revised Commitment	110,000,000.00	29,075,731.00
Actual	102,749,564.15	29,072,858.68

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2. Project Objectives and Components

a. Objectives

The Project Development Objective (PDO), as stated in the Financing Agreement (Schedule 1) and the Project Appraisal Document (PAD, p. 16) was “to increase the quality and utilization of health services with a particular focus on maternal, child and adolescent health, nutrition and disease surveillance.” The project focused its activities on the following regions of the country: North, North-Center, East-Center, West-Center, South-West, Boucle du Mouhoun and Hauts-Bassins.

This review assesses separately three objectives under the PDO: (a) Increased quality of health services with a particular focus on maternal, child and adolescent health and nutrition; (b) Increased utilization of health services with a particular focus on maternal, child and adolescent health and nutrition; and (c) Improved disease surveillance.

As part of an Additional Financing (AF) process, the targets for some PDO and intermediate indicators linked to nutrition were revised upward with no changes in project description. Therefore, a split assessment is not warranted.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

No

c. Will a split evaluation be undertaken?

No

d. Components

Component 1: Strengthening Health System Capacity (Appraisal: USD 40 million, of which USD 30 million equivalent IDA, USD 10 million Global Financing Facility (GFF); Restructuring: USD 26 million, of which USD 16 million IDA, USD 10 million GFF; Actual: USD 26 million total, including USD 16 million IDA, USD 9 million GFF). This component aimed to support the strengthening and integration of health financing policies, including the launching of the national health insurance scheme and optimization of the strategic purchasing mechanism, which was already in place. The component included three subcomponents, as follows:

Subcomponent 1.1: Establishment of the National Health Insurance Fund (NHIF). This subcomponent would finance the establishment and operationalization of the NHIF, which would provide insurance coverage of both formal and informal sectors of the population, eventually becoming the strategic purchaser of health services. Specifically, it would support the design of the mechanisms of mandatory enrolment of the informal sector, the targeting mechanisms of the poor, the determination of the package of care, management of informal and formal sector coverage mechanisms, and the design and set-up of the information system. Given that the NHIF would be established only after the project was launched, the Ministry of Health (MOH) was expected to take on these activities until the institution was in place.

As part of a December 2021 restructuring, this subcomponent was cancelled.

Subcomponent 1.2: Scale-up and strengthening of purchasing mechanisms. This subcomponent would support the strengthening and scaling-up of purchasing mechanisms such as Performance Based Financing (PBF) and free health care, building on prior work carried out in the country and on international best practice. It would finance “quality subsidies” to be paid to service providers based on the quarterly evaluations measuring their levels of quality of care, “quantitative subsidies” for services not covered by the free care scheme, payments for services provided at the community level, and subsidies to regional and district health teams for results achieved related to coaching and supervision activities. The subcomponent

would also support the inclusion of community health workers and the improvement of the incentive mechanism to health workers.

Under the December 2021 restructuring, this subcomponent was restated as **Subcomponent 1.1: Increased access to service delivery through scaling-up and strengthening purchasing mechanisms.** This subcomponent would finance an enhanced implementation of the existing free healthcare scheme, with a focus on the areas in which health facilities were overburdened by the influx of internally displaced population (IDP), benefiting both IDP and host population. Financing would be channeled at the facility level through a strengthened free healthcare system that would provide strategic purchasing grants to be disbursed based on the coverage and quality of health services delivered.

Subcomponent 1.3: Verification and cross-cutting interventions in health financing. This subcomponent would finance operational costs of Control and Verification Agencies (CVA) tasked with verification of results declared by service providers from the free care payment and PBF mechanisms. The subcomponent would also finance technical assistance to streamline processes at the purchaser and provider levels.

Under the restructuring of December 2021, this subcomponent was revised to state **Subcomponent 1.2: Strengthening health financing and governance.** This subcomponent would now focus on cross-cutting interventions in health financing and the enhancement of governance and accountability through the provision of financing to the Ministry of Health (MoH) to strengthen the overall management of the free healthcare program.

Component 2: Strengthening Delivery of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) (Appraisal: USD 45 million, of which USD 35 million IDA, USD 10 million GFF; Restructuring and actual: USD 69 million, of which, USD 49 million IDA, USD 10 million GFF, USD 10 million Power of Nutrition (PoN) Trust Fund). This component aimed to finance interventions that would strengthen the capacity of health facilities for the provision of quality services, and pilot and/or scale-up innovative and effective tools to improve coverage and quality of RMHCAH+N services. This component included four subcomponents:

Subcomponent 2.1: Strengthening maternal, newborn, child and adolescent health service delivery. This subcomponent aimed to provide comprehensive Emergency Obstetric and Newborn Care (EmONC), promote family planning with a focus on adolescent health and well-being, and strengthen primary care services for women and children through strategic investments in RMNCAH+N. This subcomponent was scaled up as part of the restructuring of December 2021.

