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Report No: PAD1938

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED IDA GRANT

IN THE AMOUNT OF SDR 37.2 MILLION
(US$50 MILLION EQUIVALENT)

TO THE

REPUBLIC OF BURUNDI

FOR A

HEALTH SYSTEM SUPPORT PROJECT ("KIRA")

February 1, 2017

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 2016)

Currency Unit = BIF
BIF 1675 = US$1
SDR 1 = US$ 1.34

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AWPB	Annual Work Plan and Budget
CAMEBU	Central Drugs Supply Agency
CAS	Country Assistance Strategy
CEA	Cost-effectiveness Analysis
CEH	Current Expenditure on Health
CERC	Contingency Emergency Response Component
CHW	Community Health Worker
CPA	Complementary Package of Activities
CPVV	Verification and Validation Provincial Committee
DA	Designated Account
DALYs	Disability Adjusted Life Years
DGP	General Directorate of Planning
DGR	*Direction Générale des Ressources* (Department in Charge of Resources Management)
DGS	Department in Charge of Health Services
DHO	District Health Office
DHS	Demographic and Health Survey
DP	Development Partner
DPSHA	*Direction de la Promotion de la Santé Hygiène et Assainissement (*Directorate of Health Promotion and Hygiene)
ESMF	Environmental and Social Management Framework
EU	European Union
FHC	Free Health Care
FM	Financial Management
GASC	*Groupement d'agents de santé communautaires* (Grouping/Cooperative of Community Health Workers)
GAVI	Global Alliance for Vaccines and Immunization
GCHW	Grouping/Cooperative of Community Health Workers
GDP	Gross Domestic Product
GoB	Government of Burundi
GRM	Government's Grievance Redress Mechanism
GRS	Grievance Redress Service

HC	Health Centers
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
HRITF	Health Results Innovation Trust Fund
HSDSP	Health Sector Development Support Project
ICB	International Competitive Bidding
ICER	Incremental Cost-Effectiveness Ratio
IFR	Interim Financial Report
IMF	International Monetary Fund
IPP	Indigenous Peoples Plan
IPPF	Indigenous Peoples Planning Framework
ISR	Implementation Status and Results Report
KIRA	Meaning wealth and good health in Kirundi
LiST	Lives Saved Tool
MCH	Maternal and Child Health
MoH	Ministry of Public Health and the Fight Against HIV/AIDS
MPA	Minimum Package of Activities
MWMP	Medical Waste Management Plan
NCB	National Competitive Bidding
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIS	National Health Information System (*Système National d'Information Sanitaire*)
PBF	Performance-based Financing
PDO	Project Development Objective
PforR	Program for Results
PHO	Provincial Health Office
PLR	Performance and Learning Review
QALYs	Quality Adjusted Life Years
RBF	Results-based Financing
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SDG	Sustainable Development Goals

SUN	Scaling Up Nutrition
THE	Total Health Expenditure
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WA	Withdrawal Application
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Bella Bird
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Magnus Lindelow
Task Team Leader:	Moulay Driss Zine Eddine El Idrissi

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Health System Support Project ("KIRA")

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Health System Support Project ("KIRA") (P156012)

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AFRICA

Report No.: PAD1938

Basic Information		
Project ID P156012	EA Category B - Partial Assessment	Team Leader(s) Moulay Driss Zine Eddine El Idrissi
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]	
Project Implementation Start Date 23-Feb-2017	Project Implementation End Date 28-Feb-2021	
Expected Effectiveness Date 23-May-2017	Expected Closing Date 30-Jun-2021	
Joint IFC No		

Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Magnus Lindelow	Timothy Grant Evans	Bella Bird	Makhtar Diop

Borrower: MINISTRY OF FINANCE			
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Project Financing Data(in USD Million)

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

Total Project Cost:	50.00	Total Bank Financing:	50.00
Financing Gap:	0.00		

Financing Source	Amount
IDA Grant	50.00
Total	50.00

Expected Disbursements (in USD Million)

Fiscal Year	2018	2019	2020	2021						
Annual	11.50	12.50	13.00	13.00						
Cumulative	11.50	24.00	37.00	50.00						

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Macro Economics & Fiscal Management, Poverty and Equity, Social Protection & Labor

Proposed Development Objective(s)

To increase the use of quality Reproductive, Maternal, Neonatal, Child and Adolescent Health services, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Components

Component Name	Cost (USD Millions)
Use of Performance-based Payments to Support the Recipient's Free Health Care (FHC) Program	40.60
Implementation Support for the FHC program-related activities	8.40
Strengthening of Newly Integrated FHC Program Service Providers through financing of minor investments/renovations works for CHWs and nursing training schools	1.00
Contingency Emergency Response Component (CERC)	0.00

Systematic Operations Risk- Rating Tool (SORT)	
Risk Category	**Rating**
1. Political and Governance	High
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other (Security)	High
OVERALL	Substantial

Compliance		
Policy		
Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

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

Legal Covenants

Name	Recurrent	Due Date	Frequency
Contingency Emergency Response Arrangements for Part 4 of the Project			

Description of Covenant

In order to ensure the proper implementation of Part 4 of the Project ("CERC Part"), the Recipient shall prepare and furnish to the Association for its review and approval, an operations manual which shall set forth detailed implementation arrangements for the CERC Part, including: (i) designation of terms of reference for, and resources to be allocated to the entity to be responsible for coordinating and implementing the CERC Part ("Coordinating Authority"); (ii) specific activities which may be included in the CERC Part, Eligible Expenditures required therefor ("Emergency Expenditures"), and any procedures for such inclusion; (iii) financial management arrangements for the CERC Part; (iv) procurement methods and procedures for the CERC Part; (v) documentation required for withdrawals of Emergency Expenditures; (vi) environmental and social safeguard management frameworks for the CERC Part, consistent with the Association's policies on the matter; and (vii) any other arrangements necessary to ensure proper coordination and implementation of the CERC Part.

Name	Recurrent	Due Date	Frequency
Recruitment of External Auditor		22-Sep-2017	

Description of Covenant

The Recipient shall recruit, no later than three (3) months after the Effective Date, an external auditor in accordance with the provisions of Section III.C of this Schedule 2 to this Agreement.

Name	Recurrent	Due Date	Frequency
Recruitment of Procurement Specialist		22-Sep-2017	

Description of Covenant

The Recipient shall, no later than three (3) months after the Effective Date, recruit to the Department of Resources Management, in accordance with the provisions of Section III of this Schedule 2, an additional procurement specialist, with qualifications, experience, and terms of reference acceptable to the Association.

Name	Recurrent	Due Date	Frequency
Results-Based Financing	**X**		Yearly

Description of Covenant

Unless otherwise agreed with the Association, the Recipient shall, in the Fiscal Year 2017, maintain its allocation to the annual budget of the Ministry of Health for the provision of the Free Health Care Program at no less than 1.5% of the Recipient's total budget expenditures as approved under the Recipient's Budget Law of said Fiscal Year and shall progressively increase such allocation by 0.1 percentage points in each subsequent Fiscal Year through the end of Project implementation.

Conditions

Source Of Fund	Name	Type
IDAT	Financing Agreement Article IV 4.01 (a)	Effectiveness

Description of Condition

The Recipient has adopted the Project Implementation Manual pursuant to Section I. C of Schedule 2 to

this Agreement.

Source Of Fund	Name	Type
IDAT	Financing Agreement Article IV 4.01 (b)	Effectiveness

Description of Condition

The Recipient has updated the Results-Based Financing Procedures Manual pursuant to Sections V.A.3 of Schedule 2 to this Agreement.

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Moulay Driss Zine Eddine El Idrissi	Team Leader (ADM Responsible)	Sr Economist (Health)	Task Team Leader	GHN13
Melance Ndikumasabo	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement Specialist	GGO07
Christian Simbananiye	Financial Management Specialist	Consultant	Financial Management Specialist	GGO19
Alain-Desire Karibwami	Team Member	Senior Health Specialist	Co-Task Team Leader	GHN01
Alice Museri	Team Member	Programming Asst.	Program Assistant	AFMBI
Aurelien Serge Beko	Team Member	Economist	Health Economist	GMF07
Evelyn Anna Kennedy	Team Member	Senior Operations Officer	Operations Advisor	GHN01
Gayle Martin	Team Member	Program Leader	Program Coordinator	AFCE1
Gertrude Mulenga Banda	Team Member	Senior Program Assistant	Sr. Program Assistant	GHN01
Ishanlosen Odiaua	Safeguards Specialist	Consultant	Social Development Specialist	GEN05
Issa Thiam	Team Member	Finance Officer	Finance Officer	WFALA
Nneoma Veronica Nwogu	Counsel	Senior Counsel	Lawyer	LEGAM
Paul-Jean Feno	Safeguards Specialist	Senior Environmental Specialist	Safeguards Specialist	GEN07
Richard Shugugu	Team Member	Consultant	Demographer	GHN01

Extended Team			
Name	**Title**	**Office Phone**	**Location**

Locations					
Country	**First Administrative Division**	**Location**	**Planned**	**Actual**	**Comments**

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Consulting services to be determined

I.STRATEGIC CONTEXT

A. Country Context

1. **Since Burundi's independence in 1962, its economic and social development has been marked by political instability.** Burundi is a small, landlocked, and densely populated country. Development has been influenced by the geographic, demographic, and political circumstances, climate shocks, and the structure of its economy, which depends heavily on natural resources—mainly coffee and tea—and foreign aid. With regard to human development, the country has achieved very modest results since independence—Burundi ranks 184 out of 188 countries on the 2014 Human Development Index.

2. **Between 2005 and 2014, Burundi experienced political stability and improved socioeconomic conditions.** Progress in the peace process and reduction in violence, combined with prudent macroeconomic management, sound public finance management reforms, and aid inflows, all helped trigger economic recovery with encouraging results: the gross domestic product (GDP) per capita, while still very low, doubled between 2006 (US$166) and 2014 (US$336) (current US$), fueled by continued economic growth averaging 9.2 percent per year.

3. **Since early 2015, the political crisis has reversed some of the previous gains and triggered a severe economic crisis.** As of August 2015, over 175,000 people fled the country, primarily into settlements in neighboring countries. In addition, development agencies estimate that thousands have moved from urban areas to more remote locations. This political instability has had a negative impact on the economy, which contracted by 3.9 percent in 2015. The crisis also had a negative impact on the health sector. Burundi's health indicators, which were already poor and lagged behind those of the rest of Sub-Saharan Africa, deteriorated further. In some urban areas, utilization of services decreased, especially in the capital city Bujumbura (-77.6% between May 2015 and September 2015). Moreover, the stock-out of drugs in many public health facilities has forced patients, users, and Free Health Care beneficiaries, irrespective of their ability to pay, to buy essential drugs from private pharmacies (400,000 pregnant women in 2015 according to UNICEF estimates).

4. **In 2014, Burundi's population was estimated at 10.8 million inhabitants, having more than quadrupled since 1950, when it was estimated at only 2.5 million.** This rapid population growth is estimated to continue in the future, given that fertility rates remain high: the Demographic and Health Survey (DHS) 2010 estimated the fertility rate at 6.4 children per woman, a marginal decline, compared to 6.9 children per woman in 1987. Given the demographic trends, the population is very young, and the working age population (15-64 years) is only a little over half (51.7 percent) of the total population (2014), with an economically active population (population that is either employed or actively seeking employment) not exceeding 40 percent.

