Public Disclosure Authorized

Public Disclosure Authorized

Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD1649

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT AND RESTRUCTURING

IN THE AMOUNT OF SDR 25.4 MILLION

(US$35 MILLION EQUIVALENT)

TO

BURKINA FASO

FOR A

REPRODUCTIVE HEALTH PROJECT

February 23, 2016

Health, Nutrition & Population Global Practice
Africa Region

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

CURRENCY EQUIVALENTS

(Exchange Rate Effective as of January 31, 2016)

CURRENCY EQUIVALENTS

(Exchange Rate Effective as of January 31, 2016)

Currency Unit	=	CFA Franc (CFAF)
CFAF 600	=	US$1
US$0.72437523	=	SDR 1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AFD	*Agence Française de Développement* /French Development Agency
ANC	Antenatal Care
BCC	Behavior Change Communication
CAS	Country Assistance Strategy
CBHI	Community-Based Health Insurance
CBO	Community-Based Organization
CBT	Community-Based Targeting
CHW	Community Health Workers
CMA	*Centre Medical avec Antenne Chirurgicale* /Medical Center with Surgical Unit
CPS	Country Program Strategy
CSO	Civil Society Organization
CSPS	*Centre de Santé et de Promotion Sociale/* Health and Social Promotion Center
CVA`	Contracting and Verification Agency
DA	Designated Account
DHS IV-MICS	Demographic Health Survey IV – Multiple Indicator Cluster Surveys
FM	Financial Management
FSW	Female Sex Workers
GA	Grant Agreement
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GRS	Grievance Redress Service
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency

	Syndrome
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
HRITF	Health Results Innovation Trust Fund
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IE	Impact Evaluation
IFR	Interim Financial Report
KfW	*Kreditanstalt für Wiederaufbau/* Reconstruction Credit Institute
MDG	Millennium Development Goals
MICS	Middle Income Countries
MSM	Men Having Sex With Men
MOH	Ministry of Health
MTCT	Mother to Child Transmission
MTR	Mid-Term Review
MWMP	Medical Waste Management Plan
NGO	Non-Governmental Agency
OVC	Orphans and Vulnerable Children
PAD	Project Appraisal Document
PADS	*Programme d'Appui du Développement Sanitaire/* Support Program for Health Development
PBHS	Package of Basic Health Services
PDO	Project Development Objective
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNDS	*Plan national de développement sanitaire (2011-2020)/* National Health Development Plan
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
SONU	*Soins Obstétricaux Néonataux d'Urgences/* Maternal and Neonatal Emergency Care
SP/CNLS-IST	*Secrétariat Permanent du Conseil national de lutte contre le SIDA et les IST/* Permanent Secretariat of the National Committee for the Fight Against HIVAIDS and STI
STI	Sexually-Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities

VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Pierre Frank Laporte
Country Manager:	Cheick Fantamady Kante
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Trina S. Haque
Task Team Leaders:	Haidara Ousmane Diadie & Paul Jacob Robyn

BURKINA FASO

ADDITIONAL FINANCING – REPRODUCTIVE HEALTH PROJECT (P153104)

CONTENTS

Project Paper Data Sheet 6

Project Paper 12

I. Introduction 12

II. Background and Rationale for Additional Financing 13

III. Proposed Changes 18

IV. Appraisal Summary 32

V. World Bank Grievance Redress 36

Mandatory Annexes

Annex 1: Revised Results Framework and Monitoring Indicators 38

Optional Annexes (only if required to justify the additional loan)

Annex 2: Detailed Description of Modified or New Project Activities 44

Annex 3: Results of Project Mid-Term Review 52

Annex 4: Map of Burkina Faso 54

Figures and Tables

Figure 1: Trends in service delivery in RBF facilities for key maternal and child health services 15

Figure 2: Trends in the quality of care scores in RBF facilities 16

Figure 3: HIV prevalence of Female Sex Workers by cities (16.5% global prevalence for FSW), Behavioral Sentinel Survey, 2010 46

Table 1: Targeted districts and populations, 2015 44

Table 2: Allocation of Additional Financing of the Burkina Faso Reproductive Health Project 49

Table 3: Allocation of IDA Additional Financing by Component and Sub-Component 49

ADDITIONAL FINANCING DATA SHEET

Burkina Faso

Reproductive Health Project - Additional Financing (P153104)

AFRICA

GHN07

Basic Information – Parent

Parent Project ID:	P119917	Original EA Category:	B - Partial Assessment
Current Closing Date:	31-Dec-2016		

Basic Information – Additional Financing (AF)

Project ID:	P153104	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B – Partial Assessment
Country Director:	Pierre Frank Laporte	Expected Effectiveness Date:	September 15, 2016
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	30-Jun-2018
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD1649
Team Leader(s):	Haidara Ousmane Diadie, Paul Jacob Robyn		

Borrower

Organization Name	Contact	Title	Telephone	Email
Ministry of Economy, Finance and Development	Hadizatou Rosine Coulibaly Sori	Minister	0022625312715	Cab_mef@yahoo.frdg.coop@finance.gov.bf

Project Financing Data - Parent (BF-Reproductive Health Project (FY12)-P119917) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date

P119917	IDA-H7510	Effective	20-Dec-2011	14-Feb-2012	22-Oct-2012	31-Dec-2016	31-Dec-2016
P119917	TF-11678	Effective	14-Feb-2012	14-Feb-2012	22-Oct-2012	31-Dec-2016	31-Dec-2016

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P119917	IDA-H7510	Effective	USD	28.90	28.90	0.00	19.47	6.92	67.38
P119917	TF-11678	Effective	USD	12.70	12.70	0.00	11.36	1.34	89.45

Project Financing Data - Additional Financing Reproductive Health Project - Additional Financing (P153104)(in USD Million)

[ ]	Loan	[ ]	Grant	[X]	IDA Grant
[ ]	Credit	[ ]	Guarantee	[ ]	Other

Total Project Cost:	35.00	Total Bank Financing:	35.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
IDA Grant	35.00
Total	35.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Haidara Ousmane Diadie	Team Leader (ADM Responsible)	Senior Health Specialist	Public Health	GHN07
Paul Jacob Robyn	Team Leader	Health Specialist	Public Health	GHN07
Mamata Tiendrebeogo	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement	GGO01
Ngor Sene	Financial Management Specialist	Financial Management Specialist	Financial Management	GGO13
Begnadehi Claude Bationo	Program Manager	Senior Operations Officer	Operations	AFMBF
Bintou Sogodogo	Team Member	Program Assistant	Administrative Support	AFMBF
Faly Diallo	Team Member	Financial Officer	Finance	WFALA
Johanna van Tilburg	Safeguards Advisor	Senior Social Development Specialist	Social Safeguards	OPSPF
Leandre Yameogo	Safeguards Specialist	Senior Environmental Specialist	Environment	GEN07
Marylou R. Bradley	Team Member	Senior Operations Officer	Operations	GHN04
Salimata Bessin Dera	Team Member	Temporary	Administrative Support	AFMBF
Shingira Samantha Masanzu	Counsel	Counsel	Legal	LEGAM
Yacouba Konate	Safeguards Specialist	Social Development Specialist	Social Development	GSU01

Extended Team

Name	Title	Location

Locations

Country	First Administrative	Location	Planned	Actual	Comments

	Division				
Burkina Faso	Centre-Ouest	Léo	X		
Burkina Faso	Southwest Region	Diebougou	X		Diebougou, Batie
Burkina Faso	Boucle du Mouhoun Region	Boucle du Mouhoun Region	X		Nouna, Solenzo
Burkina Faso	Centre-Est	Centre-Est	X		Ouargaye, Tenkodogo
Burkina Faso	Centre-Nord	Centre-Nord	X		Kongoussi, Kaya, Boulsa
Burkina Faso	Centre-Ouest	Centre-Ouest	X		Koudougou, Sapouy
Burkina Faso	Nord	Nord	X		Ouahigouya, Gourcy, Titao

Institutional Data

Parent (BF-Reproductive Health Project (FY12)-P119917)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[ ] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	38		
Public administration, law, and justice	Public administration-Health	33		
Health and other social services	Other social services	29		

Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Population and reproductive health	67
Human development	Health system performance	33
Total		100

Additional Financing Reproductive Health Project - Additional Financing (P153104)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Population and reproductive health	40
Human development	Child health	20

Human development	Health system performance	20
Human development	HIV/AIDS	20
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)
Consultants Required? Consultants will be required

I. Introduction

1. This Project Paper seeks the approval of the Executive Directors to provide an Additional Financing (AF) grant in the amount of SDR 25.4 million (US$35.0 million equivalent) to the Burkina Faso: Reproductive Health Project (P119917, Grant Number H751-BF), along with a restructuring of the parent Project. The original Project has two sources of financing: (i) an International Development Association (IDA) Grant of SDR 18.3 million (US$28.9 million equivalent), and (ii) a US$12.7 million grant from the Multi-Donor Trust Fund of Health Results Innovation (HRITF; TF011651). Both the IDA Grant and HRITF Grant were approved on December 20, 2011 and became effective on October 22, 2012. The closing date of the original IDA Grant would be extended by eighteen months to June 30, 2018 to allow sufficient time to complete the Results-Based Financing (RBF) Impact Evaluation (IE) and ensure the development effectiveness of scaled up pro-poor interventions to be financed under the AF. As of January 31, 2016, close to 73 percent of the IDA Grant (US$19.47 million) and 89.45 percent of the HRITF Grant (US$9.35 million) have been disbursed.

2. The proposed AF would continue to support the provision of a package of health services through Results-Based (RBF) and the reinforcement of reproductive health services. In addition, the AF will:

a. support the implementation of a number of recommendations from the mid-term review (MTR) that was concluded in July 2015;

b. help finance the costs associated with the expansion of ongoing piloted strategies such as community-based targeting (CBT) of the poor and community-based health insurance (CBHI);

c. introduce interventions that would address the needs of population groups vulnerable to HIV/AIDS; and

d. provide more time for the completion of the ongoing RBF impact evaluation.

3. The AF will also fill the expected financing gap in resources needed to complete the RBF pilot and IE in 2017, in particular the added cost of the new interventions that aim to increase access of the poor to health services through RBF subsidies and incentives. While implementation is expected to continue until early 2017 for the IE end line survey, current Project resources for RBF are expected to be fully disbursed by mid-2016.

4. The Project Development Objective (PDO) of the original Reproductive Health Project (P119917) is to: "*improve the utilization and quality of reproductive health services in the Recipient's territory, with a particular focus on selected regions of the Recipient*". The PDO will be revised "*to improve the utilization and quality of maternal and child health, reproductive health and HIV/AIDS services in the Recipient's territory with a particular focus on the poor and vulnerable*" as the AF will incorporate new interventions related to HIV/AIDS and improve access to essential services for the poor and vulnerable. The Results Framework has been adjusted to measure achievements related to these additional interventions.

II. Background and Rationale for Additional Financing in the amount of US$35 million equivalent

A. Background

5. The original Project components include: (i) Component 1: Delivery of Packages of Key Maternal, Child and Other Related Health Services (IDA Grant of US$22.30 million, and HRITF Grant o US$12.7 million); and (ii) Component 2: Critical Inputs for Reproductive Services (IDA Grant of US$19.30 million).