Subcomponent 2.2: Investing in the early years and nutrition. This subcomponent would support the scale-up of nutrition-specific interventions to reduce stunting, including iron, folic acid and Vitamin A supplementation, intermittent presumptive treatment of malaria, promotion of infant and young child feeding, and timely treatment of diarrhea in children. Interventions would be delivered at the community level as well as in health facilities. This sub-component was scaled up under the AF in which the PoN grant was added.

Subcomponent 2.3: Supporting civil registration and vital statistics. This subcomponent would finance the 2018 National Burkina Faso Census, seen as the backbone of the Statistical Information System (SIS) in the country, through a United Nations Contract with the United Nations Population Fund (UNFPA).

Subcomponent 2.4: Supporting multisectoral coordination for RMNCAH+N. Given that multiple sectors would be responsible for sexual and reproductive health under subcomponents 2.1-2.3, this subcomponent

would finance technical assistance to facilitate processes and coordinate among various sectors to ensure project implementation and longer term institution building.

Component 3: Reinforcing health security and supporting institutional strengthening (Appraisal and actual: USD 15 million IDA). This component aimed to strengthen the surveillance and response capacities and containment activities of the human and veterinary public health systems to public health threats, in coordination with other development partners, as well as support project implementation. This component included three subcomponents:

Subcomponent 3.1: Strengthening of national public health surveillance and information systems. This subcomponent would finance investments to improve ICT capacity for disease surveillance and coordinated responses, improving linkages between national, regional and international disease surveillance, reporting surveillance systems on animal and human health, and establishing an early warning system for infectious disease trends prediction.

Subcomponent 3.2: Strengthening health system preparedness and emergency response capacity. This subcomponent would finance the strengthening and continuous updating of cross-sectoral emergency preparedness and response plans for priority diseases and food safety.

Subcomponent 3.3: Institutional capacity building, project management, coordination and communication. This subcomponent would finance project coordination and management. In addition, it would support critical cross-cutting institutional support, including capacity building and training, identified on top of specific capacity-building under the technical components.

Component 4: Contingent Emergency Response. This component did not have a financial allocation and was included to be triggered in the event of an emergency as per Bank Policy: Investment Project Financing, paragraph 13. The rational for the inclusion of the component was that there was a moderate to high probability that an epidemic or other health emergency might occur with the potential of causing a major adverse economic and social impact requiring mitigation, response, and recovery actions. The component was not triggered during the life of the project.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

The project was originally financed by an International Development Association grant of SDR 55.7 million (USD 80 million equivalent) and a GFF grant of USD 20 million. An AF of USD 10 million from the PoN was approved in January 2021, leading to a total financing amount of USD 110 million. The project disbursed a total of SDR 55 million IDA (USD 74 million equivalent), USD 19 million GFF, and USD 10 million PoN, that is a total disbursement of 98.3 percent. Note that a lower disbursement amount in USD of the IDA grant, as compared to the original allocation, was due to exchange rate differences.

The project was approved on July 6, 2018, underwent a mid-term review in December 2020 and closed on June 28, 2024, twelve months after the original closing date of June 30, 2023. The project was restructured four times:

1. The first restructuring of January 21, 2021, was an AF from the PoN for USD 10 million aiming to scale up activities on nutrition. While there were no changes in project description, the results framework was revised adding four intermediate indicators and scaling up of specific targets on nutrition.

2. The second restructuring of December 2, 2021, responded to the context of increased conflict and the COVID-19 pandemic as well as findings and conclusions on project implementation resulting from the mid-term review. Funds were reallocated from Component 1 to Component 2, the GFF grant was extended from December 31, 2021 to June 30, 2023 (in order to align it with the project closing date), and intermediate results indicators were modified to reflect the changes in project activities under Components 1 and 2. This restructuring also added the Sahel and East regions as they were particularly affected by the internal displacements resulting from internal conflict.

3. The third restructuring of May 11, 2023, extended the project from June 30, 2023, to June 28, 2024, and the results framework was modified to reflect the one-year extension.

4. The fourth restructuring of January 19, 2025, reallocated funds between disbursement categories.

3. Relevance of Objectives

Rationale

The project objectives were highly relevant to the country's context and health sector priorities. At the time of appraisal, despite significant declines in the poverty rate, estimates indicated that about eight out of ten citizens lived on less than USD 3 per day. The country was facing a worsening political and security situation starting in 2011. The health sector had seen some improvements with under-five mortality rates decreasing from 129 to 82 deaths per 1,000 live births, neonatal mortality dropping from 28 to 23 deaths per 1,000 live births, and fertility rate going from 6 to 5.4 children per woman. Coverage of health services had also improved with 86 percent of children aged 12-23 months being fully immunized, compared to 39 percent in 2003, and 84 percent of pregnant women delivering in health facilities in 2015, compared to 66 percent in 2010. Despite this progress, the average stunting rate for the country was 21.2 percent, showing disparities among regions, some of which reached levels of 30-39 percent. Communicable diseases persisted in the country, including measles, meningitis, dengue and malaria. While access to health services had improved, the provision of quality services continued to be a challenge. For example, only 47 percent of children with acute respiratory infection who used health centers received antibiotics. Out-of-pocket expenditures continued to be high, with poor households spending more than 30 percent of their budget on health-related expenses.