5. **Rapid population growth has exacerbated pressures on land.** In 2000, Burundi was already ranked among the most densely populated countries in the world, with 260 inhabitants per km^2. By 2014, population density increased to 421 inhabitants per km^2, well above the world average of 56 inhabitants per km^2, placing Burundi in the 88th percentile of the International Population Density Index. With its extremely low urbanization rate (11 percent), Burundi has the most densely populated rural areas in the world.

6. **Improvements in social indicators are constrained by Burundi's economy, dominated by small-scale subsistence agriculture.** Agriculture provides income and employment for about 85–90 percent of the population. Although the share of agriculture in nominal GDP dropped from 44.1 percent in 2000 to 35.7 percent in 2014, Burundi still ranks in the 98th percentile of the world distribution with regard to the share of agriculture in the GDP. Most households in Burundi are dependent on subsistence agriculture. However, productivity is very low, and rain conditions (flood and dryness) and temperature swings are the source of significant vulnerability.

7. **Burundi is heavily reliant on external financing.** The Official Development Assistance (ODA) funds up to 50 percent of the country's annual budget and represents the largest source of foreign exchange reserves. The majority of the aid comes from multilateral sources. The country falls short of attracting foreign direct investments, another critical financial resource for sustainable development.

8. **Burundi remains one of the poorest countries in the world**. According to the Household Budget-Consumption Survey (2014), about 64.6 percent of the population cannot meet their basic daily needs (food and non-food) and poverty is 2.5 times higher in rural areas than in cities (68.8 percent against 27.6 percent, respectively). This striking difference results from the combined effects of (a) the general disadvantage of rural areas in access to basic social services, (b) the highest concentration of rural households on small-scale farming as the main economic activity, and (c) the low educational level of the rural population. Because they are poor, rural households can hardly afford to pay for their basic health needs, requiring Government and external support.

B. Sectoral and Institutional Context

Poor Progress on Health Outcomes

9. **Burundi's health indicators lag behind those of the rest of Sub-Saharan Africa (SSA).** Life expectancy at birth (56 years) is ranked among the lowest in the world and is two years below the average of Sub-Saharan Africa. Under-five mortality rate decreased from 152 per 1,000 live births in 2000 to 81.7 per 1,000 live births in 2015. With such a ratio, Burundi is ranked among the highest decile of the global distribution, along with countries such as Central African Republic and the Democratic Republic of Congo**.** Maternal mortality remains very high in Burundi despite the reduction from 954 per 100,000 births in 2000 to 712 per 100,000 births in 2015 (World Development Indicators 2015)[1] (see Table 1). This ratio is 1.3 times higher than the Sub-Saharan Africa average and 3.3 times higher than the world average. According to the DHS 2010, the birth weight of 10.7% of newly born babies is less than 2.5 kg, while the neonatal mortality rate is about 31 per 1,000 births.

10. **Burundi has one of the highest stunting rates of children in the world.** It has remained unchanged over the past two decades: 56 percent in 1987, 63 percent in 2000, 58 percent in 2005 and 2010 (Burundi Statistical Bureau [*Institut des Statistiques et des Etudes Economiques du Burundi*] 2012; DHS 2010); and it is still far from the target of the Sustainable Development Goal (SDG) of 29 percent.

11. **The causes of malnutrition are multisectoral.** An individual's nutritional status is ultimately determined by the availability of nutrients to the body to meet its requirements and the status of health.

[1] DHS 2010: 499 per 100,000 births

The underlying and basic causes are related to food security (access, availability, and utilization of food), maternal and child-caring practices, water and sanitation, and personal hygiene. These determinants are heavily influenced by the social status of women, institutional/organizational, political and ideological, and economic as well as environmental constraints.

12. **Fertility rates in Burundi remain among the highest in the world.** The 2010 DHS estimated the Total Fertility Rate (TFR) at 6.4 children per woman. The national average masks geographic and socioeconomic disparities. There are stark differences between fertility rates in rural areas (6.6 children per woman) and those of women in urban centers (for example, 4.2 children per woman in Bujumbura). Similarly, women with a secondary or higher education have considerably lower fertility levels (4.4 children per woman) in comparison with females who have not attended school (6.8 children per woman), underscoring the importance of expanding educational opportunities for women. An estimated 11 percent of adolescents are giving birth by 19 years of age. While some progress has been made in reducing adolescent fertility, more needs to be done to delay early marriage and initiation of childbearing. Use of modern contraception has been historically low, but expanded rapidly over the past five years. According to an analysis conducted by the United Nations Population Fund (UNFPA), the modern contraceptive prevalence rate for women in union is estimated to have reached roughly 38 percent (2015) in comparison to 18 percent in 2010. If these trends are confirmed by the forthcoming 2016 DHS, this would imply that Burundi is making important strides in beginning to tackle the stubborn high fertility rates. In fact, the UNFPA concluded that the "contraceptive revolution may be underway" which implies that Burundi may be joining other countries in the region that have mounted strong reproductive health/family planning programs (for example, Rwanda, Kenya, Ghana, and Senegal).

Table 1. Health Indicators in Burundi Compared to Neighboring Countries

	Mortality Rate, < 5 (per 1,000 Live Births)	**Maternal Mortality Ratio per 100,000 Births**	**Births Attended by Skilled Health Personnel (%)**	**Total Fertility Rate (per Woman)**	**Contraceptive Prevalence Rate (% of Women)**	**Prevalence of stunting, height for age (% of children under 5)**	**Immunization, DPT (% of Children Ages 12–23 Months)**
	2015	**2015**	**2007–14**	**2013**	**(2007–13)**	**2010**	**2015**
Burundi	**81.7**	**712 (DHS 2010: 499)**	**60**	**6.4**	**22 (NHIS: 38)**	**58**	**94**
Central African Republic	130.1	882	59	4.4	15	41	47
Congo, Dem. Rep.	98.3	693	80	5.9	17	44	81
Ethiopia	59.2	353	19	4.5	29	-	86
Kenya	49.4	512	44	4.4	46	-	89
Malawi	64.0	634	71	5.4	46	48	88
Rwanda	41.7	290	69	4.5	52	44	98
Tanzania	48.7	398	49	5.2	34	43	98

	Mortality Rate, < 5 (per 1,000 Live Births)	Maternal Mortality Ratio per 100,000 Births	Births Attended by Skilled Health Personnel (%)	Total Fertility Rate (per Woman)	Contraceptive Prevalence Rate (% of Women)	Prevalence of stunting, height for age (% of children under 5)	Immunization, DPT (% of Children Ages 12–23 Months)
	2015	2015	2007–14	2013	(2007–13)	2010	2015
Uganda	54.6	343	57	5.9	30	-	78
Zambia	64	224	47	5.7	41	-	90

Source: World Bank database and Atlas of African Health Statistics, 2016.
"-" means no data is available; DHS-Demographic and Health Survey; NHIS-National Health Information System

Health System Challenges and Sectoral Strategies

13. **The health policy framework of the health sector in Burundi has gradually been strengthened, and the country is quite advanced compared to many others (in Sub-Saharan Africa and elsewhere) in terms of introducing new and far-reaching policy reforms.** One important example of this was the introduction of a national policy of Free Health Care for pregnant women and under-5 children as well as a national policy of contracting in 2006. The latter was the basis for the introduction of Results-Based Financing (RBF) pilots in Burundi, and in 2010 Burundi became the second country in Sub-Saharan Africa (after Rwanda) to introduce RBF at a national scale in the health sector. RBF is an innovative new financing mechanism where health facilities are paid based on results produced. Other important strategies and policies have also been introduced for other key areas within the health sector, e.g. for human resources, decentralization and the creation of health districts (managed by Health Districts Offices-HDOs). Health outcomes in Burundi have improved very remarkably over the last few years (see Table 2), and the policy reforms introduced are probably responsible in large part for this. However, this performance is not enough to speed up the progress in terms of health outcomes due to a number of challenges.

14. **Public expenditures on health remain insufficient to ensure provision of basic health services.** Compared to other low-income countries in Africa, the Government of Burundi dedicates a large share of its budget to the health sector mainly because of its commitment to Free Health Care. The share of the Government budget allocated to health increased from 5.3 percent in 2007 to 10.41 percent in 2010. However, since 2010, this indicator has not increased significantly and has not yet reached the Abuja declaration target (15 percent). Between 2010 and 2013, there was an increase in current expenditure on health (CEH), which rose from BIF 286 billion in 2010 to BIF 390 billion in 2013. Nevertheless, total health expenditure (THE) per capita in real terms first increased between 2007 and 2010 from BIF 18,848 to BIF 23,777 and then decreased to BIF 20,631 in 2013 (US$29.93). Per capita expenditure is far from US$56 of THE per capita per year recommended by the Taskforce on Innovative Financing for Health Systems to ensure provision of basic health services. According to the National Health Account (NHA), households' out-of-pocket spending was over 30 percent in 2010. While this share decreased in 2013 to 19 percent of the CEH owing to social health protection schemes such as the Free Health Care (FHC) program, out-of-pocket spending still represents more than 50% of domestic sources of funds (versus 35% from the Government and 15% from other domestic sources).

15. **Burundi has inadequate human resources for health with an impact on quality of care.** The country has an average of 1 medical doctor per 20,865 inhabitants and 1 nurse per 1,542 inhabitants (compared to 1 per 3,703 and 1 per 806, respectively, in Africa). Moreover, there is an inequitable distribution of health workers with fewer of them working in rural areas (50.5 percent of physicians and 21 percent of nurses are in Bujumbura). An analysis of the current human resource development strategy identified the following additional bottlenecks: (a) the absence or non-application of education standards in some private nursing training institutions; (b) lack of a formal collaboration framework between human resources training institutions and other stakeholders, including the MoH; and (c) problems of motivation and human resource stabilization in some remote areas remain despite improvements with the support of the RBF (Facility Surveys 2010 and 2013). Because of poor quality of care, health outcomes have not improved (decline in mortality, fertility, and malnutrition) despite an increase in health service use. The MoH, with the support of its partners, has undertaken a reform of nursing training to improve the quality of nursing. Training of paramedic nursing staff at the A3 level (2 years of training) was abandoned in favor of paramedic nursing staff at the A2 level (4 years of training). However, the quality of trained students is reportedly very modest.

16. **Community health is seen as a promising approach for health promotion in Burundi but is not yet fully implemented.** Since its official launch in 2012, the community health strategy has led to (a) the recruitment of community health workers (CHWs), under the new Community Health Guidelines, in 100 percent of Provincial Health Offices (PHOs); and (b) the establishment of Groupings/Cooperatives of Community Health Workers (Groupement d'agents de santé communautaires/GCHWs) in all public health centers (HCs) (100 percent) as well as the training of 8,512 CHWs from 13 out of 18 health provinces. The RBF pilot took place at the community level in the provinces of Makamba, Gitega, and Mwaro. An evaluation of the RBF pilot, by Catholic Organization for Relief and Development Aid (CORDAID), noted that, thanks to the involvement of CHWs, the proportion of cases referred during consultations in HCs is increasing for antenatal consultation and postnatal consultations, delivery, family planning, and voluntary screening of HIV/AIDS.

17. **Serious challenges remain with the supply chain of drugs and other inputs resulting in stock-outs of drugs and inputs in health facilities.** According to performance-based financing (PBF) annual reports, 55 percent, 35 percent, and 33 percent of health facilities experienced at least one stock out of one or more tracer drugs, respectively in 2013, 2014, and 2015. The supply chain of drugs is hampered by the following constraints: (a) weak regulation (the registration system for drugs and other health products is almost nonexistent in Burundi; weak drug quality control system provided by the National Institute of Public Health; absence and/or inadequacy of certain laws and regulations, standards, and rules in the pharmacy and laboratory sector); (b) low storage capacity at the health districts (at least 50 percent of district pharmacies need to be rehabilitated and some districts do not have storage room on their premises); and (c) inefficient coordination of interventions with regard to supply and distribution of pharmaceuticals.