6. The Reproductive Health Project is supply-side oriented and involves contracting health facilities to provide key maternal and child health services to target populations in their vicinity through RBF. Health services that are targeted by the intervention include, but are not limited to, outpatient consultations, immunization of children, antenatal care services, assisted deliveries, family planning services, and prevention and treatment services for Prevention of Mother-to-Child Transmission (PMTCT), HIV/AIDS treatment, malaria and tuberculosis. The Project also supports critical inputs for reproductive and family planning services.

7. The AF aims to scale up the impact and development effectiveness of the Reproductive Health Project through RBF by: (i) promoting activities that build resilience of the poor to health shocks and supporting interventions that address the needs of groups vulnerable to HIV/AIDS; (ii) supporting the implementation of a number of recommendations from the Mid-Term Review (MTR) that was concluded in July 2015; and (iii) helping to finance the costs associated with the expansion of ongoing piloted strategies such as community-based targeting (CBT) of the poor and community-based health insurance (CBHI).

8. The Project will be now targeting 4,000,000 beneficiaries (including an additional 130,000 poor beneficiaries in support of universal health coverage under the proposed AF). As such, the AF will contribute to reducing poverty and promoting shared prosperity.

9. The AF is consistent with para 26 of OP/BP 10.00, (Investment Project Financing) under which the Bank may provide Additional Financing to support scaling up the development effectiveness of a well performing project. The proposed AF and restructuring of the Project would enable the Project to exceed its development objectives and contribute to Burkina Faso's health sector goals.

10. The Bank received a letter (ref #No 0044-Presidence du Burkina Faso) dated April 7, 2014, from the Government of Burkina Faso requesting the Association to provide additional support for the Government's efforts in the fight against HIV/AIDS. In response to this, the Bank has proposed to allocate US$35 million in IDA resources for an Additional Financing of the Reproductive Health Project to support these efforts. The request is consistent with the Bank's guidelines, namely: (i) the Project is rated Satisfactory on its Development Objective (DO) and Satisfactory for Implementation Progress (IP); (ii) all legal covenants have been complied with and there are no outstanding audit reports; and (iii) the Project will follow the World Bank's "Guidelines for the Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by

World Bank Borrowers", both dated January 2011 and revised in July 2014); and "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.

B. Country and Sectoral Context

11. Despite Gross Domestic Project (GDP) growth of 5.6 percent per annum, Burkina Faso remained among the poorest countries in Africa, with an annual per capita income of US$350 and a poverty incidence which has declined from 46.7 percent in 2009 to 40.1 percent in 2014 (INSD-Burkina Faso). Although Burkina Faso's Human Development Index (HDI) rose by a relatively high positive ratio of 0.055 over the period 2000-2006, it is still placed near the bottom of the HDI. The HDI Report published in 2015 ranked Burkina Faso 183rd among 188 countries. Burkina's social welfare indicators lagged behind even modest Sub-Saharan African averages.

12. The political and security crisis which started in 2011 culminated in widespread population protests that led to the change of Government in October 2014, marking a historic turning point for the country. The political crisis reflected the public's discontent and accumulated grievances over Burkina Faso's development outcomes. The critical issues include the high cost of living; regional disparities in basic social services; unequal redistribution of resources; youth unemployment; perceived lack of accountability, and impunity and monopolization of political power. The political crisis underscored the importance of responding to citizens' demands for good governance.

13. Despite a threefold increase in health financing over the past years, Burkina Faso remains off track in terms of meeting the Millennium Development Goals (MDGs). In 2009, the Government's health budget increased from 8.9 percent to 12.7 percent of total Government budget in 2014. The spending level of US$11.9 per capita should bring much better results in health outcomes. The budget financed the following categories of expenditures: infrastructure and equipment (40 percent), salaries (26 percent), and operating costs (34 percent).

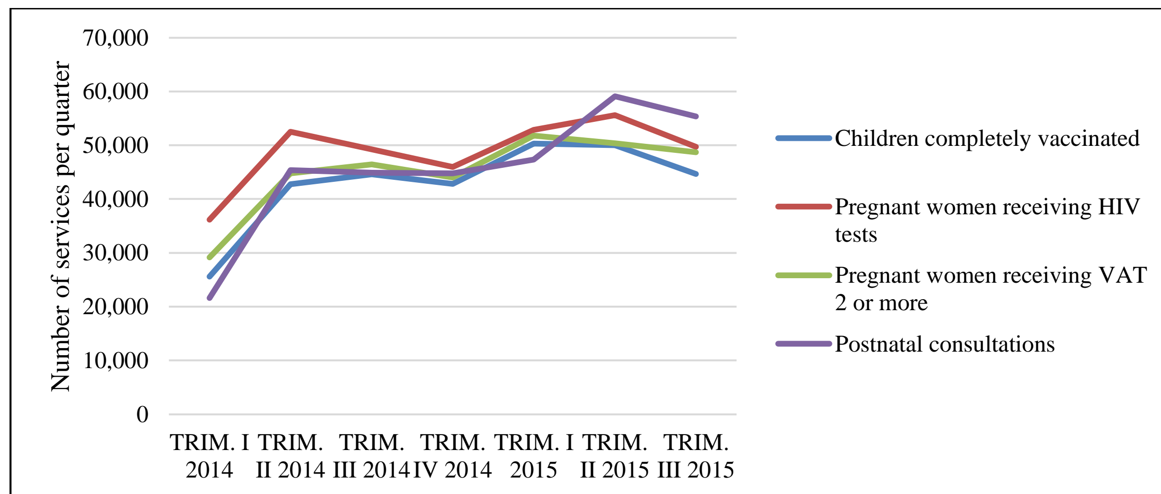
14. Notwithstanding some areas of progress (in 2010, 81 percent of children aged 12-23 months were completely immunized, compared to 39 percent in 2003), poor health outcomes remain a challenges. For example, in 2010 the infant mortality rate was 65 deaths per 1,000 live births, only a slight reduction from 2003, when the infant mortality rate was 81 deaths per 1,000 live births. In 2010, the under-5 mortality rate also remained high at 129 deaths per 1,000 live births and the maternal mortality ratio was 341 deaths per 100,000 live births. Only 56 percent of children with acute respiratory infection (pneumonia) have access to health centers for treatment and 47 percent among them received antibiotics. In addition, in 2010 only 66 percent of pregnant women delivered in health facilities. The HIV epidemic is still a generalized one and national prevalence rate is estimated at its lowest level at 1.0 percent with 1.2 percent for women and 0.8 percent for men (DHS IV-MICS, 2010).

C. Opportunities from Successful Implementation

15. A RBF pre-pilot was implemented in the districts of Boulsa, Leo and Titao from April 2011 to December 2013. The total population of the three districts is 711,361. A total of 85 primary health centers (Centre de Santé et de Promotion Sociale - CSPS) and three district

hospitals (Centre Médical avec Antenne Chirurgicale - CMA) were included in the pilot. Routine RBF data shows significant increases in the quantity and quality of services over the three year pilot period. A recently conducted IE identified a significant effect of RBF on increased utilization of antenatal care, postnatal care and deliveries. In addition to contracts with health centers and hospitals, community health workers (CHWs) were sub-contracted by health centers to refer patients to health centers for maternal and child health services, such as pre-natal consultations, deliveries, post-natal care, and vaccinations.

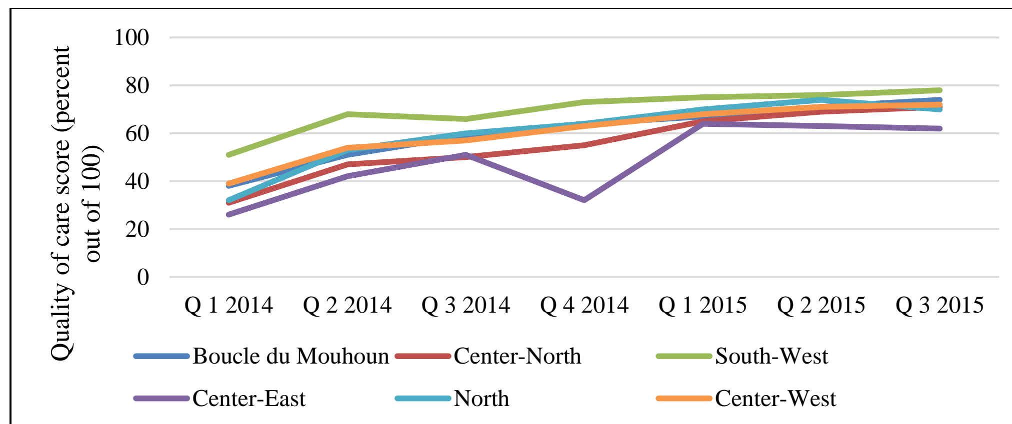
Figure 1: Trends in service delivery in RBF facilities for key maternal and child health services



16. In 2013, the technical design of the RBF program was substantially revised to support the Project-financed scale up of the RBF program. Under the new model, contracting and verification activities are managed by Contracting and Verification Agencies (CVA) that cover 1-2 regions, with antennas (branches) in each district. The list of services covered and quality assessment tools were also revised. In addition, performance contracts were introduced with central-level ministry actors, such as the RBF technical unit, the Project's implementation body (PADS), and the Direction of Studies, Planning and Health Statistics.

17. Between January and April 2014, the RBF program was rolled out to an additional 12 districts, in addition to the three pre-pilot districts. Three national NGOs have been hired by the Ministry of Health (MoH) to play the role of CVAs for implementation of contract and verification activities of the RBF scheme in the 15 districts. The scale-up covers a population of approximately 4.4 million, with approximately 600 primary and secondary care health facilities entering into RBF contracts. Quantity and quality verification activities have been ongoing in the 15 RBF districts since the rollout began in early 2014. Health center subsidy payments have been paid through December 2015. Finally, the national cloud computing system has been created and has been populated with retrospective RBF data from 2011-2014 (www.fbrburkina.org). Overall, data is showing a slow but steady increase in the quantity and quality of health services during the first two years of the scale-up (increase in the poor's access to health services, increase in contraceptive prevalence and maternal services).

Figure 2: Trends in the quality of care scores in RBF facilities



18. **Improving access for the poor through RBF and demand-side programs:** To improve health service utilization among the poor, within the context of the IE, the Project has introduced demand-side interventions such as community-based health insurance (CBHI) and fee exemption policies for the poor that reduce financial barriers and improve health seeking behavior among vulnerable populations. In both cases, community-based selection of the poor has been applied to identify the 10 percent poorest in each community, who are then enrolled into the programs.

19. As these two interventions are being studied through the impact evaluation, their rollout has been randomized at the health facility level with different packages of interventions being introduced in the regions covered by the Project. In the Boucle de Mouhoun region, CBHI has been introduced in 50 percent of the health centers covered by the RBF program. In the North, Center-East, South-West and Center-North regions, community-based exemption programs for the poor have been introduced in two-thirds of the health facilities implementing RBF. Approximately 130,000 beneficiaries have been enrolled into the programs.