The Government was committed to achieve Universal Health Coverage (UHC). A five-year health plan (Plan National de Développement Sanitaire, PNDS, 2016-2020) had been developed and included objectives related to governance, health services delivery, human resources, infrastructure, and health sector financing. Under this plan, Universal Health Insurance and free targeted health care for women and children were adopted through a National Health Financing for UHC Strategy (2017-2030). This new vision on health financing had been previously supported successfully by the Bank through the piloting of Performance Based Financing (PBF) under the Burkina Faso Reproductive Health Project (P119917).

The objectives were also well aligned with the World Bank Country Partnership Framework (CPF) for the period FY18-FY23 (Report No. 123712-BF). This CPF was later extended by one year by the Performance and Learning Review (PLR, Report No. 166080-BF, July 27, 2022), thus covering the lifespan of this project. Specifically, “Objective 2.2: Expand access to reproductive and child health services and improved nutrition” under the “Focus Area 2: Invest in human capital and social protection systems,” recognized progress made in the health sector but also emphasized the challenges linked to poor nutrition, contagious diseases and reproductive health. The Bank indicated its commitment to support the health sector through this project. The PLR acknowledged the additional challenges faced in the country due to increased internal conflict and the consequent internal displacement of the population, as well as the COVID -19 pandemic, both of which led to an increase in poverty in the country. The PLR kept Objective 2.2 as stated in the CPF but recommended greater focus in response to the fragility context and growth of IDP. The December 2021 restructuring aligned project activities to this increased focus on IDPs.

This project built on prior health sector operations, particularly the Reproductive Health Project (P119917), which piloted and carried out an impact evaluation of a Results-Based Financing program in 15 districts. Lessons derived from this PBF pilot contributed to the design of the PBF mechanism for this project. In particular, key lessons indicated the need for national leadership and institutional arrangements around PBF, timely payments of bonuses under the PBF, and adequate integration of the different health financing mechanisms, including free health care, PBF, and Community-Based Health Insurance.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1
Objective
Increase quality of health services with a particular focus on maternal, child and adolescent health and nutrition

Rationale
The theory of change stated that quality of health services would be improved through the PBF mechanism which would provide incentives to health facilities and community health workers to improve the quality of care. The PBF, as a strategic purchasing approach, was expected to deliver a predefined package of essential health services as described under national guidelines and standards. The effectiveness of the services delivered would be controlled and verified by designated agencies, and through a mechanism of community monitoring and feedback. Adequate implementation of the PBF mechanism required providers to be autonomous. Thus, the project would support assistance to coach facilities managers on such practices as financial management, social marketing, etc. As a complementary measure to the PBF, the project would support activities directly related to improving the quality of care, including assessment on training needs, purchasing of commodities and equipment, training district and regional teams to carry adequate supervision for maternal and health services, and training of service providers. Further to this, the project would provide

technical assistance, capacity building and inputs for the improvement of RMNCAH+N. These activities would be carried out as per the recommendations of the RMNCAH+N investment case, a diagnostic process which would identify specific gaps in the provision of quality of care. Improvement in quality would be measured through a quality-of-care checklist.

Outputs

The number of districts that applied the strategic purchasing approach as a purchasing mechanism for Primary Health Care (PHC) increased from a baseline of 19 districts to 47 districts, meeting the target in the project area. However, only 3 percent of the facilities received strategic purchasing quality payments on time, below the target of 75 percent. According to the ICR (p. 19), the delays were caused by misunderstandings around the implementation of strategic purchasing and its perceived overlap with respect to the free healthcare policy. As a result, while the project design intended to integrate PFM with the free health care scheme, it often resulted in parallel financing for the same services.

Together with the PBF mechanism, the project supported training of 19,304 health care personnel received training on skilled care to prevent maternal and neonatal mortality, exceeding the target of 16,678 personnel.

In addition, the project supported training and other capacity building activities: 327 healthcare providers in the South-West region received enhanced training on Infant and Young Child Feeding (IYCF); 889 healthcare workers were trained in integrated management of childhood illnesses (IMCI) initiatives using the IMCI/e-register use; coaching and supervision were provided by the Directorate of Family Health (DSF) with support from the NGO Terre des Hommes; 591 providers were trained in Emergency Triage, Assessment, and Treatment (ETAT); 60 health personnel received additional surgery training, meeting 95 percent of the country's requirement for at least two trained doctors per operating room; 50 general practitioners received training, covering 91 percent of health districts; and village midwives received training on hygiene-focused childbirth to promote safer deliveries in security-challenged areas. It is reasonable to expect that training interventions have likely contributed to a degree of improved quality of assistance and care to delivering mothers, although the actual extent of the improvements remains unknown as information on the quality of training activities was not available. A total of 21,350 assisted births were registered across several regions.