18. **The Department of National Health Information System (NHIS) will be included in the RBF program.** To enhance decision-making and evidence-based planning and budgeting, the MoH in collaboration with its partners, implemented policies and strategies to improve the NHIS. The NHIS is experiencing difficulties with producing timely data needed for decision making and meeting reporting requirements (planning, management, and response to emergencies). Several factors contribute to this NHIS situation: (a) the current system does not include the community CHW

component; (b) difficulties in coordinating subsystems; (c) inadequate monitoring of data quality; (d) stock-out of data collection tools; (e) lack of data validation mechanisms; (f) poorly motivated staff; (g) irregular investigations which limit the availability of updated information; and (h) lack of data on the private sector. RBF is expected to improve the NHIS performance and remove various bottlenecks. Performance payments will be included under component 1 (subcomponent 1 D) of the KIRA Project for staff motivation and to improve the NHIS operations.

The Government has implemented a Free Health Care Policy combined with RBF since 2010

19. **Free Health Care (FHC), Results Based Financing (RBF) and focus on high impact interventions (prevention and primary health care) continue to be among top priorities in the Government's program (health and beyond).** Burundi has been a pioneer in effectively removing financial barriers to health care services, especially for pregnant women and children, and has 10 years of experience in the implementation of FHC and RBF with six years of implementation at the national level. Free Health Care covers all pregnant women and under five children. Beneficiaries have access to all services available at public and contracted private facilities (health centers and hospitals).

20. **In April 2010, Burundi was the second country in Africa to implement RBF in the health sector nationwide**, with substantial financing from the original Health Sector Development Support Project (HSDSP) approved in 2009 complemented by additional financing in 2012. All public and most private health facilities in the country—HCs and hospitals—are covered by the program. The national RBF program is used as a mechanism to implement the Government's policy, started in 2006, of providing FHC for pregnant women and under-five children. Government funding to pay health facilities for their costs of providing FHC is transferred to facilities on an RBF basis. Facilities are paid based on their performance of delivering basic health care services to pregnant women and under-five children. The payments made under the FHC policy to the health facilities are executed as part of the national RBF program, with much lower transaction costs and simpler invoicing and with a fairly strong verification of the accuracy of the reported levels of services. Burundi's financing mechanism for its FHC-RBF program follows a programmatic approach involving 'virtual pooling' of funds. The advantages of the Burundi model include: (a) reasonable costs of coordination between all partners; (b) compatibility with individual donors' procedures and financing instruments; (c) disbursements are rapid and yet regular and predictable, with low transaction costs (procurement is not needed for the RBF payments to health facilities); (d) funds are transferred directly to health facilities; and (e) there is a high degree of transparency in the system.

21. **The RBF mechanism has improved the FHC scheme in terms of transaction cost containment and reimbursement time.** Until 2010, the impact of the FHC policy was constrained by a number of implementation difficulties. Health facilities would submit detailed invoices to the central level, specifying in detail, item by item, their expenditures incurred toward treating pregnant women and under-five children. Transaction costs were high, with these invoices having hundreds of pages. Health facilities were paid only after long delays of four to six months or often not at all. Double-billing was common, since there was no mechanism to independently verify the accuracy of the invoices submitted by the health facilities.

22. **Significant results were achieved during implementation of the FHC/RBF program** (households surveys - MPA, 2009 and 2012; and NHIS) as evidenced by the following: (a) the use of health services increased from 0.38 to 1.55 new contacts per year from 2005 to 2014; (b) a reduction

of disparities in terms of quality of care; (c) improved management and autonomy of health facilities; (d) motivation of health personnel; and (e) strengthened collaboration between HCs and stakeholders at the community level. Moreover, the FHC policy contributed to improving financial protection through a significant decrease of families' out-of-pocket spending (2014 NHA). According to a study on equity undertaken by the World Bank and the MoH, the program had an impact on reducing inequalities between rich and poor households, especially for Maternal and Child Health (MCH). For example, for many MCH services, except complete prenatal care, the poorest and the richest are equally using health services.

Table 2: Evolution of HSDSP Indicators between 2009 and 2016

Indicator	Baseline (2009)	End target (2017)	2016
Number of pregnant women living with HIV who received antiretroviral to reduce the risk of Mother to Child Transmission	1,582	3,600	3,885
Coverage of prenatal care services for pregnant women (at least 3 visits)	59.4	65.5	66.5
Contraceptive prevalence rate	19.8	34.9	37.4
Births (deliveries attended by skilled health personnel)	188,135	364,090	368,092
Percentage of health facilities that ran out of essential drugs in the previous month	0	4.9	5.1
Percentage of health facilities that have a head with A2 level nurse	0	60	62

23. **The combined FHC-RBF program of Burundi is financed by different actors** but the largest contributor is the Government of Burundi through its national budget. In all health policy documents (National Health Development Plans 2006–10 and 2011–15 and National Health Policy 2016–22), the FHC-RBF is a high priority for the government and has been at the center of the MoH's implementation priorities. Therefore, even during the peak of the political crisis, the Government has maintained its financial commitment. Two other important contributors are IDA (World Bank) and the EU. However, the program has also attracted several other technical and financial partners, each focusing on a subset of the country's provinces and/or on selected indicators only. They include the Belgian Cooperation, the Dutch Cooperation through CORDAID and HealthNet TPO, Global Alliance for Vaccines and Immunization (GAVI), and the United States Agency for International Development (USAID) through the nongovernmental organization (NGO) FHI360.

New Government Policy and Orientation for the FHC-RBF Second Generation

24. **New orientations aiming at better health interventions and outcomes were introduced in the new National Health Policy (NHP) (2016-2025)** following a review in 2016 of the five-year National Health Development Plan - NHDP (2011-2015). This new NHP is structured around: (i) universal health coverage, to improve equity in health, efficiency and sustainability; (ii) quality health services; (iii) public policies to promote and protect the health of communities, particularly vulnerable groups; and (iv) leadership to improve the competence and accountability of health authorities and actors.

25. **Free Health Care continues to be one of the Government's top priorities**. In the new health policy (2016–25), the Government is committed to supporting and improving the FHC scheme. It also intends to use RBF as a tool to support the FHC and as a complement to input-based programs and projects. In addition, the Government seeks to develop new, relevant, and ambitious policies such as community health, where RBF could play an important role in assessing and monitoring the performance of the CHWs and in motivating them. Burundi needs this program more than ever to reinforce the health system in the continued fragile context and to keep the focus on high impact interventions, improving governance and health results. The FHC-RBF has played a positive role in maintaining allocation of public resources to primary health care.

26. **The GoB is seeking to improve RBF (second generation) by giving more weight to its 'quality' component**. The FHC-RBF program reimburses health facilities for health care costs related to reproductive, MCH, and pays additional performance bonuses. This is done in one payment which includes FHC reimbursement (on average 70 percent) and a performance bonus (on average 30 percent). This payment is made through quantity and quality indicators. Because the health system is experiencing service quality issues, the Government's strategy for the second generation RBF, is to reduce the payment based on quantity indicators in favor of quality indicators to encourage health facilities to focus on the quality of care. At the hospital level, the RBF quantity component would be limited only to reimbursement of FHC. The rest of results based payments will be related to qualitative indicators.

27. **The FHC-RBF second generation will further develop the culture of performance-based financing.** It will be extended to key areas such as community health, paramedical training schools, and strategic functions of the Ministry of Health (information system, human resources, drugs regulation, etc.). By proposing performance-based payments to these strategic areas, the program aims to improve the functioning of these departments and motivate their staff. This has a direct impact on the performance of these departments that will benefit all healthcare providers by addressing key bottlenecks in the health system, such as the absence of a unified and sustainable community approach; modest quality of nursing training, etc. In addition, with a view to improving the quality of care and financial protection, the FHC-RBF second generation will focus more on the RBF quality component while maintaining the free health care at its current level (0% contribution, 0% copayment and the same benefit package).

28. **The FHC-RBF second generation program will seek to enhance its cost containment strategy**. The program experienced a record deficit of US$8 million in 2013 because of the increase in invoices submitted by health facilities and an increase in tariffs (bonuses) for certain indicators, especially for hospitals (with political and trade union pressures to increase rates and bonuses). In one year, between 2012 and 2013, payment to health facilities increased from BIF 28.4 billion to BIF 45.8 billion, which is an increase of 62 percent. In 2014, the MoH reduced RBF indicator tariffs (indicators directly linked to FHC for pregnant women and children under five were not affected) and prepared and implemented a fairly good cost containment strategy. However, despite a significant improvement, there is a need for a stronger cost containment policy.

29. **Although the FHC-RBF program is not a panacea for all health system challenges, it proved to be an important complement to other inputs based programs**. The FHC-RBF program has had a positive impact on the health system but it is far from solving all dysfunctions of this system. However, it is complementary to essential inputs based programs that support Burundi's health system

on important issues such as: (i) medicines and medical equipment supply (UNICEF, USAID, WHO, etc.), (ii) support to public health programs such as Tuberculosis, HIV/AIDS, Immunization, non-communicable diseases (Belgium Cooperation, WHO, FM, UNFPA, GAVI). It is also a good complement to other World Bank support to health, including the East Africa Public Health Laboratory Networking project and the Great Lakes Emergency Sexual and Gender-based Violence and Women's Health project.

The Government of Burundi is committed to address malnutrition and demographic challenges as national priorities

30. A **multisectoral roadmap for Scaling up Nutrition (SUN) actions was finalized in January 2012 and a National Strategic Plan for Nutrition was developed.** This plan contains nine strategic axes, including reinforcement of political commitment, infant and young child feeding promotion, micronutrient supplementation and food fortification, particularly salt iodization, and the increased integration of nutrition interventions in primary health care, down to the community level. The GoB formally launched the SUN movement in Burundi in 2013 and, in 2014, issued a decree for the formation of the National Burundi Multisectoral Platform of Food Security and Nutrition (*Plan Stratégique Multisectorielle de Sécurité Alimentaire et Nutritionnelle*) to be located at the Second Vice Presidency level, with appointment of the deputy chief of staff as the National SUN Focal Point. The GoB established a food security and nutrition budget line for the agriculture sector.

31. **The GoB adopted ambitious targets, sending strong signals about its commitment to tackle demographic challenges**. With rapid drops in mortality and persistent high fertility rates, the population growth is over 3.0 percent, which implies that the country's total population is doubling every 23 years. Conscious of the challenges posed by the rapid population growth, particularly in the light of the high population density and modest national territory (27,834 km^2), Burundi authorities adopted several policies and programs in 2011. The Government's Population Declaration has set a highly ambitious goal of achieving a rate of three children per woman and a population growth rate of 2.0 percent by 2025. The strong Government commitment augurs well for putting in place appropriate policies and programs to address these demographic challenges. To this end, Burundi needs to sustain efforts at reducing child mortality through investments to reduce morbidity and malnutrition; enhance opportunities and services for adolescent girls; expand access to high quality family planning/reproductive health services; ensure that girls complete at least the first cycle of secondary education; and expand economic opportunities to empower women to take control of their reproductive health.