20. **Supporting reproductive health and family planning services:** The reproductive health and RBF activities are closely coordinated with other development partners that provide support to the health sector, notably UNFPA, UNICEF (the lead agency for the donor group in the pooled funding for the health sector), the German Cooperation (KfW), the French cooperation (AFD), the World Bank Sahel Women's Empowerment and Demographics Project and the Global Fund. At a national level, key reproductive health and family planning indicators have progressed since the launch of the parent Project: (a) an increase in the contraceptive prevalence rate nationwide from 15 percent in 2010 to 22 percent in 2014 (vs. a target of 24 percent at end of Project); (b) an increase in the proportion of births assisted by skilled personnel from 67 percent to 86.02 percent (vs. a target of 80 percent at end of Project); and (c) an increase in the proportion of women attending postnatal consultations from 46 percent to 54 percent (vs. a target of 56 percent). The Project has most likely contributed to these trends as Component 2 is implemented at a national level.

21. **Project performance:** There are no outstanding financial audits and all audit reports are unqualified. Implementation of the safeguards requirements is rated Satisfactory. Annex 1 describes the Results Framework with performance indicators that has been updated to reflect the

outcomes of the mid-term review and the Project design and planned interventions of the proposed AF.

22. The Recipient conducted the MTR from July 15-30, 2015. The key recommendations from the MTR include: (i) to continue the implementation of the ongoing pilot in targeted areas until the completion of the impact evaluation given the impressive results achieved to improve the quantity and quality of services delivered through RBF; (ii) to maintain CBHI and community-based targeting of the poor activities throughout the duration of the operation given the results achieved, even in the initial stages, to improve health seeking behavior and financial coverage of the poor and vulnerable; (iii) to extend the end line of the impact evaluation from early 2016 to early 2017, to reconcile the initial delays in rolling out the pro-poor financing mechanisms; and (iv) to enhance the capacities of nurses and midwives, and strengthen the demand and delivery for family planning and reproductive health services. The MTR also identified that there will be a financing gap if RBF is to be supported until 2017. The proposed AF will help address the financing gap.

D. Higher level objectives to which the Project contributes

23. The overall objective of the parent Project is to improve the utilization and quality of reproductive health services in the Recipient's territory, with a particular focus on selected regions of the Recipient. Building on the experience and achievements of the parent Project, the proposed changes under the AF will support the long term objectives of strengthening the health system and of reducing maternal and child mortality and child malnutrition, thereby contributing to the attainment of MDGs 1c, 4 and 5. Thus, the AF will contribute to the Health, Nutrition and Population Global Practice's goal of ending preventable deaths and disability through the launch and acceleration of Universal Health Coverage activities. Better health and nutrition status improves human capital and produces more productive individuals who are better off economically. In addition, the AF will have a particular focus on improving access to and utilization of health services among the poor and vulnerable, leading to improvements in health and development outcomes of at-risk and vulnerable populations. Finally, the AF will contribute to the Bank's twin goals of eliminating extreme poverty and boosting shared prosperity by improving health status and human capital especially among vulnerable segments of the population, which in turn increase productivity.

24. The AF 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 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 and decrease vulnerability through high health insurance coverage. The Project would help improve: i) financial access of the poor to health services; and ii) access to assisted birth attendants and to higher-end care in the case of complications. 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.

25. The Government's renewed interest in demographic and reproductive health issues is reflected in the Country Program Strategy (CPS) for the period 2013-2016. The Project is aligned with the CPS' Strategic Axis 2: "Consolidation of Human Capital and promotion of Social Protection", by increasing access to basic social services by the poor (Education, Health) and reducing vulnerability. It is also consistent with Axis-4: Cross-Cutting Priorities: Gender, Demography, Natural Resources. 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* (Strategy for Accelerated Growth and Sustainable Development), emphasizes demographic issues with a particular focus on population growth. Finally, the proposed AF is fully consistent with the Bank's HNP Strategy (April 24, 2007). Client interest in the proposed AF is high. Since 2011, the Ministry of Health has requested the World Bank to help sustain the development and expand the implementation of RBF in the health sector. Annual regional workshops on RBF are conducted in Burkina Faso, and the national RBF technical service within the MoH has a reputation of being one of the innovative and respected RBF units in the region. They have provided technical assistance to countries such as Central African Republic and Cameroon several times since 2014.

26. The inclusion of CBHI schemes is positively viewed by other ministries involved in the preparation of the national health insurance scheme, such as the Ministry of Work and Social Security, who views the Project-supported pilot as a pre-pilot for the voluntary arm of the national scheme (which is still in its infancy). On the other hand, the CBT interventions have been designed and are being implemented in close collaboration with the Ministry of Social Affairs, and the Bank-supported Social Safety Nets Project (P124015) that has recently started and is in its second year of implementation. A joint evaluation was conducted in mid-2015 between the Bank's Health and Social Protection Task Teams to compare the community-based targeting approach used by the health operation with the proxy-means testing approach used by the Safety Nets Project. The results of this evaluation will be disseminated in early 2016 and will contribute to the national policy dialogue on targeting approaches across different sectors.

III. Proposed Changes

Summary of Proposed Changes

The proposed AF will: (i) support the implementation of a number of recommendations from the MTR that was concluded in July 2015; (ii) help finance the costs associated with the expansion of ongoing piloted strategies such as community-based targeting of the poor and community-based health insurance to improve the demand for and utilization of health services by poor and vulnerable groups, in support of Universal Health Coverage; (iii) introduce interventions that would address the needs of population groups vulnerable to HIV/AIDS and STI (in particular youth, women and high risk groups); and (iv) provide sufficient time to complete the ongoing RBF impact evaluation.

The closing date of the original IDA Grant of December 31, 2016 will be extended to June 30, 2018. In addition, proceeds from the original IDA Grant that are currently unallocated will be

allocated to Component 1.1 of the Project.

Change in Implementing Agency	Yes [X] No [ ]
Change in Project's Development Objectives	Yes [X] No [ ]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [X] No [ ]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [X] No [ ]
Reallocation between Disbursement Categories	Yes [X] No [ ]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [X] No [ ]
Change in Financial Management	Yes [X] No [ ]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [X] No [ ]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

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

Change in Project's Development Objectives

Explanation:

The PDO will be revised to: "to improve the utilization and quality of maternal and child health, reproductive health and HIV/AIDS services in the Recipient's territory with a particular focus on the poor and vulnerable", as the AF will incorporate new interventions related to HIV/AIDS and improve access to essential services for the poor and vulnerable. The Results Framework has been adjusted to measure achievements related to these additional interventions.

Proposed New PDO - Additional Financing (AF)

To improve the utilization and quality of maternal and child health, reproductive health and HIV/AIDS services in the Recipient's territory with a particular focus on the poor and vulnerable.

Change in Results Framework

Explanation:

Under the original Project, many of the indicators were defined as percentages. Given the nature of RBF data and certain core indicators, the majority of indicators have been converted from percentages to cumulative numbers. Targets have been revised to align with the proposed extension of the Project's closing date of June 30, 2018.

New indicators will track progress on the impact of the activities to be supported by the AF that are not currently covered by the current Results Framework. The indicator "Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT (number)" will be added to capture activities supported by Component 2. The indicator "Number of health services provided free of charge to the poor and vulnerable" will be added to capture activities related to Component 1.3 (community-based targeting, community based health insurance and support to UHC). The amended results framework is shown in Annex 1.

Compliance

Covenants - Additional Financing (Reproductive Health Project - Additional Financing - P153104)

Source of Funds	**Finance Agreement Reference**	**Description of Covenants**	**Date Due**	**Recurrent**	**Frequency**	**Action**
	Schedule 2, Section I.A.2(c); Date of Agreement	The Recipient shall, at all times during the implementation of the Project, maintain CNLS-IST, to be responsible for the implementation of Part B(4) of the Project, and shall take all actions including the provision of funding, personnel and other resources necessary to enable said CNLS-IST to perform said function.		☒	Continuous	New

	Schedule 2, Section I.G; Date of Agreement	Each HIV/AIDS Intervention shall be eligible for financing upon the Recipient's determination, on the basis of an identification process and appraisal conducted in accordance with the criteria, guidelines and detailed procedures set forth in the Project Implementation Manual and in a manner satisfactory to the Association, that the HIV/AIDS Interventions satisfies the eligibility criteria specified in the Project Implementation Manual.		☒	Continuous	New
	Schedule 2, Section I.B.4; Date of Agreement	Not later than March 1 in each calendar year: (i) prepare and furnish to the Association for its review and evaluation of the Unit Price for each PBHS and recommendations for any adjustments; (ii) afford Association a reasonable opportunity to exchange views on		☒	Yearly	New

		said evaluation and recommendations; and (iii) adopt and apply adjusted Unit Price for each PBHS as approved by Association under PBHS Sub-grants.				
	Schedule 2, Section I.D.1; Date of Agreement	Not later than December 15 in each calendar year, prepare and furnish to the Association for its approval, a program of activities proposed for inclusion in the Project during the following calendar year; including: (a) a detailed timetable for the sequencing and implementation of such activities; and (b) a proposed financing plan for such activities.		☒	Yearly	New

Covenants - Parent (BF-Reproductive Health Project (FY12) - P119917)

Ln/Cr/TF	Finance Agreement Reference	Description of Covenants	Date Due	Status	Recurrent	Frequency	Action
IDA-H7510	Section 4.01; Schedule 2, Section I.B	(a) The GA has been executed and delivered and all conditions precedent to its effectiveness (except the		Complied with	☒		No Change

		effectiveness of the FA); (b) the Recipient has adopted the Implementation Manual, approved by IDA. Frequency: Yearly					
IDA-H7510	Section 4.01; Schedule 2, Section I.A.2	(a) establish 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. Frequency: Continuous		Complied with	☐		No Change
IDA-H7510	Schedule 2, Section I.D	The Recipient shall prepare and furnish to IDA for prior approval, Annual Work Programs of activities proposed for inclusion in the Project. Frequency Yearly		Complied with	☐		No Change
IDA-H7510	Schedule 2, Section I.E.5(b) |	Engage an independent expert, whose terms of reference, qualifications		Complied with	☐		No Change

		and experience are satisfactory to IDA, to conduct independent verifications of the delivery of services under PBHS Sub-project. | Frequency: Continuous					
IDA-H7510	Schedule 2, Section E	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. Frequency: Yearly		Complied with	☐		No Change

Conditions

Source Of Fund	Name	Type
IDA	Category 1	Disbursement

Description of Condition

No withdrawal shall be made under Category (1) the until the proceeds of the Original Financing allocated to Category (1) of the table in Section IV.A.2 of Schedule 2 to the Original Financing Agreement have been fully disbursed.

Source Of Fund	Name	Type
IDA	Category 2	Disbursement

Description of Condition

No withdrawal shall be made under Category (2) until the proceeds of the Original Financing allocated to Category (2) of the table in Section IV.A.2 of Schedule 2 to the Original Financing

Agreement have been fully committed or disbursed.