Throughout the project area, IYCF Learning and Support Groups were established within the community approach framework to promote better adoption of good practices and recommendations to local beneficiaries.

Outcome

The average score on the quality-of-care checklist was 20.13, short of the original target of 70 and the revised target of 60.The checklist included 36 areas to be assessed covering facility and human resource management; planning; internal and external communication; financial resources, procurement and logistics management; infrastructure and equipment maintenance; availability of information systems; document management; and organization of patient care and services. Information would be collected through interviews with stakeholders, including health workers and patients, document reviews, and direct observation of the facility and its operation.

Rating

Modest

OBJECTIVE 2

Objective

Increase the utilization of health services with a particular focus on maternal, child and adolescent health and nutrition

Rationale

The Theory of Change stated that the utilization of health services would increase subject to improvement in the quality of health services (see Objective 1), as well as the implementation of the free healthcare scheme focusing on the poor and vulnerable population, and the provision of inputs such as essential products, medical materials equipment and distribution of small-quantity lipid-based nutrient supplements (SQ-LNS). These actions were expected to lead to increased utilization of quality maternal, child, and adolescent health and nutrition services as evidenced by key indicators related to child immunization, institutional births, mother and child supplementation, and improved children's dietary diversity. In addition, support to the national census and to the civil registration and vital statistics would contribute to improved targeting of the project, improved health services planning, and adequate monitoring of child and maternal mortality.

Outputs

The number of women using modern contraceptives was 2,837,944 women, slightly below the target of 2,952,812 women.

The percentage of infants 0-5 months of age exclusively breastfed in targeted regions increased from a baseline of 55.8 percent to 69.6 percent, below the target of 80 percent.

The percentage of children 6-23 months of age with minimum dietary diversity in targeted regions increased from 24.6 percent to 31.6 percent, slightly below the target of 32 percent.

The percentage of children 6-59 months of age receiving Vitamin A supplementation within the last six months in targeted regions increased from a baseline of 75.8 percent to 77.1 percent, below the target of 95 percent.

The percentage of women receiving iron and folic acid supplementation for 90 or more days at last pregnancy in targeted regions increased from 50 percent to 88.9 percent, exceeding the target of 85 percent.

The number of children aged 6-23 months receiving Lipid based Nutrient Supplements (LNS) in targeted regions was 331,250 children, somewhat below the target of 345,972 children.

Outcomes

The number of people who received essential health, nutrition and population (HNP) services were 21,342,846, exceeding the original target of 5 million people, and the revised target of 21,241,392 people.

The number of women and children who received basic nutrition services were 16,378,107 women and children, exceeding the original target of 3 million, and nearly achieving the target of 16,409,344.

The number of children who were immunized was 2,539,730, exceeding the original target of 750,000 and the revised target of 2,337,200.

The number of deliveries attended by skilled health personnel was 2,447,257, above the original target of 750,000, almost achieving the target of 2,494,848.

Although country-wide progress in RMNCAH+N indicators cannot be directly attributed to the project, Burkina Faso showed important progress during the project period as shown in the table below (from Table 5 RMNCAH+N KEY INDICATORS, ICR p. 21):

Number	Indicators	Baseline(1)	Progress (2)
1	Maternal mortality ratio	223 (2019)	198 (2021,2023)
2	Under-five mortality rate	87.3 (2019)	48 (2021,2023)
3	Infant mortality rate	56 (2019)	30 (2021,2023)
4	Institutional deliveries (3)	79 (2019)	91.8 (2023)
5	Children vaccinated for BCG	93.6 (2019)	101.3 (2023)
6	Infants under 6 months on exclusive breastfeeding (4)	59 (2015)	77.5 (2023)

1 General Population Census, 2019

2 Demographic and Health Survey, 2021 and Ministry of Health, 2023 Dashboard of Health Indicators, Août 2024.

3 Statistical YearBook, 2019, 2023

4 Standardized Monitoring and Assessment of Relief and Transitions Survey, 2019

Rating
Substantial

OBJECTIVE 3
Objective
Improve disease surveillance

Rationale
The Theory of Change stated that improved disease surveillance would be achieved through the development of a surveillance system and the strengthening of health system preparedness and emergency response capacity. The surveillance system would include: (a) implementation of an electronic monitoring system for disease surveillance and coordinated responses, (b) improving the linkages between national animal health and human health surveillance information systems, and (c) the operationalization of mechanisms to facilitate cross-border collaboration in surveillance. These activities would be implemented through the development of community and district level surveillance systems and processes across the animal and human health

sectors. Training would be provided to relevant stakeholders at the community, district and health facility levels to achieve timely reporting.