C. Higher Level Objectives to which the Project Contributes

32. **The Health Systems Support project (KIRA) aligns with the new vision of the health sector in Burundi (2016–25 National Health Policy) that promotes a "second-generation of the FHC-RBF program."** Despite its strengths, the FHC-RBF program in its present form is facing difficulties in addressing health system bottlenecks. Thus, the rationale for this second generation FHC-RBF program is to support improvements related to malnutrition, quality of health services (to address maternal and child mortality), problems of paramedical training, and lack of a community health policy.

33. **The project contributes to SDGs 2 and 3.** SDG 3 is to ensure a healthy life and promote the well-being for all. The project through its support to strengthen quality of care, especially in basic health facilities, contributes to several targets under Goal 3, namely reducing maternal mortality (Target 3.1); reducing under-five mortality and neonatal mortality (Target 3.2); universal access to sexual and reproductive health services (Target 3.7); achieving universal health coverage (Target 3.8); increasing health financing; and recruitment, development, training, and retention of health personnel (Target 3.c). The project through its activities related to the prevention and management of malnutrition also contributes to SDG 2 which aims to eradicate hunger, ensure food security, improve nutrition, and promote sustainable agriculture.

34. **The KIRA Project is in line with the dual objective of the World Bank Group to reduce poverty and promote shared prosperity and the Regional Strategy for Africa that focuses on strengthening governance and public sector capacities.** The Country Assistance Strategy for Burundi has two strategic pillars: first pillar, improving competitiveness by establishing an enabling environment for inclusive growth and poverty reduction; and second pillar, increasing resilience by consolidating social stability. The Health System Support "KIRA" Project (KIRA meaning wealth and good health in Kirundi) would contribute to poverty reduction and increased resilience through its focus on FHC and improving access and quality of care, especially in basic health facilities. The second generation RBF project (with robust verification and counter-verification, a better cost containment strategy, and more emphasis on quality) is a part of the Performance and Learning Review (PLR) (February 2015) of the health, nutrition, and population (HNP) section of the Country Assistance Strategy 2013–16 (Report 72334-BI). The PLR highlighted that "the World Bank engagement in the health sector is expected to move to the next stage of reforms (building on the successful RBF program to increase access to services), with a focus on improving quality and financial sustainability." Removing bottlenecks in the health system will be crucial to improving the performance of health facilities. In addition, there is an urgent need to put in place a sustainable funding mechanism. For this reason, the PLR suggests a shift in the approach toward supporting the health sector through expanding performance-based payment that is applied to personnel in the health system to include CHWs, community representatives, national health management system, regulatory authorities, public health programs, and so on.

35. **The proposed operation is also aligned with the 2012–15 Poverty Reduction Strategy Paper (PRSP II) which is anchored in the 2025 Burundi Vision.** The project through its focus on access to quality health care contributes to the Government's 2025 Vision which aims, among others, to strengthen the health system including health financing and fertility reduction.

36. **The project is aligned with the 2011 World Development Report recommendations on conflict, security and development**. This report recommends that even in the case of post-conflict contexts, countries and development partners prioritize long-term policies in order to reinforce institutions (such as ministries of health), develop, and strengthen sustainable health systems.

37. **The project complements ongoing and new projects under development in the portfolio.** This includes: (a) the HSDSP which closes in June 2017; (b) the East Africa Public Health Laboratory Networking Project (US$25 million) which aims to establish a network of efficient, high quality, accessible public health laboratories for the diagnosis and surveillance of tuberculosis and other communicable diseases; and (c) the Great Lakes Emergency Sexual and Gender-based Violence and Women's Health Project (U$15 million) which aims to expand the provision of services to mitigate

the short- and medium-term impact of sexual and gender-based violence; and increase utilization of a package of health interventions targeting poor and vulnerable females.

38. **The KIRA project is being prepared in tandem with a nutrition project funded by the Japanese Social Development Trust Fund (JSDF).** The Burundi Maternal and Child Nutrition Enhancement Project ((US$3 million) aims to increase access to nutrition services among selected persons in Gihofi and Makamba provinces, in the southern region of Burundi. The KIRA project will complement this operation through: (i) developing RBF packages at all levels with nutrition indicators; (ii) enhancing community health workers performance to promote appropriate nutritional behavior; (iii) support to the National Nutrition Program through results based payments.

39. **The KIRA Project and the Social Safety Nets Project (P151835), US$40 million approved December 2016** target almost the same population: women and children. The objective of the Social Safety Net Project is to provide regular cash transfers to extreme poor and vulnerable households with children, in selected areas, while strengthening the delivery mechanisms for the development of a basic social safety net system. The Project will also contribute to general improvement in health and the nutrition of children and pregnant and lactating women.

40. **The KIRA Project will be implemented in close collaboration with the Government and relevant partners.** Other international partners support public health programs in Burundi. They include GAVI supporting the Expanded Immunization Program and the Global Fund supporting HIV/AIDS, tuberculosis, and malaria control programs. The Belgian Cooperation provides assistance and performance payments to nursing schools. The Global Fund, UNICEF, USAID, and other partners provide support to the Central Drugs Supply Agency (CAMEBU) and community outreach through performance based payment of CHWs under the RBF program.

II.PROJECT DEVELOPMENT OBJECTIVES

A. Project Development Objective (PDO)

41. **The objective of the project is to** increase the use of quality Reproductive, Maternal, Neonatal, Child, and Adolescent Health services, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

B. Project Beneficiaries

42. **The KIRA project will target mainly pregnant women and children under the age of five.** The number of direct beneficiaries is estimated to reach 2.32 million people in 2017 and 2.55 million people in 2021, just under a quarter of the population of Burundi. Girls, adolescents, and women represent 62 percent of the beneficiaries of the project. The remaining population of Burundi will be indirect beneficiaries of the project that supports FHC-RBF in the entire country. The project aims at improving the performance of all 546 public health facilities, the overwhelming majority of faith-based health facilities and some 'for profit' private HCs.

C. PDO Level Results Indicators

43. **The KIRA Project has five indicators that will be used to monitor progress in reaching the project development objectives:**

(a) People who have received essential health, nutrition, and population (HNP) services:

  (i) Children immunized (number)

  (ii) Women and children who have received basic nutrition services (number)

  (iii) Deliveries attended by skilled health personnel (number)

(b) Pregnant women who received four antenatal care visits within the first 28 gestational weeks (percentage)

(c) National quality average score of district hospitals (percentage)

(d) Contraceptive prevalence rate for modern methods (percentage)

(e) Contraceptive prevalence rate among adolescents (percentage)

III.PROJECT DESCRIPTION

A. Project Components

44. **The KIRA Project builds on the achievements of the HSDSP while seeking to address current weaknesses and limitations of the existing FHC-RBF program.** Under Component 1, the project will support the continued implementation of the FHC-RBF program through the provision of facility-based performance based payments, while also expanding the RBF program to community level. The project will also help address higher level system constraints through the provision of incentive payments to nursing schools and MoH strategic departments. Under Component 2, the project will finance support functions for the implementation of the FHC-RBF program. This includes verification/counter-verification activities, capacity building of MoH and project management support, and promotion of demand for health care services especially for the vulnerable groups through communication activities. Component 3 supports financing of very small investments/equipment for CHWs and nursing schools (in form of lump sums). A contingency emergency response component (CERC) is included under component 4 of the project.

Table 3: Synthesis of components, activities and entities supported under the KIRA project

<table>
<tr><th>Entities</th><th>Component 1</th><th>Component 2</th><th>Component 3</th><th>Component 4</th></tr>
<tr><td>Health Providers (HCs and Hospitals)</td><td rowspan="5">Performance based payments</td><td></td><td></td><td rowspan="5">CERC</td></tr>
<tr><td>CHWs</td><td></td><td>Lump sum (financing of very small investments/ equipment)</td></tr>
<tr><td>FHC-RBF claims and administration/Verification entities</td><td rowspan="2">- Some running costs
- Capacity Building
- Project management</td><td></td></tr>
<tr><td>MoH Strategic Departments</td><td></td></tr>
<tr><td>Nursing schools</td><td></td><td>Lump sum (financing of very small investments/ equipment)</td></tr>
</table>

Component 1: Use of Performance-based Payments to Support the Recipient's FHC Program - US$40.60 million

45. **This component will pay health providers and other health entities according to their performance**. This includes health facilities; community health workers; FHC-RBF claims and administration/verification departments; MoH central strategic departments; and nursing schools.

Subcomponent 1.A: Payment of FHC-RBF to health facilities (US$29.3 million)

46. **Reimbursement of the FHC and the RBF payments will be done nationwide to public health facilities, non-profit health providers, and some private health facilities according to a well established standard national procedure.** FHC is well-defined by the law (Presidential Decree No. 100/38 of 16 March, 2010) and RBF is applied according to a single RBF Procedures Manual. Services and performance indicators are clearly defined by the manual that differentiates the list of Minimum Package of Activities (MPA) in HCs and the list of Complementary Package of Activities (CPA), in hospitals (see MPA and CPA lists in annex 6).

47. **Payment to health facilities will be based on their performance in delivering a defined package of health services.** This package includes nutrition activities; prevention services; maternal, neonatal, adolescent, infant, and child health services; malaria; HIV/AIDS; tuberculosis; and family planning. The package may be revised/adjusted as the program evolves.

48. **RBF payments to health facilities will be directly linked to pre-defined quantity and quality indicators with more emphasis on quality.** The MoH, with support from its international partners, is reviewing the FHC-RBF program at the level of health facilities to focus on the quality part of RBF. At the level of hospitals, the RBF quantity component will be limited only to reimbursement of services related to FHC. All other quantity indicators will be removed. At this level, focus will be on improving the quality of care.

49. **For HCs, the quantity and quality aspects will be maintained because, at this level, performance with regard to utilization of health services (quantities) and improving the quality of care is still awaited.** However, the weight of the quality component will be revised upward to encourage HCs to further improve the quality of health services; and the rate of the 'quantity' indicators will be revised downward, except indicators pertaining to FHC.

50. **Additional activities will accompany this quality promotion process.** These activities will be supported through funds from the KIRA Project and also by additional technical assistance (from the World Bank and other partners). Two activities will be implemented by the MoH. Quality competitions will be organized between health facilities of the same level (HCs, hospitals) to further increase quality of services, and prizes will be awarded to the best HCs and hospitals. This is intended as a first step towards a more institutionalized quality assurance mechanism in the health facilities with the development of policy documents and a quality strategy, the development of quality and referential standards, and the establishment of a gradual system of accreditation of health facilities by moving toward a certification process.

Subcomponent 1.B: Performance Based Payments to community health workers cooperatives (US$4.2 million)

51. **The new RBF component will target about 12,000 CHWs and will therefore, be implemented gradually.** The CHWs are grouped into 860 cooperatives called Grouping/Cooperative of Community Health Workers. Each GCHW comprises between 10 and 15 CHWs. Implementation will be carried out in areas where pilot projects have taken place and where the approach and the community culture are highly developed. This progress is the result of various partner programs such as UNICEF and the Global Fund.

Community Health Workers Cooperatives or Groups GCHWs (Groupements d'Agents de Santé Communautaire – GASC) are local non-governmental organizations. The *Commune Administration* officially approves their legal status. There are 863 GASCs and more than 12,000 CHWs (on average each GASC is composed of 14 CHWs). Every single GASC is working with one HC and technically coached by a HC staff (Health Promotion Technician). All active CHWs have been trained to deliver health promotion activities, prevention and very basic health services at community level.