Source Of Fund	Name	Type
IDA	Effectiveness	Effectiveness

Description of Condition

The Additional Condition of Effectiveness consists of the following, namely that the Recipient has adopted the revised (see Minutes of Negotiations, para. d) Project Implementation Manual in accordance with the provisions of Section I.B of Schedule 2 to the Financing Agreement.

Risk

Risk Category	Rating (H, S, M, L)
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Low
4. Technical Design of Project or Program	Low
5. Institutional Capacity for Implementation and Sustainability	Low
6. Fiduciary	Low
7. Environment and Social	Low
8. Stakeholders	Low
OVERALL	Low

Finance

Loan Closing Date - Additional Financing (Reproductive Health Project - Additional Financing - P153104)

Source of Funds	Proposed Additional Financing Loan Closing Date
IDA Grant	30-Jun-2018

Loan Closing Date(s) - Parent (BF-Reproductive Health Project (FY12) - P119917)

Explanation:

The closing date of the original IDA Grant of December 31, 2016 will be extended to June 30, 2018 to allow sufficient time for the completion of the Results-Based Financing impact evaluation and to ensure development effectiveness of the newly scaled-up pro-poor interventions.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-H7510	Effective	31-Dec-2016	31-Dec-2016	30-Jun-2018	31-Dec-2016
TF-11678	Effective	31-Dec-2016	31-Dec-2016	31-Dec-2016	

Change in Disbursement Arrangements

Explanation:

Disbursement arrangements have been updated to (i) reflect the full funding of the proposed AF by an IDA grant; there will be no HRITF funds for the AF; and (ii) for Sub-component 2.4, SP/CNLS-IST will be responsible for the overall management and implementation of this sub-component, including procurement and financial management.

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

Disbursement estimates have been updated to align with the planned interventions of the proposed AF.

Expected Disbursements (in USD Million)(including all Sources of Financing)

Fiscal Year	2017	2018								
Annual	15.00	20.00								
Cumulative	15.00	35.00								

Allocations - Additional Financing (Reproductive Health Project - Additional Financing - P153104)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	USD	Part A (1)	10,000,000.00	100.00
IDA	USD	Parts A(2), A(3), B(1), and B(2)	15,000,000.00	100.00
IDA	USD	Part B(4)	10,000,000.00	100.00
		Total:	35,000,000.00	

Reallocation between Disbursement Categories

Explanation:

Under the original Project, SDR 1.1 million will be reallocated from Category "Unallocated" to "Category 1" to continue the provision of a package of health services through Results-Based Financing.

Ln/Cr/TF	Currency	Current Category of Expenditure	Allocation		Disbursement %(Type Total)	
			Current	Proposed	Current	Proposed
TF-11678	USD	GD,NCS,CS,TR,OP C, Part A (1)	8,800,000.00	8,800,000.00	52.00	52.00
TF-11678		GD,NCS,CS,TR,OP C, Part A (2),A(3)	3,900,000.00	3,900,000.00	71.00	71.00
TF-11678		Designated Account	0.00	0.00	0.00	0.00
		Total:	12,700,000.00	12,700,000.00		
IDA-H7510	XDR	GD,NCS,CS,TR,OP C, Part A (1)	5,000,000.00	6,100,000.00	48.00	48.00
IDA-H7510		GD,NCS,CS,TR,OP C, Part A (2),A(3)	1,000,000.00	1,000,000.00	29.00	29.00
IDA-H7510		GD,NCS,CS,TR,OP C, Part B	11,200,000.00	11,200,000.00	100.00	100.00
IDA-H7510		UNALLOCATED	1,100,000.00	0.00	0.00	0.00
IDA-H7510		Designated Account	0.00	0.00	0.00	0.00
IDA-H7510		Designated Account	0.00	0.00	0.00	0.00
		Total:	18,300,000.00	18,300,000.00		

Components

Change to Components and Cost

Explanation:

The proposed AF will: (i) improve the delivery and quality of a reproductive health service package through results-based financing and (ii) support critical inputs for reproductive health and HIV/AIDS services. In addition to continuing support for activities under Components 1 and 2 of the parent Project, the AF will support (i) under Component 1, the scaling up of ongoing piloted strategies such as community-based targeting of the poor and the provision of community-based health insurance, along with the introduction of a new list of health services that will be provided

free of charge to beneficiaries; and (ii) under Component 2, include a new sub-project and related activities that aim to increase demand for and utilization of HIV/AIDS preventive as well as reproductive health services, with particular focus on high risk groups (i.e., sex workers, men having sex with men (MSM), detainees).

COMPONENT 1: Improving the delivery and quality of a reproductive health service package through results-based financing (US$21.0 million equivalent, IDA AF)

- Provision of Results-Based Financing;
- Support to the implementation and supervision of Results-Based Financing; and
- Support to Universal Health Coverage through improving financial access to health services for poor and indigent populations.

Component 1 will continue the implementation of RBF in the six selected regions where the roll-out began in early 2014. RBF is being implemented to address critical impediments confronting the delivery of services at the district level. These challenges include the: (i) scarcity of funds to meet operating expenses; (ii) lack of focus on achievement of results and lack of accountability mechanisms of the district health system; and (iii) modest managerial capacity at the district level.

In the six selected regions, the MoH will support the provision of health services to be delivered and paid through the RBF system in selected health care facilities and continue to cover the provision of packages of basic health services (PBHS). The package of services will have a large focus on maternal and neonatal health, but will also continue to include non-maternal services (i.e. child visits, immunizations etc.), adolescent services, HIV/AIDS and STI, tuberculosis, and malaria, to ensure that health care facilities do not neglect other services.

The AF would provide support to the provision of the package of services under the PBHS, which will also now include the list of services provided free of charge to beneficiaries of the community targeting and insurance interventions currently being piloted, as well as new HIV/AIDS-related indicators. This component will also continue to support activities related to contracting, verification and training for RBF.

COMPONENT 2: Supporting critical inputs for reproductive health and HIV/AIDS services (US$14 million equivalent, IDA AF)

- Continue to support critical inputs for reproductive health services with a particular focus on training of health professionals;
- Provide drugs and equipment to improve obstetrical and neonatal services and for biomedical waste management;
- Strengthen demand for family planning and reproductive health services; and
- Target youth, women and high risk groups in the fight against HIV/AIDS and STI and ensure better uptake of HIV treatment and prevention services as well as reproductive health services.

Component 2 will support reproductive health interventions related to the fight against HIV/AIDS and reproductive health services. It will be implemented at national level and will have four subcomponents: (i) training of nurses, skilled birth attendants and doctors; (ii) provision of drugs

and equipment to improve obstetric and neo-natal services; (iii) strengthening demand for family planning and reproductive health services; and (iv) demand creation strengthening HIV prevention, to support PLWHA and reproductive health services for youth, women and high-risk groups.

Youths, women and high risk groups (in particular Sex Workers, MSM, prisoners, miners and truckers) account for a disproportionate share of the epidemic and act as vector of transmission in the general population. Targeting those groups in concentrated and mixed epidemic settings has proven to be the most efficient way of investing in the HIV response. The Project will support interventions designed to create demand for treatment and prevention services from those high risk groups and facilitate access to services, while also strengthening the provisions for prevention and treatment services for key populations provided by the Ministry of Health.

Current Component Name	**Proposed Component Name**	**Current Cost (US$M)**	**Proposed Cost (US$M)**	**Action**
Delivery of Packages of Key Maternal, Child and Other Related Health Services	Improving the delivery and quality of a Reproductive Health Service Package through Result-Based Financing	22.30	43.30	Revised
Critical Inputs for Reproductive Services.	Supporting critical inputs for reproductive health and HIV/AIDS services	19.30	33.30	Revised
	Total:	41.60	76.60	

Other Change(s)

Change in Implementing Agency

Explanation:

The Permanent Secretariat of the National Committee for the Fight Against HIV/AIDS (SP/CNLS-IST) will be the implementing agency responsible for HIV/AIDS interventions under the new Sub-component 2.4.

Implementing Agency Name	**Type**	**Action**
SP/CNLS-IST	Implementing Agency	New

Change in Institutional Arrangements

Explanation:

The implementation arrangements for Component 1 of the AF will remain the same. For the

implementation of RBF, the three CVAs the Recipient recruited under the original Project will continue to conduct contracting and verification activities, while the *Programme d'appui du développement sanitaire,* PADS (Health Development Support Program) will make RBF payment subsidies upon validation of results. The National RBF Technical Service will continue to coordinate technical inputs and policy dialogue related to RBF.

For Component 2, the implementation arrangements will remain the same through the PADS (the Project implementing unit established under the Bank-financed Health Sector Support and AIDS Project (P093987) for Sub-components 2.1, 2.2 and 2.3. For Sub-component 2.4, Project activities will be implemented by the Permanent Secretariat of the National Committee for the Fight against HIV/AIDS and STI (SP/CNLS-IST) which implemented the HIV/AIDS part of the Bank-financed Health Sector Support and AIDS Project (P093987). All monitoring and evaluation, procurement and financial management will be implemented by the PADS and SP/CNLS-IST as it relates to Sub-component 2.4. The PADS is staffed by a multidisciplinary team including a Coordinator, a Financial Management Specialist, an Accountant, a Procurement Specialist, a Monitoring and Evaluation 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. PADS has also been managing other large programs supported by the Global Alliance for Vaccination and Immunization (GAVI), the Global Fund against AIDS-Malaria and TB, the Dutch Cooperation, AFD (French cooperation, KfW (German cooperation), UN agencies such as UNICEF and UNFPA, and others. The Project will continue to be overseen by the Steering Committee created for the Reproductive Health Project which is chaired by the General Secretary of MoH, and includes Directors of all major departments, donors and technical assistance partners.

The SP/CNLS-IST is the technical arm of the National Council for the Fight against AIDS and STIs (CNLS-IST) chaired by the President of Burkina Faso. The minister responsible for health is the vice president of the CNLS-IST which includes representatives of ministries, civil society, private sector and technical and financial partners involved in the fight against HIV/AIDS and STIs. The Financial Management Unit of the SP/CNLS-IST has qualified staff with experience confirmed in the management of projects funded by international donors. The Unit has managed resources allocated to the fight against HIV / AIDS and STIs by the Government of Burkina Faso, the World Bank, UNDP, UNICEF, UNAIDS, the Netherlands, Norway, Japan, Spain and Denmark.

The Project Implementation Manual (PIM) has been revised to incorporate changes in Project design and related implementation arrangements. These are summarized in Annex 2. The adoption of the revised PIM is a condition of effectiveness.

Change in Financial Management
Explanation:
The SP/CNLS-IST will implement Sub-component 2.4 and will provide quarterly interim financial reports (IFRs) to PADS within 30 days after the end of the semester. The PADS will in turn consolidate these reports and submit a consolidated IFR to the Bank within 90 days after the end of the semester. It should also allow both the internal and external auditors of PADS to have access to the Project's books of accounts and verify outputs. In addition, the SP/CNLS-IST should open a project account such that Project funds are not commingled with other funds. The Financial Management system of SP/CNLS-IST satisfies the World Bank's minimum requirements under OP/BP10.00. Indeed, the FM system used for the implementation of the part B of the Health Sector Support & Multi-sectoral AIDS Project (P093987), closed in December 2014, is always in place. The SP/CNLS-IST does not have any audit report overdue. The SP/CNLS-IST will have its own designated account for disbursement of financing related to activities in Sub-component 2.4. The reporting on the use of advances to the designated account will be accompanied by an unaudited Interim financial report (IFR).