The strengthening of health system preparedness would be carried out by (a) the updating of cross-sectoral emergency preparedness and response plans for priority diseases and for food safety, (b) regular testing, assessment, and improvement of such plans, (c) expansion of the health system surge capacity for emergency response and infection prevention and control, (d) supporting the emergency operations center, and (e) periodic outbreak simulation exercises to asses functionality of emergency notification systems.

Outputs

The number of mechanisms established for the coordination of relevant sectors for implementation of International Health Regulations (IHR) increased from a baseline of 2 mechanisms to 3 mechanisms, below the target of 4 mechanisms. These mechanisms included: (a) the completion of an electronic, interoperable business platform for surveillance, early warning, and public health emergency response together with stakeholder training, (b) the development of standard operating procedures for integrating zoonoses into the early warning system, and (c) the creation and validation of an integrated strategic plan to combat priority zoonoses under the One Health approach, and the procurement of reagents for arbovirus surveillance in the fight against dengue (ICR p. 19).

The WHO Joint External Evaluation (JEE) for periodic assessment and scoring of relevant capacities and monitoring progress in compliance with IHR core capacities, which was planned for June 2024, was not yet carried out (as reported by the TTL).

The number of health personnel trained in applied epidemiology was 139 staff, exceeding the target of 102 staff.

The number of laboratory personnel trained in techniques used for core testing techniques and quality control procedures was 261 staff, exceeding the target of 250 staff.

Other outputs supported this objective (ICR, p. 16), including the following:

- The project facilitated the establishment of One Health Regional Committees through regulatory decrees and contributed to the development of the National Preparedness and Response Plan for COVID-19, which supported health safety initiatives through the Ministry of Finance.
- Under Component 3, the project provided extensive training for healthcare professionals. A total of 591 providers were trained in Emergency Triage, Assessment, and Treatment.
- To further strengthen public health emergency preparedness and response, the project supported the development of "white plans" for the Dédougou Regional Hospital Center, including an operational health response plan for the humanitarian and security crisis in Burkina Faso, benefiting the Health Emergency Response Operations Center.

Outcome

The number of multi-hazard national public health emergency preparedness and response plans implemented increased from a baseline of 1 plan to 3 plans, achieving the target. These plans and the

coordination mechanisms were expected to ensure that response efforts addressed a broad range of public health threats such as epidemics, natural disasters and humanitarian crises.

The ICR (p. 16) reported that the project significantly strengthened the country's national health surveillance and information systems. The project completed the establishment of an electronic, interoperable business platform for surveillance, early warning, and public health emergency response, along with stakeholder training on its use, with exceeded targets, including laboratory staff training in diagnostic techniques and quality control methods to improve early disease detection, and health personnel training in field and applied epidemiology, as discussed above under outputs.

While the project delivered key inputs and capacity-building activities, the ICR did not provide direct evidence of measurable improvements in disease surveillance outcomes. Thus, efficacy for this objective is rated as Modest.

Rating
Modest

OVERALL EFFICACY

Rationale
Objective 1 (to increase the quality of health services with a particular focus on maternal, child and adolescent health and nutrition) and Objective 3 (to improve disease surveillance) were rated Modest, as they were partly achieved. Objective 2 (to increase utilization of health services with a particular focus on maternal, child and adolescent health and nutrition) was rated Substantial, as they were almost fully achieved. The reported outcomes were largely attributable to the project's key interventions, and, according to the ICR (p. 19), they are expected to ultimately benefit over 21 million people.

Overall efficacy was rated Modest, as there was modest achievement of two of the objectives used in the assessment of the overall efficacy.

Overall Efficacy Rating
Modest

Primary Reason
Low achievement

5. Efficiency

At the time of appraisal, a Cost Benefit Analysis could not be carried out due to the limited availability of data. However, the PAD noted that the project would positively impact financial risk protection by decreasing out-of-pocket payments through the scaling up of the insurance component of the NHIF, the optimization of the free healthcare scheme, and the improved effectiveness and quality of care in the Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N) services. Previous studies had shown that RMNCAH+N interventions were highly cost-effective. As part of the project, studies were planned to conduct an

equity and cost-efficiency assessment to evaluate the expected impact of the planned interventions. The prevention measures against infectious diseases were also expected to be cost-efficient, given that they remained a leading cause of mortality (especially for children under five) and a threat to the health system, as previously experienced with the Ebola epidemic in neighboring countries.

The AF carried out a Cost Benefit Analysis (CBA) for the scaling up of the nutrition interventions. The period considered was ten years, requiring an additional amount of USD 42.7 million annually. The CBA estimated that 29,000 deaths would be prevented, and 505,000 disability-adjusted life years (DALYs) would be averted, positively impacting 179,000 children. The estimated benefit was USD 883 million, leading to a benefit-cost ratio of 2.4, using a 3 percent discount rate for both costs and benefits, and assuming 3 percent GDP growth, and children starting to work at 18 years of age. The CBA was carried out for a priority package, costing USD 15 million over five years in seven regions. This analysis resulted in benefits with a net present value of USD 108 million, an internal rate of return of 7 percent, and a benefit-cost ratio of 8.7.