Development Partners and Income Generating Activities are the main sources of funds. Under the RBF program, and based on contracts signed with the CPVV, GASCs will receive their payment directly from the project designated accounts to their bank accounts. 70% of this payment will be allocated individually to CHWs according to their performance. The remaining 30% will be used for income generating activities and overheads.

52. **RBF payments will be made directly to the GCHWs (like for health facilities), each with a bank account, according to a list of pre-defined services and indicators by the national RBF Procedures Manual.** Each month, the performance of CHWs will be consolidated at the GCHW to which they belong. Payment based on the performance will be made in one operation directly to the GCHW. Performance is linked to pre-defined activities on (a) health promotion and prevention, (b) referral services to appropriate HCs, and (c) community-based distribution of some inputs (nutritional ingredients, condoms, nets, and so on).

53. ***Subcomponent 1.C: Performance Based Payments to FHC-RBF claims and administration/verification departments (US$5.0 million)***

54. **Performance based payments to FHC-RBF claims and administration/verification departments will continue to be made according to their performance.** These comprise the National Technical Unit in charge of the coordination of the FHC-RBF program, the verification and validation provincial committees (CPVVs), the Provincial Health Offices, District Health Offices, and the Department in Charge of Resources Management (*Direction Générale des Ressources*, DGR). These entities play a key role in the RBF operations and success of the program. They will receive performance bonuses according to rules defined by the RBF Procedures Manual used under the ongoing HSDSP project.

Subcomponent 1.D: Performance Based Payments to Nursing Schools and MoH strategic departments supporting health facilities (US$2.1 million)

55. **This subcomponent will support central MoH strategic departments** to strengthen their performance culture and thus improve their support for the smooth functioning of health facilities. These comprise: (a) the public health programs in charge of nutrition and reproductive health; (b) the National Health Information System (*Système National d'Information Sanitaire*, NHIS), and (c) regulatory units in charge of drugs and human resources. These performance based payments will be used to improve both their operations (for example, purchase of small equipment, office furniture, computers, and so on) and the motivation of their staff.

56. **This subcomponent will also provide performance based payments to nursing schools.** The contracting-in of nursing schools started with the support of the Belgian Cooperation will continue while improving the existing mechanism. The ministry of health, with the support of the Belgian Cooperation, implemented a contracting approach for nursing schools according to the RBF approach with a focus on technical and administrative activities. It is important to ensure continuity of this program, given the good results: improved quality of training of A2 level paramedic nursing staff, better supervision of internships, better technical and pedagogic guidance to teachers, incentives for underpaid schools staff, and strengthened management. Support from the Belgian Cooperation will end in March 2017. Performance bonuses to these schools will serve to improve their operations and motivate staff and teachers. Only public schools and non-profit schools are included.

57. **Nursing schools are assessed quarterly by peers (other nursing schools) facilitated by the RBF Technical Unit and the MoH department in charge of nursing.** Schools are paid and assessed quarterly based on criteria such as (a) number of students in the first year, (b) number of permanent teachers, (c) delivery of lectures, (d) educational support, (e) supervision of interns in the field at health facilities that meet the required standards, (f) educational/pedagogic sessions, and (g) management committee sessions. A proportion of these funds is used for staff motivation and another to support nursing schools functioning.

Component 2: Implementation Support for the FHC program-related activities - US$8.40 million

58. **This component will support strategic activities** such as (a) the verification and counter-verification processes, (b) the MoH capacity building, (c) Project management, (d) promotion of health care services demand, and (e) social and environmental safeguards activities.

Subcomponent 2.A: Support to verification and counter verification processes (US$5.0 million)

59. **The KIRA Project will continue to finance verification and counter-verification activities to enhance quality and effectiveness of health services while containing operating costs.** Verification of claims consists of ex-ante verification, done before the payment is made, and counter verification or ex post verification (performed by independent entities), done once the payment is made. However, the following changes will be introduced:

(a) To strengthen verification while containing costs, the Project proposes the recruitment of external contracted workers who will receive a monthly salary and will be made available to the CPVVs. These experts will increase the quality and the governance of the verification process.

(b) The latter will then have the mission of verifying quantitative services in the health facilities (HCs and hospitals) and assessing the technical quality at the HCs. Assessing the technical quality in hospitals by peers will continue.

(c) As the CPVVs will be composed of civil servants and contracted workers, it is expected that the current verification cost will decrease by approximately 35 percent.

(d) The Project will finance the salaries of contracted workers in charge of assessing the quality and quantity as well as performance bonuses of the CPVVs' civil servants.

(e) The Government will finance the operational costs as well as the salaries of the CPVVs' civil servants.

Subcomponent 2.B: Supporting project management (US$2.9 million)

60. **Project Management Support.** This includes monitoring and evaluation, FM, social and environmental safeguards, management and coordination of the project, and communication. Financial audits and ad hoc surveys will also be financed. Similar to the HSDSP, it will be done through financial support to the RBF National Technical Unit and experts in charge of management of the KIRA Project, within the MoH.

Subcomponent 2.C: Supporting the promotion of demand at community level and social and environmental safeguards activities (US$0.5 million)

61. **The Project will provide funding to the same community activities as under the HSDSP to increase the demand for health care and promote healthy behavior, especially assisting vulnerable groups, notably the Batwa, to have access to health services.** This includes capacity building and training of community-based actors and the use of media, public awareness campaigns, and various communication activities.

62. **The project will also support the implementation of social and environmental safeguards activities,** notably assistance to the Batwa population (indigenous people) to better access health services, and set up an additional number of Montfort-type incinerators to improve biomedical waste management.

Component 3: Strengthening of Newly Integrated FHC Program Service Providers through financing of minor investments/renovations works for CHWs and nursing training schools - US$1.00 million

63. **This support concerns nursing training schools and CHWs.** A lump sum will be allocated to each school to finance small investments (for example, technical equipment, computers, software, library supplies, very small renovation works) focusing on small-scale upgrading. Renovation works will be limited to improvement works on existing buildings. Support to the CHWs consists of providing them with a kit that includes, among others, bicycles, umbrellas, boots, medicine boxes, gears, hats, and white coats.

Component 4: Contingency Emergency Response Component (CERC) - US$0.00

64. **A CERC will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints.** This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

B. Project Financing

65. **The KIRA Project is fully financed by IDA (US$50 million) over a period of four years (mid-2017 to mid-2021).** This financing complements contributions from the government and by international partners who support the national FHC-RBF program. The GoB is the largest financer of the program followed by the World Bank and the EU. The EU will allocate €40 million to this program over a period of three years (2017–19). Other major international partners are also active in this area (GAVI and Belgian Cooperation), and some are interested in supporting the community component (Global Fund to fight AIDS, tuberculosis and malaria, and some international NGOs).

66. **The option of using a Program for Results (PforR) instrument was explored, but was excluded for the following reasons:**

- For fragile-and-conflict-afflicted states, due to the risks of elite capture, there is a need to ring-fence the World Bank contribution and have the resources flowing to the grassroots/community level. In the case of Burundi, the Investment Project Financing instrument is the appropriate one under the prevailing security conditions as the Investment Project Financing confers supervision rights to the World Bank.
- The FHC-RBF program is also supported by other international partners. It is fully financed through a virtual basket fund, including the share from the Government, which is executed according to an existing manual, where it will be very difficult to include a Program-for-Results instrument.
- The critical economic and political context is not conducive.
- The payments due to facilities are transferred every month (high frequency) and directly to health facilities' bank accounts.
- There is a component related to the CHWs who are paid neither by the Government nor by health facilities.

C. Project Cost and Financing

67. The project has a total cost of US$50 million to be financed with IDA resources. Its components are summarized in Table 4.

Table 4: Project Cost and Financing

Project Component	Project Cost	IDA Financing	% Financing
Component 1: Use of Performance-based Payments to Support the Recipient's Free Health Care (FHC) program	**40.6**	**40.6**	**100**
1.A: Performance Based Payments to health facilities	29.3	29.3	100
1.B: Performance Based Payments to CHWs	4.2	4.2	100
1.C: Performance Based Payments to FHC-RBF Claims and Administration/Verification Departments	5.0	5.0	100
1.D: Performance Based Payments to Nursing Schools and MoH Strategic Depts	2.1	2.1	100
Component 2: Implementation Support for the Free Health Care Program-related activities	**8.4**	**8.4**	**100**
2.A: Support to the verification and counter verification processes	5.0	5.0	100
2.B: Project management support	2.9	2.9	100
2.C: Promotion of demand at community level and social and environmental safeguards activities	0.5	0.5	100
Component 3: Strengthening of newly integrated FHC service providers through financing of minor investments/renovation works for Community Health Workers (CHWs) and nursing training schools	**1**	**1**	**100**
Component 4: Contingency Emergency Response Component (CERC)	**0**	**0**	**100**
Total Costs	**50**	**50**	**100**

D. Lessons Learned and Reflected in the Project Design

68. **The KIRA Project's design has taken into account lessons learned from both the HSDSP and programs from other countries.** These lessons pertain to the content of the project as well as its implementation, including all coordination efforts with the Government and international partners.

69. **One of the strengths of the ongoing HSDSP is the involvement of nongovernmental organizations at different levels.** Community-based NGOs and local-elected officials are engaged in the FHC-RBF program. Indeed, they are involved in assessing the perceived quality (quality of services received in health facilities perceived by the population), community outreach, and demand promotion for better use of health services by the communities, particularly the Batwa (indigenous population targeted by social safeguards). Elected officials also play an important role through the CPVVs and health facilities management committees (*comités de gestion*). The KIRA Project will maintain this community and citizen engagement/commitment.

70. **Coordination with the Government and international partners is crucial for both the project design and its implementation.** Discussion and coordination with partners is important to promote harmonization and avoid duplications of effort. For example, the KIRA Project will not finance drug supply, it will only support drugs regulation because other partners (UNICEF, Global Fund to fight AIDS, tuberculosis, and malaria and USAID) already support the supply agency CAMEBU. Moreover, as long as the support of the RBF program is done through a single procedures manual during implementation, it is very important to coordinate all efforts with the Government and all partners involved.

71. **The good performance achieved before the 2015 crisis and the resilience of the health system during and after the crisis are partly due to the HSDSP (P101160) that is supporting FHC-RBF.** The Government and its partners continue their commitment to the FHC-RBF program as it operates with a unified mechanism which builds health system performance even during a fragile context through funding high impact interventions while also addressing the most vulnerable populations.

72. **One of the project's priorities is to target high-impact interventions already included in the HSDSP project.** These priorities include activities related to community health services, reproductive, maternal, newborn, child, and adolescent health as well as nutrition. There are also strategic interventions aimed at improving the quality of care in general.

73. **The RBF approach has been successfully implemented in several countries and has shown promising results in terms of service coverage**. However, the World Bank's evaluation (DEC, 2016) showed that when RBF is combined with prepayment schemes promoting the demand side, it has a better impact on the health system (cases of Argentina, Burundi, and Rwanda) than stand-alone RBF programs.

74. **Because of bottlenecks observed during the execution of the HSDSP, the second generation RBF and the KIRA Project propose to extend performance payment beyond health facilities (similar to other African countries such as Rwanda and Zambia).** The following areas were identified to be taken into account by the KIRA Project: (a) the CHWs; (b) nursing schools; (c) public health programs including reproductive health and nutrition; (d) the NHIS; and (e) regulatory and programming bodies at the central and provincial levels. Drug supply is covered under the second generation RBF, but is not financed under the KIRA Project as this aspect is supported by other international partners as mentioned earlier.