Change in Implementation Schedule
Explanation:
The proposed AF would: (i) support the implementation of a number of recommendations from the MTR that was concluded in July 2015; (ii) help finance the costs associated with the expansion of ongoing piloted strategies such as community-based targeting of the poor and community-based health insurance; (iii) introduce demand-driven interventions that would address needs of population groups vulnerable to HIV/AIDS and STI; and (iv) provide more time for completion of the ongoing RBF impact evaluation. The AF will also fill the expected financing gap in resources needed to complete the RBF pilot and impact evaluation in 2017, in particular the added cost of the new interventions that aim at increasing access of poor to health services through RBF subsidies and incentives. While implementation is expected to continue until early 2017 for the impact evaluation end line survey, current Project resources for RBF are estimated to be fully disbursed by early 2016. The extension of the closing date of the original IDA Grant by eighteen months to June 30, 2018 will allow for the results of the RBF impact evaluation to be disseminated and lessons learned from the evaluation integrated into the program design for the final year of implementation (2018). The implementation schedule has been updated to align and reflect the above changes in Project design and the planned activities to be implemented during the extended period.

IV. Appraisal Summary

Appraisal Summary
Economic and Financial Analysis

Explanation:

The AF is expected to (i) scale-up results-based interventions for the strengthening of health service delivery with a particular focus on the poor and vulnerable; and (ii) support critical inputs for reproductive health and HIV/AIDS services. The investments have potential high development impact and are operationally efficient.

1. DEVELOPMENT IMPACT

A comprehensive economic assessment for the proposed Project could not be done due to the limited up-to-date data and information available to develop a formal cost-benefit analysis. However, the operation is expected to improve the living conditions of the population through improved access to quality health care, in particular for the poor and vulnerable populations who did not have access to services in the past due to financial barriers. Component 1 will support health service supply through Results--Based Financing and improve demand and utilization through the insurance and fee-waiver programs for the poor. Component 1 will also strengthen the HMIS for more effectiveness in the M&E and outcomes of the health system as a whole. Component 2 will contribute to the quality of reproductive health and HIV/AIDS services by ensuring that critical inputs such as training and commodities are made available. At-risk groups will be a key focus of Component 2. Project activities will likely yield other direct and indirect benefits in the short- and long-term.

1.1. Delivery of quality health care services and health system strengthening

Addressing basic maternal, child and reproductive health brings dividends in both the short- and long-term. The package of services included in the Project is technically sound and consistent with the country's health strategy and Lancet's recommendation on priority, high-impact interventions to reduce child and maternal mortality rates. Notwithstanding some areas of progress (81 percent of children aged 12-23 months are completely immunized in 2010 DHS-MICS IV, compared to 39 percent in 2003), among 1000 children at birth, 65 will die before reaching their first birth day. The risk to die between birth and fifth anniversary is 129 deaths per 1,000 live births (DHS-MICS IV). These rates are among the highest in Africa. The maternal mortality ratio is 341 deaths per 100,000 live births. Only 56 percent of children with acute respiratory infection (pneumonia) have access to health centers for treatment and 47 percent among them received antibiotics. Only 66 percent of women deliver in health facilities.

Investing in reproductive health is a high-impact intervention. Evidence shows that in sub-Saharan Africa, two-thirds of the disease burden for women of reproductive age is attributable to sexual and reproductive health problems. One of the most cost-effective reproductive health interventions is family planning (US$1.55 per new user per year) which can prevent up to one-third of all maternal deaths by delaying childbearing, spacing births, and avoiding unintended

pregnancies. Family planning can also reduce infant mortality and morbidity through birth spacing and improved adolescent health by reducing high risks of pregnancy-related deaths. For every US$1 invested in family planning, the future savings are as high as US$4 in Zambia, US$7 in Bangladesh, and US$8 in Indonesia. The bulk of the Project resources will go to maternal, reproductive and child health services supported via RBF. Hence, the returns on investment are potentially high especially when integrated with maternal and child health services in a fragile context as in this Project.

1.2. Child nutrition

The AF will also target child nutrition. Evidence indicates that children under the age of 24 months who are stunted earn significantly lower incomes throughout their productive lives. Thus, the benefits of reducing stunting in the Project areas may contribute to increase income-earning capacity of the beneficiaries for whom stunting is prevented. The most recent empirical estimates of the negative effects of stunting on worker productivity and adult earnings range from 10 to 20 percent. In the meantime, a significant proportion of child mortality in Burkina Faso can be attributed to the poor nutritional status of children. About 26 percent of children under the age of five are underweight and 35 percent are stunted (MICS, 2010). Child nutrition services will be targeted and supported by the RBF intervention. Economic benefits linked to child nutrition have been documented in the economic and scientific studies in many developing countries. Estimates from a number of studies in the last 20 years indicate that the economic returns of nutrition interventions rank among the highest in comparison with other developmental interventions. These results are achieved by the high productivity-enhancing effects of nutrition programs. It is therefore expected that in Burkina Faso, the economic return of child nutrition aspects of the program is high.

2. JUSTIFICATION FOR PUBLIC INVESTMENT

Due to the high levels of chronic poverty and low human development outcomes in Burkina Faso, this operation is an appropriate instrument to provide assistance to the most vulnerable and affected people. The vast majority of the population (77 percent) lives in rural areas and is affected by illiteracy (71 percent in 2007). The 2015 United Nations Development Program (UNDP) Human Development Index ranks it 183rd among 188 countries with comparable data. In 2009, the poverty headcount ratio at national poverty line was estimated at 47.44 percent of the total population (Institut National de la Statistique et de la Démographie, 2012).

Since 2003, Demographic and Health Surveys have included an indicator of the households' socio-economic status. These data can be used to show the association of poverty with health coverage and outcomes. They show the enormous size of the poor–rich gap, in particular for maternal health as the biggest gap can be observed for contraception use and deliveries.

An evaluation of the needs in emergency obstetric and neonatal care was conducted by the World Bank, United Nations Fund for Population Activities (UNFPA), United Nations Emergency Children's Fund (UNICEF) and World Health Organization (WHO) in 2011. It showed that the quality of care was highly variable. Many health facilities were characterized by poor reception of patients by providers, inefficiency in resource utilization and time allocation of providers lead

to long waiting lines, insufficient equipment and drugs and a lack of skills in health staff. The lack of skills of the Ministry of Health (MoH) personnel for basic and emergency care was analyzed in detail in this report and pointed to the importance of in-service training to update the knowledge and improve the skills of the personnel (World Bank, 2011).

The cost effectiveness and return on investment for the delivery of primary health care services and overall health system strengthening were analyzed based on core interventions that will be introduced under the AF. The bulk of these resources will go to health facilities under performance-based contracts for the delivery of packages of health services, the management and technical assistance necessary to enable them to deliver high quality health services. As such there is strong justification for financing the RBF intervention supported by the AF.

3. VALUE ADDED OF BANK'S SUPPORT

The World Bank has extensive experience with health system strengthening in the region, as well as technical expertise in designing RBF programs. This experience and technical knowledge will contribute to the results achieved through the Project. The health, nutritional, social and economic impacts of the Project should be very high since it is targeting populations living in a context of very high poverty and poor human development outcomes. The strengthening of health facilities will have a positive impact on the populations of the targeted areas. The Project and Bank's technical assistance will also contribute to strengthen the health system as a whole for better results delivery in areas not directly covered by the Project.

4. EFFICIENCY ON IMPLEMENTATION

The AF will continue the successful roll-out of RBF but put an even larger focus on ensuring access to quality services for the worst off, particularly populations who faced insurmountable financial barriers prior to the fee-waiver and insurance programs. The RBF Technical Unit functions well within the Ministry of Health and the Project implementation unit continues to appropriately manage the fiduciary aspects of the Project. Therefore, the incremental cost of adding activities linked to the AF is marginal. Moreover, RBF monitoring and verification tools have already been developed, benefiting from the extensive experience of the approach in Burkina Faso and other countries in the region.

Technical Analysis

Explanation:

RBF programs are increasingly implemented in low and middle income countries to improve health service quality and utilization. In April 2011, a RBF program pre-pilot was launched in Boulsa, Leo and Titao districts in Burkina Faso with the objective of increasing the utilization and quality of maternal health services. The impact of this program was recently evaluated. The primary data source was facility-level administrative data from the national health management information system (HMIS). To assess program impact, the evaluation used a case-control interrupted time series design, comparing the changes in health service utilization post-introduction with changes in matched control areas.

The evaluation found that all three maternal health service utilization indicators examined increased significantly in RBF areas. On average, RBF facilities had 2.3 more antenatal care visits (95 percent CI [0.432 – 4.209]), 2 more deliveries (95 percent CI [0.017 – 4.051]) and 9.5 more postnatal care visits (95 percent CI [6.072, 12.873]) each month. Compared to the service provision levels prior to the interventions, this implies a relative increase of 27.5 percent for ANC, of 9.1 percent for deliveries, and of 118.3 percent for postnatal care. The RBF program was effective in increasing utilization of essential maternal health services.

The design of RBF arrangements in Burkina Faso is based on the best practices observed and experiential knowledge gained through original financing of the parent Project as well as the pre-pilot in Burkina Faso and other successful RBF projects in the region. For instance, the proposed AF will continue supporting Contract and Verification Agencies (CVA) covering each region. Close collaboration with development partners will help greatly in promoting and monitoring RBF results. Similarly, the mechanism to determine RBF credits is a "fee-for-service conditional on quality" system, which has been applied with successful results in other RBF projects such as in Rwanda, Burundi, Congo, Zambia, Zimbabwe, Nigeria, Benin, DRC, Cameroon and Chad. Such a system ensures that (i) the RBF mechanism is clear and can easily be understood by health workers and communities and (ii) the increase in the quantity of care is not detrimental to quality.

Social Analysis

Explanation:

The proposed AF is expected to have a positive social impact by improving access to health care services for vulnerable households. Component 1 (through the payment for performance) will provide incentives for health facilities to reduce staff absenteeism and to improve staff responsiveness with patients. As a result, health facilities with RBF contracts will in turn provide more and better care for marginalized populations.

Moreover, the AF will have a positive impact on gender in Burkina Faso. Given that the Project's objectives are to improve maternal and child health in target areas, improving women's health is an essential component of the intervention. Particular attention will also be given to ensuring active participation of women in Project areas through the use of community-based organizations (local NGOs, women's groups, agricultural groups, etc.). The Project is expected to have a positive impact not only on pregnant women but on all women, as RBF credits will improve the quality of care for the identified package of health services essential for the general population.

Finally, demand-driven support for HIV preventive activities among high risk and vulnerable groups can have positive effects in risk reduction behaviors that help to prevent HIV/AIDS, and in cases where people are infected or affected, that appropriate and responsive care and support are provided.