At closing, a CBA was conducted focusing on the DALYs averted as a result of people receiving essential health services. Specifically, the services considered were those leading to children (0-11 months) being immunized, deliveries being attended by skilled health personnel, and children (6-59 months) receiving vitamin A supplementation every six months. A five percent discount rate was used and assumed to be constant throughout the project. A 2.5 percent annual population growth rate was used. DALYs were valued using the Gross National Income (GNI) per capita of USD 850. The total investment was estimated at USD 80 million (present value in 2018, actual nominal costs for the project were USD 100 million). The estimated benefits of the project were USD 168 million, resulting in a net present value (NPV) of USD 88 million and a benefit-cost ratio of 1.09.

Project implementation was slow up to the mid-term review. The disbursement rate was 22 percent during the first three years of the project until December 2021. Delays were due to changes in counterparts and implementation strategies, as well as disruptions caused by the COVID-19 pandemic. The mid-term review led to the restructuring of the project, in which some activities were canceled, the results framework was revised, funds were reallocated among disbursement categories, and new safeguard policies were implemented. The project implementation unit was overburdened, managing two projects (including the COVID-19 Response Project), and only towards the end of the implementation period were these issues resolved. Part of the challenges faced by this unit was the lack of prior experience with the World Bank and weak monitoring of implementation activities. As a result, Terms of Reference (ToRs) lacked adequate quality, there were difficulties in adhering to the Bank's fiduciary rules, there were delays in processing payments, and communication of project challenges to the World Bank was poor. The mid-term review contributed to improving these challenges, and disbursements picked up thereafter. Long preparation periods for bidding documents delayed the procurement processes. Contracts with UN agencies also faced challenges due to delays in implementation. The project was extended by 12 months and achieved 98 percent disbursement.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐ Not Applicable
ICR Estimate	✓	9.00	86.00 ☐ Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives was rated High, as objectives were fully aligned with national health policy and strategies and with the World Bank's Country Partnership Framework. Efficacy was rated Modest, as aggregated objectives were partly achieved. Efficiency is rated Substantial given the cost-effectiveness of project interventions, but with some shortcomings in implementation aspects which moderated overall efficiency. These ratings are consistent with an overall outcome rating of Moderately Unsatisfactory, as there was modest achievement of two of the objectives used in the assessment of the overall efficacy.

a. Outcome Rating

Moderately Unsatisfactory

7. Risk to Development Outcome

The original project design aimed to support in building several institutions and processes to improve the quality and access to health services. The project facilitated interinstitutional coordination such that collaboration across different levels of government and with NGOs and development partners was improved. In addition, the project contributed to increased community awareness on behavioral changes and improved nutrition practices as well as increasing the demand of health services. The project also supported the implementation of strategic purchasing mechanisms to improve resource allocation and ensure free health care for pregnant women and children under five, even if not fully successful. The NHIF and the PBF were not implemented due to frequent changes in government policies, exacerbated by the COVID-19 pandemic and civil strife. The lack of these institutions put at risk the processes that support free health care policies as well as efficient financing of health services.

The World Bank approved in January 2025 the Burkina Faso Strengthening Health System Performance and Resilience Project (P180539). The follow-on project builds on the Health Services Reinforcement Project under similar objectives, recognizing that institution capacity building and improved governance are necessary to ensure adequate and sustainable health financing. Thus, it focuses on strengthening NHIF and strengthening the strategic purchasing mechanism.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project design aimed to improve the quality and access to RMNCAH+N services in selected regions in Burkina Faso. The project drew from sector data from the 2010 Demographic and Health Survey and the 2011 evaluation of emergency obstetric and neo-natal care needs, whereby RMNCAH+N services were prioritized. The project also built on the experience and lessons from a prior project, the Reproductive Health Project (P119917). The latter project had supported the pilot implementation of the PBF and community level health insurance mechanisms, drawing important lessons. One key aspect of these lessons was the need for a strong institutional framework that would ensure timely transfers of funds based on on-site verification of results. However, as the project was designed, the institutional framework for the NHIF was not installed and the role was assigned to the MOH temporarily. This resulted in significant delays in implementation and eventually the cancellation of most activities on health financing reform.

The project institutional and implementation arrangements were new, as they were subsumed under the Ministry of Health's structure, as opposed to the previous operation which was managed under a separate program. A Project Implementation Manual was not ready at appraisal and became a condition for effectiveness. Financial management (FM) arrangements took into account this new structure, but having identified some weaknesses in the national directives and regulations, a separate FM unit was established under the Directorate of Administration and Finances. In the case of procurement, the MOH's structure would also be used. Intensive training of dedicated staff had been foreseen. M&E was under the responsibility of the Project Implementation Unit. Data would be collected via the web-based PBF system and the DHIS-2 system. PIU staff were expected to train stakeholders throughout the system.