75. **International experience, especially in Africa, has shown that strengthening the health system and building its resilience to shocks is crucial.** Past experience has shown that weak health systems in Guinea, Liberia and Sierra Leone did not allow these countries to contain the Ebola epidemics when they started, and caused severe human and economic damage for the three countries. In the current fragile context in Burundi, the health system should be supported to strengthen its resilience and ability to respond to possible shocks including potential epidemics.

IV.IMPLEMENTATION

A. Institutional and Implementation Arrangements

76. **The KIRA Project will build on the successful implementation experience of the HSDSP project.** Throughout the HSDSP, the implementation performance has been Moderately Satisfactory or Satisfactory despite the difficult context. The institutional and implementation arrangements including the FM, procurement, and safeguards, enabled the HSDSP to achieve a good performance, as reported in supervision missions' aide mémoires and Implementation Status and Results Reports (ISRs). As these implementation arrangements also played a positive role in the resilience of the HSDSP and the FHC-RBF program, the KIRA Project will maintain them with slight modifications as captured in the following paragraphs.

77. **The project's activities will continue to be embedded within the MoH and aligned with its functions because the Ministry has extensive experience in project management with the World Bank** (three projects since 2009: HSDSP, East Africa Public Health Laboratory Networking Project and the Great Lakes Emergency Sexual and Gender-based Violence and Women's Health Project). The Ministry of Health has shown a high degree of leadership and ownership of the programs supported by the projects that it manages. Throughout the life of health projects managed directly by the ministry, financial management and procurement were transparent and effective. The alternative of creating a project management unit has been discussed and rejected, as it does not guarantee a better project funds management. This alternative is also technically risky because it could demotivate the MoH staff and gradually jeopardize the investment made in terms of MoH management capacities.

78. **Similar to the HSDSP, no Project Implementation Unit will be created**. Different departments of the ministry will continue to ensure the same responsibilities with some changes, as described in the following paragraphs, due to additional subcomponents of the Project related to the CHWs, nursing schools, and so on.

79. **This integration within the MoH will be maintained while some other Development Partners (DPs) are looking for non-government alternative mechanisms to channel their financial support to Burundi**. The project is maintaining these arrangements for the following reasons:

(i) All DPs involved in supporting FHC-RBF program use the same single and unified claims system (verification, counter-verification and validation). This includes the European Union, GAVI, Belgian Cooperation and Global Fund to fight against AIDS, tuberculosis and malaria;[2]

[2] FHC-RBF programs need to be kept as a unified scheme, including its claims system (verification and validation activities). Channeling funds through NGOs or private firms does not allow the project to support the verification and validation processes because external entities cannot create a parallel or additional claims mechanism. Moreover, if all Development Partners use external entities to deal with results based payments, no one will support the FHC-RBF process. This situation could have a significant negative impact on the governance of the FHC-RBF program;

(ii) The core team in charge of day-to-day management of the FHC-RBF program is composed of high level civil servants selected on a competitive basis with a prior approval from IDA;

(iii) The existing competencies within various departments of the ministry are complemented by highly skilled staff recruited by the project to provide technical support in various areas such as financial management, procurement, social and environmental safeguards, among others.

80. **The Department in charge of Health Services (DGS) will ensure the overall coordination of the KIRA Project.** It will also be responsible for the implementation of some subcomponents of the Project. Two other MoH departments: the General Directorate of Resources (DGR) and the General Directorate of Planning (DGP) will be responsible for implementing the remaining Project activities. The DGR will also assume the role of the deputy coordinator in charge of fiduciary aspects of the project. In the absence of the head of the DGS, the DGR director will assume the function of acting KIRA Project coordinator.

81. **The role of the DGS.** In addition to its function as the general coordinator of the Project, the DGS will have other responsibilities such as the following:

(a) Supervise the RBF Technical Unit in all activities related to results based payments to health facilities;

(b) Supervise the RBF Technical Unit in all activities related to RBF payments to public health programs and CHWs;

(c) Implement and monitor activities related to environmental and social safeguards.

82. **The role of the DGR.** The DGR will assume the function of deputy coordinator and will be charged with the following responsibilities:

(a) Oversee financial management and procurement;

(b) Serve as KIRA Project technical focal point for the Ministry of Finance;

(c) Co-implement, with the RBF Technical Unit, all activities related to results based payments including nursing schools and regulatory bodies.

83. **The role of the DGP.** The DGP will be in charge of (a) the KIRA Project monitoring and evaluation and (b) co-implementation, with the RBF Technical Unit, of all activities relating to results based payments to the NHIS.

84. **The role of the RBF Technical Unit.** This unit will coordinate, implement, and monitor the FHC-RBF program. Hence, the RBF Technical Unit will continue to be the technical focal point for the World Bank team in charge of the KIRA Project. Although other departments are co-responsible for the implementation of various results-based payment subcomponents under the Project, the ultimate responsibility of RBF implementation is assumed by the RBF Technical Unit.

85. **The KIRA Project will continue to support the MoH with regard to local expertise.** Similar to the HSDSP, the Project will continue to make available some local experts to the ministry

in the areas of financial management/accounting, procurement, monitoring and evaluation, environmental and social safeguards, information technology/online databases, and communication.

86. **Because of the extension of the RBF program, it is necessary to further strengthen the capacity of the MoH.** Through the HSDSP experience, it appears that the MoH has enough senior staff members and experts in the departments mentioned earlier. However, the implementation of new activities introduced under the Project (such as nursing schools and the CHWs) will require a strengthening of the ministry. One additional expert in procurement will be recruited and funded by the project and one community health specialist will be appointed by the ministry. The procurement expert will be made available to the DGR, and the community health expert will be assigned to the RBF Technical Unit. The KIRA Project will also finance local or overseas training to build the capacities of senior staff members and experts responsible for its implementation.

87. **Under the FHC-RBF program implementation,** eight main functions have been defined with the involvement of all levels of the health system (central, provincial, and district levels; public institutions, private entities, and civil society):

(a) The provision of care is provided by hospitals and public, faith-based, and private HCs, as well as the CHWs.

(b) Verification of services is provided by:

  (i) the CPVVs teams for quantitative verification of all contracted providers (CHWs, HCs, and hospitals);

  (ii) peers for quality evaluation in hospitals;

  (iii) the CPVVs for assessing the quality in HCs and services provided by the CHWs;

  (iv) local organizations (community-based) in charge of community verification (accuracy of services); and

  (v) the RBF Technical Unit senior staff members and the central administration, who will handle the performance verification of nursing schools, public health programs, regulatory bodies, and the NHIS.

(c) Counter verification – this function will focus on the quality of health facilities services and the performance of the CHWs, PHOs, DHOs, and CPVVs. It will be undertaken once every six months by an independent external body and by local associations that conduct community surveys on perceived quality of health care.

(d) Purchasing of services from the CHWs, HCs, district and regional hospitals will be handled by the CPVVs; and the MoH at the central level will manage purchasing of services from national hospitals.

(e) Financing of the FHC-RBF program is ensured by the Ministry of Finance, on the governement side, and international partners.

(f) The technical coordination of the FHC-RBF program at all levels is entrusted to the RBF Technical Unit (as mentioned earlier).

(g) Regulation is ensured by the MoH central services and PHOs.

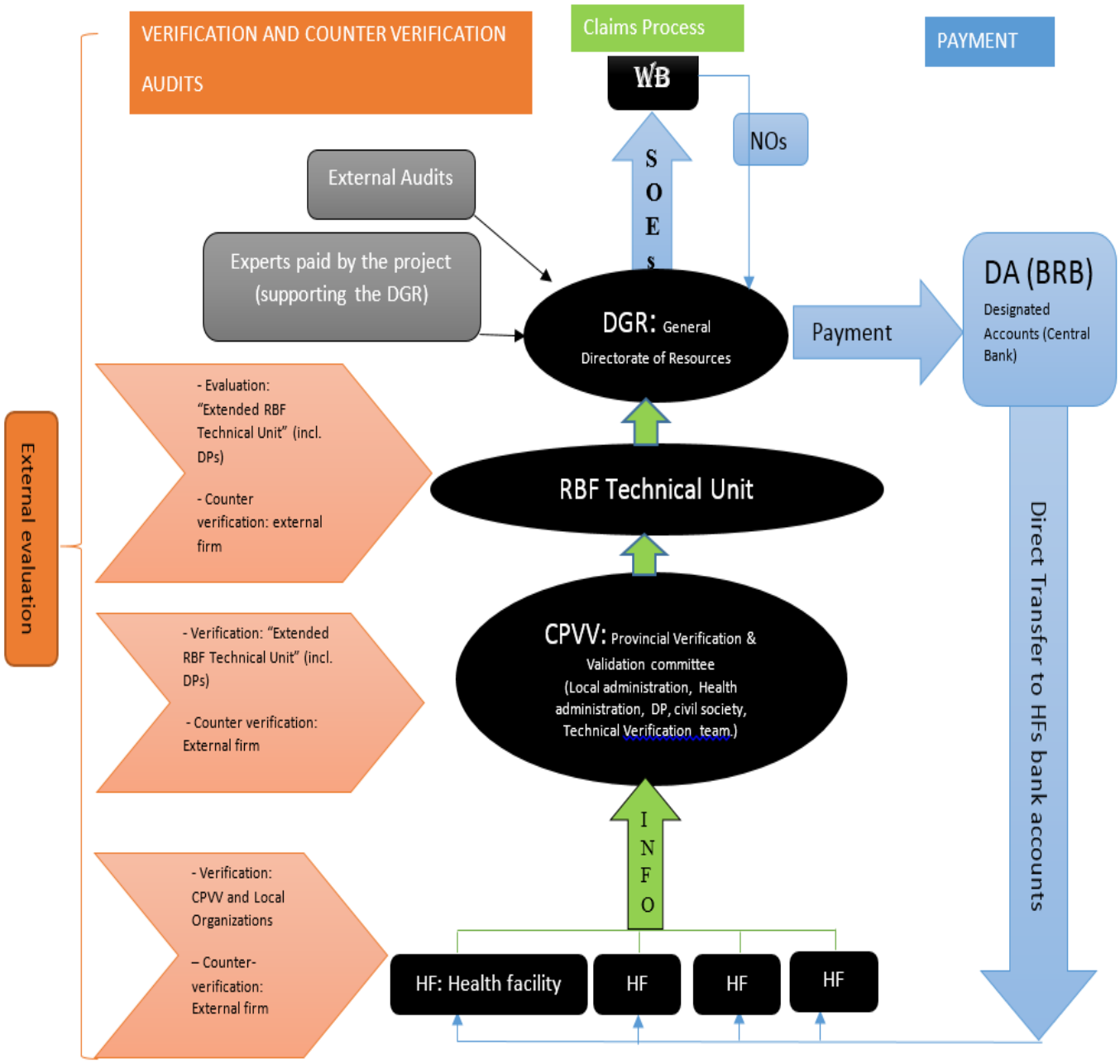
(h) The voice of the population will be ensured through health committees involved in HCs management as well as the above mentioned local organizations used in verification and in users' satisfaction surveys.

88. **Evaluation of the quality of HCs will be done by the CPVVs to achieve greater efficiency and to contain costs.** As part of the HSDSP, this evaluation is currently done either by independent NGOs (6 provinces) or by the provinces and districts themselves (12 provinces). In the latter case, this evaluation is to some extent a conflict of interest because provincial and district offices are supposed to supervise the majority of HCs. Evaluations of the HCs' technical quality by the NGOs in all provinces will be too costly (US$3 million per year; US$12 million for four years). Therefore, the KIRA Project will recruit contracted workers who will receive monthly salaries and would be made available to the CPVVs. These would then (a) handle the quantitative verification task of services provided by the CHWs and health facilities (HCs and hospitals) and (b) assess the technical quality of the HCs. At district and regional hospital level, evaluation of the technical quality by peers will continue. For national hospitals, an enlarged team of the RBF Technical Unit will oversee the assessment of the technical quality by peers.