Environmental Analysis
Explanation:
Under the proposed AF, the environmental category of the Project will remain B - due to the potential for increased medical waste generation from health facilities and the need for proper management and disposal of this waste. The main safeguard instrument under this policy will be the Medical Waste Management Plan (MWMP). The plan, developed and disseminated (Infoshop in the World Bank and in country newspapers) in February 2011, is being implemented by the Ministry of Health (MoH) and it is agreed that the same plan will be applied in the context of the Additional Financing as the components and the targeted areas of the AF remain the same. The MWMP will be evaluated in 2016 along with the Mid-term review of the National Health Development Plan (and renewed together with it in 2016). In addition, health centers will report on hazardous medical material waste management since that action will be included as an indicator to be evaluated and purchased in RBF. In fact, the quantified quality checklist used by RBF to pay for performance on the quality measure, measures this element. The weighting for this aspect will be increased, and the adherence to the guidelines will be checked, and paid for, quarterly.
Risk
Explanation:
The overall risk is rated as Low. Apart from the recent political turmoil, which has recently concluded in a peaceful democratic election and transition of power in November 2015, the original main risk related to the introduction of a new Results-Based Financing (RBF) instrument in a relatively low capacity setting, remains relevant. The Project's design addresses these issues by involving experienced NGOs and emphasizing training efforts at the central, regional, and local levels. Furthermore, the risk of having health workers manipulating results indicators is significantly reduced by ex-ante verification by the CVA, and ex-post verification by the CSOs. Finally, weak governance including contract negotiations and management (contract award, monitoring & evaluation, fraud and corruption prevention, etc.) could result in NGO contracts that do not deliver value-for-money. The implementing agency, design, and delivery quality risks are rated as Low. 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.

V. World Bank Grievance Redress

27. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-

compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Revisions to the Results Framework		**Changes to the Original Results Framework**
PDO		
Current (PAD)	*Proposed*	
To improve the utilization and quality of reproductive health services in the Recipient's territory with, a particular focus on selected regions of the Recipient.	Changed	New PDO: To improve the utilization and quality of maternal and child health, reproductive health and HIV/AIDS services in the Recipient's territory with a particular focus on the poor and vulnerable.
PDO indicators		
Current (PAD)	*Proposed change**	
PDO#1: Contraceptive prevalence rate	Indicator revised	New indicator: New acceptors of modern contraceptive methods (number)
PDO#2: Proportion of births assisted by skilled personnel	Target revised	Target revised
PDO#3: Proportion of women attending postnatal consultations	Indicator revised	New Indicator: Number of women who received postnatal consultation between the 6th days/6th week of delivery
PDO#4: Children fully immunized	Indicator revised	New Indicator: Number of children completely vaccinated
No PDO#5 in original PAD	New indicator to cover Component 1.3	New Indicator: Number of poor and vulnerable persons who receive health services free of charge
No PDO#6 in original PAD	New indicator to cover Component 2.4	New Indicator: Pregnant women living with HIV who received antiretroviral to reduce the risk of PMTCT (number)
Intermediate Results indicators		
Current (PAD)	*Proposed change**	
IOI#1: Percentage of pregnant women receiving at least 2 doses of anti-tetanus immunization		
IOI#2: Percentage of facilities that received RBF credits on time	Target revised	Target revised
IOI#3 Pregnant women receiving antenatal care during a visit to a health provider	Indicator changed and target revised	Indicator changed to Percentage of pregnant women receiving at least 2 antenatal care visits during a pregnancy

Revisions to the Results Framework		**Changes to the Original Results Framework**
IOI#4: Couple years protection (CYP)	Dropped	Indicator dropped due to difficulty in measurement
IOI#5: Percentage of Caesarian sections	Indicator changed and target revised	Indicator changed to Percentage of Cesarean-sections among planned pregnancy
IOI#6: Percentage of women of reproductive age that are satisfied with the quality of RH care and services provided in public sector facilities.	Dropped, New indicator to cover Component 1.3	Indicator changed to Percentage of target population enrolled in community-based health insurance schemes
IOI#7: Health personnel receiving training [cumulative]	Target revised	Preservice and in-service training
IOI#8: Number of CEmONC public sector health facilities	Dropped	Indicator dropped due to difficulty in measurement
IOI#9: Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT (number)	Indicator changed	New indicator: Number of pregnant women receiving VCT services
IOI#10: Percentage of facilities with no contraceptive stock-outs in last three months		
IOI #11: Percentage of women aged 15-19 who know of at least one modern family planning method	Dropped	Indicator dropped due to difficulty in measurement

Annex 1: Revised Results Framework and Monitoring

Burkina Faso: Reproductive Health Project Additional Financing (P153104)

Project Name:	Reproductive Health Project - Additional Financing (P153104)			Project Stage:	Additional Financing	Status:	FINAL
Team Leader(s):	Haidara Ousmane Diadie	Requesting Unit:	AFCF2	Created by:	Paul Jacob Robyn on 07-Oct-2015		
Product Line:	IBRD/IDA	Responsible Unit:	GHN07	Modified by:	Marylou R. Bradley on 17-Feb-2016		
Country:	Burkina Faso	Approval FY:	2016				
Region:	AFRICA	Lending Instrument:	Investment Project Financing				
Parent Project ID:	P119917	Parent Project Name:	BF-Reproductive Health Project (FY12) (P119917)				

Project Development Objectives

Original Project Development Objective - Parent:

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.

Proposed Project Development Objective - Additional Financing (AF):

To improve the utilization and quality of maternal and child health, reproductive health and HIV/AIDS services in the Recipient's territory with a particular focus on the poor and vulnerable.

Results

Core sector indicators are considered: Yes	Results reporting level: Project Level

Project Development Objective Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Marked for Deletion	Contraceptive prevalence rate	☐	Percentage	Value	15.00	21.90	24.00
				Date	31-Dec-2010	30-Apr-2015	31-Dec-2016
				Comment			
New	New acceptors of modern contraceptive methods (number)	☐	Number	Value	0.00	360000.00	770000.00
				Date		30-Jun-2015	30-Jun-2018
				Comment			
Revised	Proportion of births assisted by skilled personnel	☐	Percentage	Value	0.00	86.20	88.00
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
Revised	Percentage of women who received postnatal consultation between the 6th days/6th week of delivery	☐	Percentage	Value	0.00	38.60	42.00
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
Revised	Children immunized (number)	☒	Number	Value	0.00	256000.00	860000.00
				Date	18-Apr-2012	30-Jun-2015	30-Jun-2018
				Comment			
New	Number of poor and vulnerable persons who receive health services free of charge	☐	Number	Value	0.00	7500.00	100000.00
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
New	Number of pregnant women living with HIV who received antiretroviral to reduce the risk of PMTCT (number)	☐	Number	Value	0.00	5284.00	6135.00
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
Intermediate Results Indicators							

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Percentage of pregnant women receiving at least 2 doses of anti-tetanus immunization	☐	Percentage	Value	0.00	81.80	86.00
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
Revised	Percentage of facilities that received RBF credits on time	☐	Percentage	Value	0.00	60.00	80.00
				Date	31-May-2012	30-Apr-2015	30-Jun-2018
				Comment			
Revised	Percentage of pregnant women receiving at least 2 antenatal care visits during a pregnancy	☐	Percentage	Value	0.00	74.50	76.50
				Date	31-May-2012	31-Mar-2015	30-Jun-2018
				Comment			
Marked for Deletion	Couple years protection (CYP)	☐	Number	Value	529272.00	841282.00	1100000.00
				Date	30-Dec-2010	30-Apr-2015	31-Dec-2016
				Comment			
Revised	Percentage of Cesarean-sections among planned pregnancy	☐	Percentage	Value	0.00	2.30	3.10
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
Marked for Deletion	Number of CEmONC public sector health facilities	☐	Number	Value	4.00	30.00	56.00
				Date	09-Dec-2010	31-Mar-2015	31-Dec-2016
				Comment			
New	Percentage of target population enrolled in community-based health insurance schemes	☐	Percentage	Value	0.00	2.00	15.00
				Date	01-Jan-2012	30-Jun-2015	30-Jun-2018
				Comment			
Marked for Deletion	Pregnant women living with HIV who received	☐	Percentage	Value	52.00	90.00	73.00
				Date	30-Dec-2010	31-Mar-2015	31-Dec-2016

	antiretroviral to reduce the risk of MTCT (number)			Comment			
Revised	Health personnel receiving training [cumulative]	☐	Number	Value	0.00	1739.00	4000.00
				Date	31-May-2012	31-Mar-2015	30-Jun-2018
				Comment			
New	Number of pregnant women receiving VCT services	☐	Number	Value	0.00	706470.00	889090.00
				Date	02-Feb-2016	25-Feb-2015	30-Jun-2018
				Comment			
Revised	Percentage of facilities with no contraceptive stock-outs in last three months	☐	Percentage	Value	71.10	91.04	100.00
				Date	31-Dec-2010	30-Apr-2015	30-Jun-2018
				Comment			
Marked for Deletion	Percentage of women aged 15-19 who know of at least one modern family planning method	☐	Percentage	Value	83.00	91.00	91.00
				Date	31-Dec-2010	31-Mar-2015	31-Dec-2016
				Comment			
Marked for Deletion	Percentage of women of reproductive age that are satisfied with the quality of RH care and services provided in public sector facilities.	☐	Percentage	Value	0.00	90.00	70.00
				Date	31-May-2012	25-Feb-2015	31-Dec-2016
				Comment			

Annex 2: Detailed Description of Modified or New Project Activities

Burkina Faso: Reproductive Health Project Additional Financing (P153104)

1. The proposed AF would continue to support implementation of RBF and the reinforcement of reproductive health services. In addition, the AF will: (i) support the implementation of a number of recommendations from the mid-term review (MTR) that was concluded in July 2015; (ii) help finance the costs associated with the expansion of ongoing piloted strategies such as CBT of the poor and CBHI; (iii) introduce interventions that would address needs of population groups vulnerable to HIV/AIDS; and (iv) provide more time for completion of the ongoing RBF impact evaluation.

2. **Component 1: Improving the delivery and quality of a Reproductive Health Service Package through Results-Based Financing** *(US$21.0 million equivalent IDA AF)*. This component will continue implementation of RBF in the six selected regions where the rollout began in early 2014. The main change in this indicator is that this component will finance HIV services to be delivered and paid through RBF. RBF is being implemented to address critical impediments confronting the delivery of services at the district level. These challenges include the: (i) scarcity of funds to meet operating expenses; (ii) lack of focus on achievement of results and lack of accountability mechanisms of the district health system; and (iii) modest managerial capacity at the district level. In addition to the three pre-pilot districts (Boulsa, Leo and Titao), 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 15 selected districts are listed in Table 1 below.