The risk assessment had an overall rating of Substantial. All specific risks were also rated as Substantial. Mitigation measures included the use of the Investment Case (to be prepared under the GFF) as a platform to align stakeholders on investment priorities and the provision of significant capacity building in support of all project activities. The security issues in the country were also recognized and were expected to be addressed through contracting of local non-governmental organizations.

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

The World Bank team carried out regular supervision support with comprehensive reporting through Implementation Status and Results Reports (ISRs) and Aide Memoires. Missions were carried out twice per year, shifting to virtual missions during the COVID-19 pandemic. The mid-term review was carried out in December 2020 as planned (original target date was January 2021). This review prompted a restructuring process to respond to the political context in the country by restructuring the project to focus on areas with high concentrations of internally displaced population or insecurity and to revise the health financing component of the project given the delays experienced up to that point. The project supported the government in financing inputs for the COVID-19, but did not trigger the CERC component because of

changes in safeguards in the Bank which would have required additional processing time and difficulties meeting country requirements for its activation. Instead, the Bank processed an emergency operation in support of actions to address the COVID-19 pandemic. The additional financing in support of the nutrition activities, financed by the Power of Nutrition trust fund was approved three years after appraisal, even though the Bank intended to have it approved at about the time of project approval.

The Bank team provided strong technical support and led the dialogue on strategic purchasing with Government and development partners. The Bank also provided training in M&E, financial management and procurement. National consultants provided technical assistance in RMNCAH+N, community health, information systems, and CRVS. A total of ten ISRs were produced, providing detailed information on project status and key issues. During the initial period, the project faced some implementation difficulties linked to continuity in task team leadership which was exacerbated by multiple changes in government counterparts. Despite these challenges, the Bank team, including in-country specialists, ensured continuous communication. The internal conflict in the country caused the Bank to activate Operational Policy (OP) and Bank Procedure (BP) 7.30 on de facto governments, stopping disbursements for a period of approximately four months.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The project design included a clear results chain, outlining activities, expected outcomes, and long-term impacts. However, it did not assign specific indicators to each objective. The results framework did include indicators that allowed for monitoring progress toward all three objectives. Some intermediate indicators proved difficult to track or needed clarification, which led to adjustments during the AF and restructuring phases. For Objective 1, the only outcome indicator—the average score on the quality-of-care checklist—depended on a complex instrument that required responses to 36 areas and 147 criteria.

M&E design relied on data collected via the web-based PBF system as well as from the national Demographic and Health Information System (DHIS-2). Data would be aggregated for the project's quarterly and annual report. The Project Implementation Unit (PIU), responsible for the project's M&E, would develop and implement the monitoring system. The PIU would carry out training and capacity building at the relevant government levels to ensure adequate data reporting. An independent review would be sought by technical consultants, and annual program evaluations and strategic planning exercises would be carried out for each component. A learning agenda would also be developed through the GFF Investment Case which was expected to include impact evaluations, qualitative research, specific surveys, and process evaluations. The project was also expected to support key national surveys such as the DHS,

Multiple indicator Cluster Surveys (MICs), health facility surveys and national health accounts, as well as the national census.

Several indicators were target numbers as opposed to proportions. The intention (as reported by the TTL) was to monitor actual coverage numbers given the difficulty in measuring the overall number of potential beneficiaries in geographical regions in a context of significant internal migration.

b. M&E Implementation

During the early stages of the project there were significant delays such that data were not available to monitor the project. In addition, insecurity in some regions in the country hindered data collection as access to some intervention sites was limited.

The GFF Investment Case (published in May 2020) provided data on RMNCAH+N indicators and identified bottlenecks and proposed solutions (GFF Annual Report 2020-2021). The AF of January 2021 and the restructuring of December 2021 included new nutrition indicators and revised the design of the results framework, deleting some indicators that had been identified as difficult to monitor. For example, in the case of the indicator “Percent of newborns receiving birth certificates,” digitalization of certificates was delayed, even though there had been progress with registration of births and deaths under the Civil Registration and Vital Statistics system. Therefore, the indicator could not easily be measured. These revisions to the results framework facilitated the monitoring of project indicators. The PIU carried out regular tracking through quantitative surveys focused on health structures, patient interviews at different facility levels to measure service utilization and quality, focus group discussions, and key informant interviews. Data was collected also from health facilities and other intervention sites. The M&E system relied on a technology-based approach, allowing for efficient and reliable capturing of data. M&E experts in the MOH also produced regular reports tracking project targets.

c. M&E Utilization

Once M&E implementation started, regular reports were produced and shared with stakeholders. These reports were consulted regularly with local health authorities, project staff and community stakeholders. Monitoring reports contributed to policy adjustments, such as prioritization of certain nutrition interventions including dietary diversity and micronutrient supplementation and the need to increase training for health workers.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