89. **All FHC-RBF implementation modalities that the KIRA Project is financing will be included in the RBF Procedures Manual.** The RBF Technical Unit has the responsibility to produce and update the Procedures Manual which is the most important tool for implementing the FHC-RBF. This unit is also in charge of preparing the FHC-RBF annual reports (technical and financial reports). Finally, the RBF Technical Unit will improve the RBF database to include the new components of the program pertaining to the CHWs, nursing schools, regulatory bodies, public health programs, and the NHIS.

90. **Under the FHC-RBF program, funds are channeled from the Designated Accounts directly to health services/providers**. As shown in the figure below, the claims process starts at facilities and goes up to the CPVV for verification and validation, and then claims are transmitted to the RBF technical unit for an additional validation. For payment, claims are transmitted to the DGR (supported by experts paid by the project) for a final validation at the MoH level. The World Bank teams (Disbursement and Task Team) receive Statement of Expenses from the DGR, review them and provide Non Objection (NO). Once the NO is provided, the MoH transfers funds from the Designated Accounts directly to health facilities or services bank accounts.

Figure 1: KIRA FHC-RBF Claims and Payment Cycle



Notes:

- Involved health facilities (643 health centers and 54 hospitals) are public and private across the country;
- More than 600 local NGOs are involved in the verification and counter-verification;
- External evaluation and counter-verification carried by international NGOs, such as COPED, Catholic CORAID, CORDAID, HealthNet TPO;
- Public health centers are managed by a management committee composed of civil servants and elected community representatives
- Each health facility (public and private) has a private bank account with a commercial bank.

B. Results Monitoring and Evaluation

91. **The KIRA Project focuses primarily on intermediate outputs to measure project performance with regard to achieving the PDO.** This choice is underpinned by the nature of the project that finances and supports the FHC program (covering children and pregnant women) through the RBF mechanism.

92. **The project will rely on multiple sources of information such as the annual report of the NHIS, the database of the FHC-RBF, household surveys, and facility surveys.** Indeed, similar to the HSDSP, the KIRA Project will finance some surveys such as household (midline and end line) and health facility surveys (midline and end line).

93. **The KIRA Project supports the MoH in its duties to strengthen the NHIS and the RBF database.** This support is important not only to inform the progress of the Project toward the development objective, but also to improve the evidence-based planning and budgeting processes.

94. **As the KIRA Project is concerned with addressing the needs of the poor and their access to health services as well as gender issues, it will finance an equity study including potential gender related inequalities as part of the monitoring and evaluation process.** This study will analyze the impact of the RBF-FHC on equity with regard to health status, access to health care services, benefit incidence analysis, and impoverishment.

C. Sustainability

95. **For financial sustainability reasons, the Government will increase its financial contribution to the FHC-RBF program.** Throughout the HSDSP period, the Government has met its financial commitments. This has enabled the program to continue operating even during the 2015–16 crisis. This share of the Government is equivalent to a minimum of 1.4 percent of the general state budget. However, to mark its commitment to support this important program and to reinforce its sustainability, the Government will increase its contribution to the program each year by 0.1 percentage points from the general budget: its share will then move to 1.5 percent in 2017, 1.6 percent in 2018, 1.7 percent in 2019, 1.8 percent in 2020, and 1.9 percent in 2021.

96. **Sustainability is not only financial, but also technical and institutional. Therefore, the KIRA Project will continue the same technical strengthening support to the MoH.** This will be not only through training activities included in the project, but also through technical assistance financed outside the project (for example, to support the quality assurance process).

97. **The preparation of a new cost containment strategy is a kind of assurance against financial risks.** Past experiences have shown that the lack of cost containment mechanisms had a negative impact because it did not enable the program to avoid cost escalation between 2013 and 2014. However, the implementation of an effective strategy to contain costs from late 2014 (included in the Procedures Manual) helped to curb the deficit, despite the declining international partners contributions during the crisis period, particularly in 2015. The KIRA Project aims to support the GoB to continually improve this strategy.

V.KEY RISKS

A. Systematic Operations Risk Tool (SORT)

Risk Category	Risk Evaluation
1. Political and Governance	High
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of the Project	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other (Security)	High
TOTAL	Substantial

B. Overall Risk Rating and Explanation of Key Risks

98. **The overall risk rating of the Project is considered to be substantial mainly due to the high 'political and governance' and 'security' risks**. There is a risk of a protracted repeated crisis and a fragility trap if the underlying factors of the 2015 political crisis are not addressed. Such a political situation could prevent implementers from focusing on the project's technical management and FM. The project would continue to be anchored within the MoH under a national RBF technical unit as this arrangement has shown to work well even in times of crisis. In the long-term, this institutional arrangement is expected to safeguard the sustainability of the health system and its ability to deal with any emerging health crises. While there are risks, these will be managed from the fiduciary perspective. The growing insecurity with the current crisis has had a negative impact on access to health care for the population living in affected areas (especially Bujumbura). Morever, this situation forced development patners to reduce their staff in the field and subsequently their interventions. If the crisis were to exacerbate, component 4 of the Project could be activated and used to transfer funds from the project to deal with an emergency (natural or man-made).

99. **In terms of macroeconomic management, the risks are substantial.** Burundi's political crisis has interrupted a decade of good and stable economic performance. In 2015, the real GDP decreased (by 3.9 percent) for the first time since 2003. The budget deficit soared in 2015 (about 5.6 percent against 3.4 percent in 2014). Although budgetary and current account deficits are very high, they have not yet triggered an inflationary spiral. Domestic prices rose only by 5.5 percent in 2015 due to good harvests, a drop in world prices, and a stable exchange rate. However, there are indications that the current level of the exchange rate is overvalued (more consumers are turning to the black market) and foreign exchange reserves have almost dried out (less than six weeks of imports). The 2016 MoH budget was halved because of this negative macroeconomic situation and the 'austerity budget' that has prioritized security expenditures. This drastic reduction negatively affects essential public health services production and supply. However, despite the crisis in the country, the GoB has so far provided the requisite counterpart funding for the ongoing project. The KIRA project will continue to work with Government towards a cost containment strategy which will involve the GoB as the largest financer of the FHC-RBF program.

100. **The risk related to technical design is substantial.** The introduction of the community health component makes the project design more challenging due to the large number of community health workers (12,000) and the complexity of the contracting modalities for the CHWs. To mitigate this risk, the KIRA Project will implement this policy gradually together with other partners such as UNICEF, Global Fund for fighting against AIDS, tuberculosis and malaria, and international NGOs. Moreover, the Project includes technical assistance for this component in order to help the ministry to implement a phased roll-out of this strategic activity.

101. **The risks in terms of institutional capacity for implementation and sustainability are substantial.** Expanding RBF to cover other actors in the health system (CHWs, NHIS, and nursing schools) as well as the high turnover at management level will represent a technical challenge for the MoH. The KIRA Project includes a comprehensive technical assistance and capacity building activities (component 2) to mitigate this risk.

102. **Fiduciary risks are substantial.** Because of the macroeconomic situation described above, there is a high risk of budget support misappropriation and elite capture. In addition, all international agencies and organizations have been invited to close their bank accounts in commercial banks and transfer their dollar-denominated funds to the Central Bank. Although it is an international practice, in the current special context, this decision could exacerbate the risk of misappropriation. It could also cause payment and project implementation delays. Mitigation measures include: (a) continued implementation of the project through the MoH RBF technical unit which has shown strong management even in the current fragile context; (b) funds would continue to flow directly to the local level to support front-line health services underpinned by a strengthened verification/counter-verification system for RBF payments; (c) development of the project's Procedures Manual in accordance with the World Bank procedures; (d) continued project support to the MoH of high-level local experts in the areas of FM/accounting and procurement; and (e) at least two FM onsite supervisions visits will be conducted every year to ensure that strong FM systems are maintained for the grant throughout the life of the Project.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Economic Analysis

103. **The Health Systems Support Project ("KIRA") aims to increase the quality of Reproductive, Maternal, Neonatal, Child, and Adolescent Health Services.** The KIRA Project will build on project activities and achievements of the ongoing project (HSDSP), which constitute a solid foundation, while trying to increase the impact on the performance of the health system. The project will contribute to Burundi's development through the following pathways: improving mother and child survival and reducing mortality related to communicable diseases; saving unnecessary health care costs and social care costs; increasing productive labor force; promoting equity and shared prosperity; and improving health system efficiency.

104. **The project will contribute to improving mother and child survival and reducing mortality related to communicable diseases.** It will promote interventions that address malnutrition; increase coverage of effective mother and child health interventions such as family planning, assisted deliveries, pre- and post-natal care, and integrated management of childhood illnesses; promote preventive care and vaccination; and improve the management and treatment of communicable diseases, in particular HIV/AIDS, tuberculosis, and malaria. The project will also contribute to saving health care costs related to disease treatment by focusing on cost-effective preventive and curative measures and saving on the social economic burden that is related to extra care needed for children who are stunted and who suffer from preventable diseases. It will also reduce cost related to unsafe delivery that can have lifelong consequences. With improved health and nutrition status, more children will also survive into adulthood and work more productively as a result of better cognitive development. Women who are saved from maternal deaths will contribute directly to productive activities or relieve household members who would have had to provide child care without their presence. The free health care policy will also prevent households and individuals from catastrophic or impoverishing expenditures by granting them access to basic health services free of charge.

105. **The project will contribute to improved technical and allocative efficiency in the health service delivery system.** By strengthening institutional capacity and improving availability and quality of key inputs, more facilities will be pushed to the production function frontier, and therefore, deliver better services to the extent possible at a given cost. The project will also contribute to improved allocative efficiency at health facilities and community levels. Indeed, the project focuses on primary health care and community-based activities, which are the most cost-effective modalities to provide a defined package of high-impact services. It will support the Burundi health system to become more results-focused and to get value from the money invested by supporting the RBF approach. It will enable decision makers and managers at all levels to be more evidence-based in policy analysis, planning, and budgeting by supporting the country's monitoring and evaluation system, analytics, and capacity building in evidence-based decision making.

106. **Public sector engagement is justified by the critical role of the Government in regulating the health sector, and by the project's economic and social goals.** Investments funded through the project will strengthen health service delivery and improve institutional capacity. Public sector intervention is critical to promote good health in the general population, making sure that no one is

left behind. Public sector investments are key to provide and promote preventive health services and support equity improvements to access good quality RMNCAH services. These interventions also have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which advocate for public sector intervention.

107. **The value added of the World Bank support to Burundi on RBF and FHC are** (a) its technical input based on international experience on health systems strengthening and specifically on RBF and capacity to mobilize a wide range of technical expertise to support key strategies and reforms and (b) its convening role in Burundi (since 2010) to support the mobilization of additional resources for innovative health interventions in the country. Furthermore, the ongoing HSDSP has been successful in supporting the Government to implement key reforms such as PBF and FHC.

108. **A cost-effectiveness analysis was performed on the total program costs and program effectiveness was assessed using lives saved.** The software Lives Saved Tool (LiST) was used to convert the coverage of a wide variety of health services to health outcomes (number of lives saved). Results show that interventions planned through the KIRA Project can save numerous children's and mothers' lives. The incremental number of lives saved, compared to the counterfactual scenario of the number of programs, reaches 6,357 children under five and 374 mothers over the four-year period.