Table 1: Targeted districts and population, 2015

Region	District/prefecture	Population (2015)
Boucle du Mouhoun	Solenzo	342,288
	Nouna	334,518
Center East	Ouargaye	341,063
	Tenkodogo	226,327
North	Ouahigouya	494,597
	Titao	183,235
	Gourcy	214,978
Center North	Boulsa	436,683
	Kaya	598,571
	Kongoussi	354,906
Center West	Koudougou	481,101
	Leo	272,717
	Sapouy	222,924
South-West	Batié	91,831
	Diébougou	131,748
	Total	**4,727,487**

3. *Sub-component 1.1 – Reinforcement of health service delivery through Results-Based Financing (US$10.0 million equivalent IDA AF).* In the six selected regions, the MoH will support the provision of health services to be delivered and paid through the RBF system in selected health care facilities and continue to cover the provision of packages of basic health services (PBHS). The package of services will have a large focus on maternal and neonatal health, but will also continue to include non-maternal services (i.e. child visits, immunizations etc.), adolescent services, HIV/AIDS, tuberculosis, and malaria, to ensure that health care facilities do not neglect other services. In addition, the package of services to be financed under the PBHS will also include the list of services provided free of charge to beneficiaries of the community targeting and insurance interventions currently being piloted, as well as new HIV/AIDS-related indicators.

4. *Sub-component 1.2: Support to RBF implementation and supervision (US$5.0 million equivalent IDA AF).* To ensure the successful implementation of the RBF and ensure independent contracting and verification mechanisms are applied, CVAs have been contracted and put in place in each of the six regions. At the National level, the National RBF Technical Service will coordinate policy development and capacity building, especially in the areas of setting RBF indicators and targets, procurement and disbursements for RBF subsidy payments. The CVAs will assist in the verification of quantity and quality of services delivered at facility level and help strengthen the M&E system (through the online RBF portal); and sub-contracting with local organizations for community verification of services delivered by contracted health centers. This will allow the General Direction of Studies and Sectorial Statistics within the MoH to authorize reimbursements under PBHS Sub-grants by the payer (*Programme d'appui au développement sanitaire,* PADS) to health facilities; and finally, review the performance of civil society organizations (CSO) contracted to carry out consistency checks between facilities records and exit surveys of patients. The Project will also train stakeholders (local government, local health verification teams, traditional birth attendants and other community-based agents) in the districts and municipalities in the principles of RBF and best practices for implementation. The specific role of each stakeholder group will be explained to stakeholders to ensure their understanding and adherence to the RBF approach.

5. *Sub-component 1.3: Supporting Universal Health Coverage through improving financial access to health services for poor and indigent populations (US$6.0 million IDA AF).* This sub-component will continue carrying out the ongoing studies and associated pilot programs to identify, evaluate and harmonize the different approaches applied to the delivery of packages of basic health services, with a particular focus on improving financial access to maternal and child health services for the poor and vulnerable. The mechanism that will be used to identify the poor followed a rigorous and verifiable approach which cover health care for indigents provided at health facility levels. The Project introduced fee-waivers for certain essential services for the systematically identified 130.000 vulnerable households. In order to fill the financial gap caused by this loss in facility revenue through the absence of direct payments, facilities will be reimbursed for services provided free to the vulnerable by the RBF system. The sub-component will support the training of COGES (Comité de Gestion) and decentralized health structures to strengthen the delivery of services at community level. The behavior change communication (BCC) strategies, community-based health insurance and the community level training will be carried out by specialized firms. Finally, the sub-component will support analytical work and

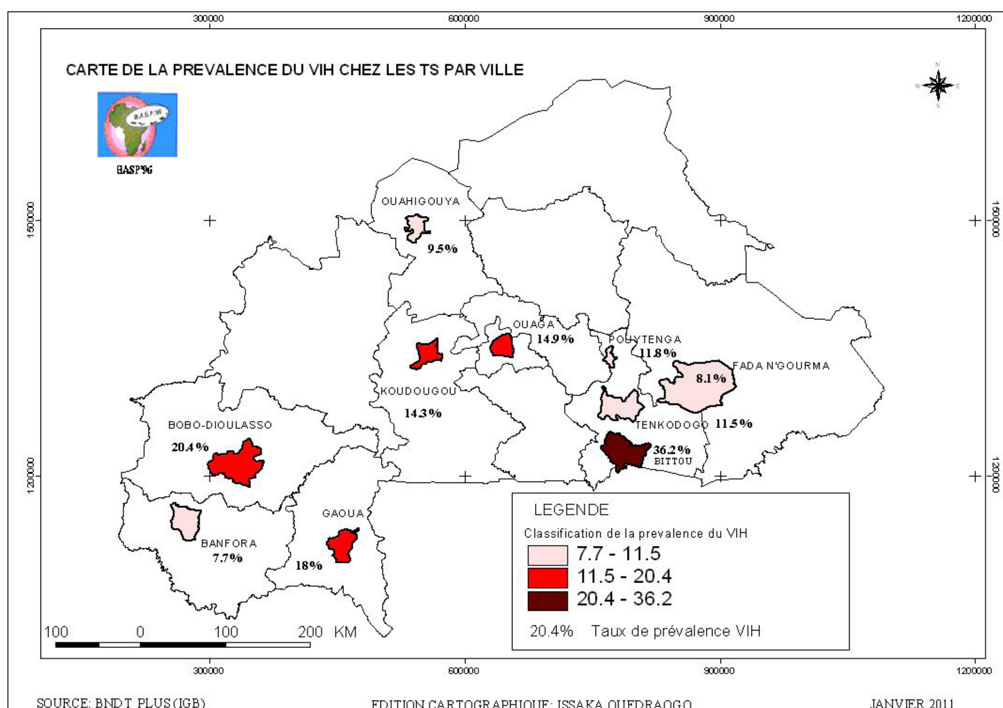
technical assistance for the pilot of the Universal Health Insurance scheme that is planned to start in 2017.

6. 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.

7. **Component 2. Supporting critical inputs for reproductive health and HIV/AIDS services** *(US$14.0 million IDA AF).* This component will support HIV/ADS and reproductive health services. It will be implemented at national level and 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 HIV prevention, to support PLHIV and reproductive health services for youth, women and high-risk groups.

8. Young people, women and high-risk groups (in particular sex workers, MSM, prisoners, miners and truckers) account for a disproportionate share of the epidemic and act as vector of transmission in the general population. Targeting those groups in concentrated and mixed epidemic settings has proven to be the most efficient way of investing in the HIV response. The Project will support interventions designed to create demand for treatment and prevention services from those populations and facilitate access to services; and strengthening of prevention and treatment services for key populations provided by the MoH.

Figure 3: HIV prevalence of female sex workers by cities (16.5 percent global prevalence for FSW), Behavioral Sentinel Survey, 2010



9. *Sub-component 2.1: Training of health professionals (US$2.0 million IDA AF).* This sub-component will strengthen the capacities of the teachers and training of trainers for the pre-service training and in-service training of health professionals providing reproductive health services (nurses, midwives, etc.). It will improve the knowledge and skills of the teachers of the National School of Public Health, in maternal and child health and HIV/AIDS.

10. *Sub-component 2.2: Provision of drugs and equipment to improve obstetrical and neo-natal services (US$2.0 million IDA AF).* This subcomponent will provide vehicles, equipment and emergency delivery kits for a selected number of 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.

11. *Sub-Component 2.3: Strengthening demand for family planning and reproductive health services (US$0.0 million IDA AF).* No additional resources will be provided for this component under the AF.

12. *Sub-component 2.4: Strengthening Creation of HIV/AIDS and STI demand for prevention and treatment among PLWHA, youth and women (US$10.0 million IDA AF).* This Sub-component will support interventions that fall in two categories described below. The AF will finance voluntary counseling and testing; demand-side proposals for high risks groups; consultant services; goods, including certain critical commodities and medicines for PMTCT and STIs; workshop and training; equipment, including complementary incinerators for medical waste management; and operating costs.

13. Supporting HIV prevention and positive behavior change: The AF will support the (i) scale up coverage of HIV prevention activities among high risk groups (commercial sex workers, MSM, and detainees, among others) through the implementation of community demand-driven activities that prevent risky behaviors; (ii) scale up voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services; (iii) support the development and implementation of an integrated HIV/AIDS Behavior Change Communication (BCC) Strategy; (iii) improve early diagnosis and case management of HIV, STI and opportunistic infections through the dissemination and training on updated guidelines and early voluntary testing; and (iv) strengthen HIV/AIDS prevention and reproductive health interventions for in and out of school youths.

14. The AF will support the *creation and implementation of demand-driven HIV prevention activities and voluntary counseling and testing (VCT)* among youth, women and high risk groups. The activities will cover: i) geographic mapping activities to determine the location, volume and type of actors; and ii) prevention and HIV testing and counseling, with links to the continuum of prevention and care for youth, women and high key risk populations groups. Specific programs with objectives and expected results are being incorporated in the revised implementation manual of the Project, to be approved by IDA and later made available to civil society organizations (CSOs)/non-governmental organizations (NGOs) for implementation. During implementation, contracts may be concluded and / or launch additional calls for proposals on the basis of the priority outcomes to be achieved to implement the Government's National Strategic Framework for HIV/AIDS/STI. The proposals submitted by CSO/s/NGOs

should lead to increased use of reproductive health services and the combined HIV /AIDS and STI preventive services by the different target groups.

15. The strategy for the different interventions targeting high risk groups includes: (i) an integrated approach with direct services provided to high risk groups; and (ii) capacity building of NGOs and CSOs, Community Health Management Committees, and decentralized SP/CNLS-IST teams that work with target beneficiary groups. This approach requires several interventions for which support will be provided by the AF: (i) well targeted behavior change interventions and case management of Sexually-Transmitted Infection (STI); (ii) access to VCT and psychosocial support; (iii) contracting appropriate and experienced NGOs that are already involved in the first phase of the original Project; (iv) significant participation of target beneficiaries; (v) improve access to quality health services; and (vi) sustainable financing to ensure continuity of interventions. The AF will provide support to women's organizations to strengthen their capacities to program and implement gender-sensitive activities focused on HIV prevention and to negotiate terms in sexual relationships and prevent sexual violence including the problems related to female mutilation.

16. The Project Implementation Manual (PIM) has been updated to include the guidelines and operating procedures for the identification, selection, funding, implementation and monitoring of proposals for HIV prevention activities for high risk. The adoption of the updated PIM is a condition of effectiveness.

17. The AF will also support *integrated HIV/AIDS Behavioral Change Communication (BCC) interventions* promote healthier sexual behaviors through condom use and reduction of partners targeted specifically to high risk groups as well as decentralized VCT for HIV, training of health personnel for better PMTCT management and BCC interventions to increase use of prenatal services. Similarly, BCC will be needed for early testing and treatment of STIs, universal precaution measures and management of accidental exposure to HIV, and to prevention of sexual violence against women. Implementation will continue to draw on the experience of working with CSO, NGO, line ministries and local authorities to develop IEC/BCC and care interventions targeted to miners, sex workers, MSM, uniformed personnel, in school and out of school youth, health workers, local story-teller ("griotes"), religious and traditional authorities and other groups.