At the time of appraisal, the project was rated as Environmental Assessment Category B, partial assessment. The main factor triggering Environmental Assessment OP/BP 4.01 was the potential adverse

environmental impacts associated with biomedical wastes, generated by the provision of health services. An Environmental and Social Management framework was prepared and a Medical Wastes Management Plan, originally prepared in 2015 was updated for this project. Actions included waste segregation, proper biomedical waste disposal, and environmental monitoring during the rehabilitation of health facilities. The social framework focused on including vulnerable groups and promoting gender equity. Environmental and Social Assessment (ESA) and Stakeholder Engagement Plans were developed. However, there were delays and logistical issues impacting implementation of these plans. A Grievance Redress Mechanisms (GRM) was implemented, but no complaints were registered. Safeguard risks were rated moderate throughout the project except for the period prior to the first restructuring in which rating was substantial. Safeguards implementation was rated as moderately satisfactory throughout the life of the project.

b. Fiduciary Compliance

Fiduciary Risk for both Financial Management (FM) and Procurement was Substantial throughout the life of the project. At appraisal the institutional assessment indicated that counterpart agencies lacked experience with respect to World Bank operations. In the case of FM, the initial assessment found that, in addition to the lack of knowledge of Bank processes and procedures, the software used for budget and accounting was not effective and that the accounting for externally financed projects was managed through Excel. An action plan was agreed to ensure compliance with Bank requirements. Throughout implementation there were significant delays resulting in low disbursement rates. There were no pending audits. FM ratings throughout project implementation were moderately satisfactory, except for a satisfactory rating at closing.

In the case of Procurement, the assessment also identified significant issues with respect to delays in internal MOH procurement processes largely due to the absence of a procedure manual. A Project Procurement Strategy for Development was prepared which included a procurement plan covering the first 18 months of project implementation. In addition, a Project Implementation Manual would be developed prior to effectiveness which would include the project's internal organization, role and responsibilities, as well as procedures for calling for bids, selecting consultants and awarding contracts. During implementation, there were significant delays. In some cases, UN agencies (UNOPS, UNFPLA, WFP, WHO and UNICEF) were contracted to implement specific activities or act as technical advisors. However, in these cases there were also some delays due to difference with UN procedures and priorities. Procurement rating was moderately satisfactory throughout project implementation, except at closing when it was upgraded to satisfactory.

c. Unintended impacts (Positive or Negative)

None

d. Other

N/A

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	
Bank Performance	Satisfactory	Moderately Satisfactory	The project was not fully ready for Implementation both in terms of institutional context and implementation instruments.
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

12. Lessons

The ICR provides lessons from the project, a selection of which are restated below:

Projects undertaken in situations of fragility, conflict, and violence benefit from designs that are flexible and adaptable. The design of the project was modified to meet evolving needs, while remaining committed to its focus on maternal, child, and adolescent health and nutrition. As circumstances changed, the project expanded its geographical reach to include new regions, particularly to support internally displaced populations. Partnerships were established with United Nations agencies and non-governmental organizations to enhance service delivery, especially in areas where the Ministry of Health (MOH) faced challenges in providing essential health and nutrition services.

Health financing strategies are complex, and an adequate and clear institutional framework can facilitate effective implementation. The project's original design aimed to support the implementation of the National Health Insurance Fund (NHIF) which would pool all health sector funds, would manage the Performance Based Financing program and would be responsible for the overall management of the free healthcare scheme focused on essential health services for mothers and children under the age of five. The main challenges in the case of the health sector in Burkina Faso were the frequent changes in leadership in key institutions and the lack of consensus on integrating the free healthcare scheme with strategic purchasing. Since the establishment of the NHIF was delayed, the MOH continued to make payments, often leading to parallel financing for the same services through the free healthcare scheme and the strategic purchasing scheme. Further to this, payments for strategic purchasing arrived late due to lack of understanding on how to manage the process.

The effectiveness of a health system can be enhanced by strengthening disease surveillance, as it particularly strengthens capacity to prevent, detect and respond to health threats. Activities supported under this project contributed to enhanced disease surveillance, the development of the national One Health platform, and a public health emergency operations center. Still, gaps in human, technical and financial resources demonstrated that that this is a long-term effort that requires

sustained capacity-building efforts as well as a harmonized vision among all key stakeholders, including central and local governments as well as development partners.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was clearly written, providing a detailed overview of the project's performance and its restructurings considering the changing context in the country. The Theory of Change was clear and adequately reflected the links between project activities, outputs and outcomes. The ICR was results oriented. The ICR included a detailed cost benefit analysis. The report was consistent with the guidelines, but was moderately lengthy with a main text of 29 pages. The efficacy analysis did not clearly differentiate between the utilization and the quality objectives. On a minor note, the ICR could have provided an explanation on the mechanism used for strategic purchasing under the project, in lieu of the original PBF.

a. Quality of ICR Rating
Substantial