18. Mitigating socio-economic consequences of HIV/AIDS epidemic**.** The AF will finance interventions to strengthen: (i) care and support for persons affected and infected by HIV/AIDs; (ii) the responsiveness of reproductive services to the needs of high risk groups; (iii) the capacity of CSOs/NGOs and other relevant associations in promoting a gender sensitive approach for addressing HIV/AIDS. It will support (i) the training of professionals from the mass media in order to enhance their understanding and public communication of the issues related to HIV infection and prevention, the determinants and dynamics of the epidemic, the role of gender and gender violence issues, and special needs of PLWHA and OVCs; (ii) training of more than 100 local actors/singers ("griotes") in all regions to support their role as behavior change communicators; and (iii) capacity building for CSOs/NGOs to further strengthen their capacity in addressing HIV issues with a heightened gender-sensitive lens. The AF will also continue to support the design and implementation of annual action plans of other important public sector

ministries that may have an increased impact in some of the high risk groups (i.e., youth, young adolescent girls, commercial sex workers, MSM, detainees, truck drivers, miners.)

19. Coordination and monitoring: Leadership, coordination, monitoring and evaluation by SP/CNLS; the Bank will help SP/CNLS strengthen its leadership and coordination capacities. The support provided will include a strong focus on transition planning to identify a more sustainable financing and implementation model for the SP/CNLS and the national HIV/AIDS response.

20. **Financing:** The total cost of the Additional Financing is US$35 million equivalent. The costs and financing plan for the original operation, restructured operation, and for the AF are presented below.

Table 2: Allocation of Additional Financing of the Burkina Faso Reproductive Health Project

Components	Original Project (in US$ million)	Components	Additional Financing (IDA) (in US$ million)	Total (in US$ million)
1. Delivery of Packages of Key Maternal, Child and Other Related Health Services	22.30	1. Improving the delivery and quality of a Reproductive Health Service Package through Results-Based Financing	21.00	43.30
2. Critical Inputs for Reproductive Services	19.30	2. Supporting critical inputs for reproductive health and HIV/AIDS services	14.00	33.30
Total	**41.60**		**35.00**	**76.60**

Table 3: Allocation of IDA Additional Financing by Component and Sub-Component

Components	Additional Financing IDA (in US$ million)
Component 1: Improving the delivery and quality of a Reproductive Health Service Package through Results-Based Financing	**21.0**
Sub-Component 1.1: Reinforcement of health service delivery through Results-Based Financing	*10.00*
Sub-Component 1.2: Support to RBF implementation and supervision	*5.0*
Sub-Component 1.3: Supporting Universal Health Coverage	*6.0*

through improving financial access to health services for poor and indigent populations	
Component 2: Supporting critical inputs for reproductive health and HIV/AIDS services	**14.0**
Sub-Component 2.1: Training of health professionals	*2.0*
Sub-Component 2.2: Provision of drugs and equipment to improve obstetrical and neo-natal services	*2.0*
Sub-Component 2.3: Strengthening demand for family planning and reproductive health services	*0.0*
Sub-component 2.4: Strengthening Creation of HIV/AIDS and STI demand for prevention and treatment among PLWHA, youth and women	*10.0*
Total	**35.0**

21. **Implementation Arrangements:** The MoH will have the overall responsibility for the Project. The Project will continue to be overseen by the Steering Committee created for the Reproductive Health Project which is chaired by the General Secretary of the MoH, and includes Directors of all major departments, donors and technical assistance partners. As with the original Project, the PADS continue to be the implementing entity for Component 1 of the AF. For the implementation of RBF, the three CVAs who have been recruited under the original project by the Recipient will continue to conduct contracting and verification activities, while PADS will continue to make RBF payment subsidies upon the validation of results. The National RBF Technical Service will continue to coordinate technical inputs and policy dialogue related to RBF under the direct coordination of PADS. For Component 2, the PADs will continue to be the implementing entity for Sub-components 2.1, 2.2 and 2.3. Sub-component 2.4 will be implemented by the Permanent Secretariat of the National Committee for the Fight against HIV/AIDS and STI (SP/CNLS-IST) for HIV-related activities. The SP/CNLS-IST will implement the new sub-component 2.4 and will have its own designated account for the disbursement of the IDA Grant allocation to this sub-component.

22. The PADS is staffed by a multidisciplinary team including a Coordinator, a Financial Management Specialist, an Accountant, a Procurement Specialist, a Monitoring and Evaluation Specialist and an NGO Specialist to follow up contracts with NGOs and their performance, and administrative assistants. They have the skills and experience for fiduciary management developed through the implementation of the Health Sector Support and AIDS Project and related additional financing. The PADS has also been managing other large programs supported by the Global Alliance for Vaccination and Immunization (GAVI), the Global Fund against AIDS-Malaria and TB, the Dutch Cooperation, AFD (French cooperation, KFW (German cooperation), UN agencies such as UNICEF and UNFPA, among others.

23. For Sub-component 2.4, Project activities will be implemented by the SP/CNLS-IST which implemented the HIV/AIDS part of the Bank-financed Health Sector Support and AIDS Project (P093987). The SP / CNLS-IST is the technical arm of the National Council for the Fight against AIDS and STIs (CNLS-IST) chaired by the President of Burkina Faso. The minister responsible for health is the vice president of the SP/CNLS-IST which includes representatives of ministries, civil society, private sector and technical and financial partners involved in the fight against HIV/AIDS and STIs. The Financial Management Unit of the SP/CNLS-IST includes qualified staff with experience in the management of projects funded by international donors. The Unit has managed resources allocated to the fight against HIV/AIDS and STIs by the Government of Burkina Faso, the World Bank, UNDP, UNICEF, UNAIDS, the Netherlands, Norway, Japan, Spain and Denmark.

24. The PIM has been updated to reflect the changes in Project design introduced under the AF.

Financial management and disbursement arrangements

25. The financial management (FM) system of SP/CNLS-IST has been reviewed by the Financial Management Specialist and the conclusion is that SP/CNLS-IST has the fiduciary capacity to manage a separate designated account (DA). The FM system they used for Part B of the Bank-financed Health Project (P093987) that closed in December 2014 is still in place. SP/CNLS-IST does not has any overdue audit report.

26. SP/CNLS-IST will implement sub-component 2.4 and will have its own DA for the disbursement of financing related to activities in this sub-component.

27. SP/CNLS-IST will have to provide quarterly interim financial reports (IFRs) to PADS within 30 days after the end of the quarter. The PADS will in turn consolidate all these reports and submit a consolidated IFR to the Bank within 45 days after the end of the quarter. It should also allow both the internal and external auditors of PADS to have access to the Project’s books of accounts and verify outputs. In addition, the SP/CNLS-IST should open a project account such that Project funds are not commingled with other funds.

Annex 3: Results of Project Mid-Term Review

Burkina Faso: Reproductive Health Project Additional Financing (P153104)

1. The Mid-Term Review (MTR) of the Project was conducted from July 15-30, 2015. The latest annual report of RBF technical service in Burkina Faso (2014) highlights the encouraging results in terms of health service utilization, improvement in the quality of health services and an overall strengthened health system. However, some bottlenecks have prevented successful implementation of the program. Some of these are summarized below:

   a. Weak buy-in by other Government actors and lack of complete autonomy by health facilities;

   b. Financial deficit of the overall RBF program. Overlap between Government's subvention of deliveries provided at health center level and RBF complementary package of services, resulting in inefficiencies in the financing methods; and

   c. Database (on the web-based portal) analysis and decision making are done after the reports have already been made.

2. ***Results-Based Financing:*** The first results of RBF in Burkina Faso are encouraging with better performing health workers and the involvement of the private sector (37 health facilities and 6 regional contract development and verification agencies). Over the period of 15 months, subsidy payments of approximately US$7 million have been made. The RBF program already shows economic multiplier effects by creating employment and injecting money into villages, townships, and communities. The main achievement is the improvement of the quality of health services from 46 percent in the first quarter of 2014 to 66 percent in the fourth quarter of 2014. Each of the 12 health facilities visited during the MTR indicated important improvements (recruitment of additional staff, rehabilitation of facilities, purchase of beds/mattresses, payment of performance bonuses, more accurate HMIS and data collection). A welcomed improvement is the introduction of the RBF web-based portal that is accessible to the public and from which qualitative and quantitative results of the health facilities in the Project can be downloaded. There have been significant improvements in some quantitative indicators (voluntary testing for HIV, the prevention of mother to child transmission of HIV and postnatal care.

3. ***Impact evaluation:*** Community-based Health Insurance (CBHI): A total of 17 schemes have been put in place with enrolment beginning in May 2015. A total of 25,718 indigents were identified and enrolled into the program, or 8.3 percent of the population. Approximately 1,500 people from the general population (non-indigent) enrolled, or 1.5 percent of the population. In total, about 10 percent of the population were enrolled after the first 4 months of the program. The identification cards for CBHI enrollees have being finalized and distributed in 2015. In the meantime, enrollee lists at each health center are being used.

4. ***Community-based targeting of the poor:*** Approximately 107,000 indigents have been identified through the community selection process. Data for identification cards has been collected. Identification cards have been printed and distributed. In the meantime, enrollee lists

at each health center are being used in some health centers, while others prefer to wait until the identification cards arrive.

5. ***IE baseline survey:*** A summary of the impact evaluation baseline results was presented to the MoH and key development and research partners. The presentation was well-received and it was suggested that a 2-3 day workshop be organized so that the results of the impact evaluation baseline survey can be presented and discussed in detail.

6. ***Supporting critical inputs for reproductive health services:*** The Project financed the training of 120 midwives for three years and contributed to the continuous training of 403 nurses and doctors in reproductive health and AIDS. To reach the WHO norm of one midwife for 5,000 inhabitants, the country needs to train 2,000 more midwives. The strategy to reach this number has been discussed and agreed upon with the MoH and will be launched in 2016.

7. The Project purchased equipment for reproductive health (RH) services, including contraceptives (Jadelle implants and condoms), vehicles and motorbikes. The BCC was conducted by 172 national NGOs across the 13 regions. The following actions to further strengthen RH services were proposed during the MTR: i) deepen the contribution of civil society system to improve women's access to RH services; ii) integrate local NGOs in the health district management teams so that the results they achieve can also be taken into account by the health management information system; iii) focus the actions of community-based health agent (Agents de Santé a Base Communautaire) on prevention and promotion activities for RH; iv) place the community-based RH services under the supervision of health districts; and v) strengthen the RH strategies at school level and outside school for teenagers and young adolescents.

8. ***The principal conclusions of the MTR were as follows:***

a. Harmonize the delivery subsidy (*soins obstétricaux néonataux d'urgences*, SONU) and RBF subsidies;

b. Conduct a workshop with all key stakeholders to clarify the implementation procedures, establish collaborative relationships between stakeholders, facilitate the transfer of skills, discuss challenges and provide feedback, and introduce new performance contract indicators related to the CBHI and CBT activities;

c. Decide on the management of the indigent database needs;

d. Develop an improved database management/analyses system for tracking claims and verifying quality of care for the CBHI schemes; and

e. Organize the Impact Evaluation Workshop in January 2017.

Annex 4: Map of Burkina Faso

Burkina Faso: Reproductive Health Project Additional Financing (P153104)