109. **The Incremental Cost-Effectiveness Ratio (ICER) estimated for the overall program suggests that the cost of saving one life over the project period would be US$7,101, which seems like a good investment and, therefore, provides sound justification for the project.** Estimated economic growth benefits related to increased productive years also demonstrate the high value of the project. Using a per capita GDP of US$276 per capita, taking into account only productive labor years, the value of benefit related to improved MCH is estimated to be US$63.16 million. The net value of benefit is US$15.27 million, and the benefit-cost ratio is US$1.32, meaning that for every US$1 invested through the project, there will be a yield of US$1.32.

Financial Analysis

110. **Burundi is making the transition from a post-conflict to a stable economy.** Burundi has recorded rather high and stable economic growth between 2004 and 2014 (oscillating between 4 percent and 5 percent), but 2015 was marked by an important negative downturn. The GDP growth is expected to recover gradually from 2016 onward. The economic growth, however, was outpaced by population growth and per capita GDP has been declining over the past decade.

111. **Current health financing programs could become unsustainable as the Government may increasingly be unable to reimburse hospitals for the services provided.** Indeed, while the abolition of fees for health services for children under five years and pregnant women substantially improved social inclusion, the Medical Assistance Program is not fully funded. Greater reliance on domestic revenues was recommended by the International Monetary Fund (IMF) to reduce reliance on donor support and mitigate the impact of aid volatility. As domestically financed public investment and pro-poor spending have invariably suffered during fiscal adjustment, the IMF warned that 'quick win' social programs such as the FHC for pregnant women needed to be safeguarded to ensure inclusiveness and buy-in by the population for the authorities' poverty reduction and growth strategy.

112. **Overall, there has been a steep increase in spending on health between 2010 and 2013 which increased from BIF 288 billion in 2010 to BIF 390 billion in 2013.** In per capita terms, however, THE almost stagnated, reaching US$30 in 2013 (2014 NHA). The government budget to health as a percentage of the GDP is high compared to countries in the region (reaching 10.18 percent in 2013), but this is not translated into better health outcomes and probably reflects the fact that other countries have higher GDP and, thus, higher spending on health in absolute terms.

113. **Health financing in Burundi is highly and increasingly reliant on external sources. In 2013, 62 percent of total health spending was from external resources.** Households, through out-of-pocket payment, represented the second financing source (with 19 percent of THE in 2013). The Government was only the third financing source, representing 13 percent of total health spending. Over the period 2010 to 2013, the share of external assistance in THE increased while the share of out-of-pocket spending decreased, probably as a result of the FHC policy (NHA).

114. **Between 2000 and 2013, external assistance increased more than tenfold in constant 2015 U.S. dollars. External assistance on health is primarily disease-oriented.** It mainly finances the MCH programs as well as HIV/AIDS and malaria programs. The share of external resources going to health systems strengthening, although limited, has been growing in recent years. Fiscal space for health in Burundi critically depends on the sustainability of external funding, the extent to which additional government and other domestic resources can be used to finance health services and efficient use of the money available.

115. **It is expected that this project will be financially balanced, but close monitoring of the macroeconomic and budget situation will be needed. The project investment, US$12.5 million per year** over a four-year period, accounts for a significant portion of the annual government budget on health. Taking 2013 data (latest NHA data available), the annual investment of US$12.5 million is 5 percent of THE (US$250 million), but 38 percent of the government spending on health. In more recent years, however, the MoH budget suffered from poor execution. In 2014, only 61 percent of credits were actually disbursed. If budget execution does not improve, the financial sustainability of the project could be weakened. The annual project cost indeed represents 44 percent of the MoH's 2014 expenditures. The 2015 execution data is not yet available, but it is expected to be comparable, if not worse, due to the crisis.

116. **The MoH has been actively engaged during project preparation and is committed to contribute to US$44 million over the course of the project.** The annual country contribution would thus represent almost half of the MoH's executed budget. Besides the pressure this puts on the MoH budget and the threat it represents for other expenditures, there is also a risk that the Government will not be able to honor its commitment, if budget execution issues are not addressed. On the positive side, however, it is important to note that the ministry has strong ownership of this project which represents the core of its intervention in the sector; it is therefore expected that expenditures related to the project will be prioritized and secured.

B. Technical

117. **The project is relevant and consistent with the aim of improving Burundi's health system performance, particularly in a fragile environment.** The KIRA project would be a continuation of the current operation, but also a way to support and improve the Government's FHC program through

combining it with RBF. The project extends the RBF to important areas of the health system such as community health, regulation/governance, health information system, and nursing schools in order to reinforce the health system. Indeed, these components will contribute to improving the overall performance of the health system in Burundi and strengthen the national FHC-RBF program. The project components are complementary and the budget for each component and subcomponent is reasonable and balanced.

118. **The project arrangements are built upon the ongoing operation (HSDSP) which has been effective with regard to institutional and technical arrangements.** These arrangements allowed the HSDSP to be resilient during the period of political crisis in 2015. The project is in fact about 1 year ahead of schedule in terms of disbursements and had a positive effect on the health system (as recognized by World Bank supervision missions and international partners). However, because of the expansion of the KIRA Project activities, which plans to extend the coverage of the RBF to other actors in the health system, it is planned to recruit some additional experts to effectively implement the new activities related to community health, nursing schools, and the health information system. In terms of governance, these arrangements are appropriate since the audit reports and evaluation missions have not disclosed any cases of fraud or corruption in the ongoing project neither before nor during the crisis.

C. Financial Management

119. **The financial management (FM) system and performance of the various implementing departments of the MoH as of the onoging project (Health Sector Development Support Project: "HSDSP: P101160") are acceptable to IDA.** The MoH will be responsible for the financial management of the KIRA Project and will remain the World Bank's focal point. The MoH, with the support of existing national experts under the HSDSP, is familiar with the World Bank's FM requirements and is currently managing the ongoing phase of this IDA-financed project and for two other additional projects. The FM of the KIRA Project will follow the same approach as the implementation arrangements in place for the ongoing project managed by the MoH. The current FM staffing is adequate. The Interim un-audited Financial Reports (IFR) are prepared every quarter and submitted to the World Bank regularly in a form and substance acceptable to IDA. There is no overdue audit report for the Project or for the sector at the time of preparation of this new project. All last audit reports have been unqualified and all evaluation missions and audits have not disclosed any cases of fraud or corruption in the ongoing project. During the last three years, the financial management performance of the project has been constantly rated as Satisfactory**.** There is no change in the risk ratings for financial management, i.e. the inherent risk (country level, entity level and project level) is substantial because of the country context; however, the control risk (budget, accounting, internal control, fund flow arrangement, reporting and external audit) is rated as Moderate. The overall risk (inherent risk and control risk) should be rated as Moderate.

120. **Two Designated Accounts (DAs) will be opened at the central bank, the Bank of the Republic of Burundi on terms and conditions acceptable to IDA under the fiduciary responsibility of the MoH.** One DA will be used for the IDA funds for providing advances for the RBF and the second account will be used for providing advances for the non-RBF activities. The fiduciary arrangements to be used for the management of these bank accounts will be the same as for the DAs now in place for the ongoing HSDSP project. The counterpart funds from the Government for the KIRA project will be deposited into an account of the Government, and maintained at all times

throughout the project period, on terms and conditions acceptable to the World Bank. The Project fiduciary unit will prepare quarterly an Interim Financial Report to the World Bank. The project will be audited by an independent external auditor as it was for the initial project. The audit report together with the management letter will be submitted to the World Bank within 6 months after the end of fiscal year. Annex 3 provides full details of the financial management and disbursement arrangements.

D. Procurement

121. **Since the project concept note was held prior to the roll out of the New Procurement Framework of July 1st, 2016, procurement for this project will be carried out in accordance with the following World Bank's:** (i) "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011, revised July 2014; (ii) "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011, revised July 2014; (iii) "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2008, revised in January 2011.

122. **A procurement risk assessment for the MoH was conducted in May and updated in October 2016 using the World Bank tool "Procurement Risk Assessment and Management System - (P-RAMS)" based on past experience of the current institutional arrangement when implementing three other World Bank-funded projects in the health sector.** It was worth noting that the procurement team has relevant experience in applying World Bank procurement procedures but there is need for additional support as well as better definition of accountability for procurement decision making within the Ministry of Health. The main risk factors identified and their mitigation measures are summarized in Annex 3.

123. **A simplified procurement plan for at least the first 18 months of the project was by the Borrower and agreed with the World Bank at negotiations.** During implementation, the procurement plan will be updated in agreement with the project team as required - at least annually - to reflect actual project implementation needs and improvements in institutional capacity. It will be available in the project's database and a summary will be disclosed on the World Bank's external website once the project is approved by the IDA's Board of Directors.

E. Social (including Safeguards)

124. **At the social level, the KIRA Project will contribute to improving access to universal health care for all Burundians by further reducing inequalities between poor and rich households, especially with regard to MCH care.** Focusing on health delivery to vulnerable groups in Burundi society will reduce current trends of stunting among young children and contribute to improving nutrition and, ultimately, to productivity.

125. **The Batwas, who make up approximately 1 percent of the population, are recognized as an indigenous group in Burundi.** They are among the most vulnerable groups in Burundi society. Despite constitutional provisions for Batwa representation in the national parliament, there is limited impact on the lives of most Batwas who remain extremely vulnerable. This is compounded by a lack of access to arable land, lack of livestock, acute household malnutrition, and social exclusion. As part of the implementation of the Indigenous Peoples Plan (IPP) under the previous World Bank-financed

HSDSP-IPP, the MoH carried out various activities targeted at improving Batwa access to public health care. These activities included targeted sensitization and mobilization activities focused on health, nutrition, personal hygiene, and civic registration of marriages and births to facilitate the acquisition of relevant documentation to access health care. Through these activities, 6,000 Batwas obtained medical assistance cards, which enable them to gain access to public health care services. Batwa representation in local health committees, at management and implementation levels has also increased. Batwas also make up just over 5 percent of the 12,000 CHWs nationwide.

126. **The environmental and social category of the project is B and the following safeguards policies are triggered:** Environmental Assessment (OP/BP 4.01) and Indigenous Peoples (OP/BP 4.10). OP/BP 4.01 will address issues linked to the increased generation of infectious and hazardous health care waste as well as inclusion of all categories of beneficiaries, especially the poor and vulnerable, to the project services, while OP/BP 4.10 will ensure the inclusiveness of the indigenous peoples, the Batwas, present in the project area. OP/BP 4.12, on Involuntary Resettlement, is not triggered, as the KIRA Project activities—PBF and institutional strengthening—have no potential for land acquisition or economic displacement. Visits to sample sites during the pre-appraisal mission revealed that the extent of works from the ongoing HSDSP project, upon which the KIRA Project builds, did not include any major works.

127. **The MoH prepared an Indigenous Peoples Planning Framework (IPPF) for the KIRA Project.** The IPPF focuses on the acquisition of 16,000 medical assistance cards for Batwas, who did not benefit from HSDSP activities. To this end, the assistance of the Batwas already engaged in the public health services will be solicited to ensure that the specific needs of the community are addressed. These specific needs, as expressed during consultations in four provinces in September 2016, relate to personal hygiene, sexual and reproductive health, early pregnancy, and sexual violence toward Batwa women. Other issues that came out during the consultations regard access to education and employment opportunities, child nutrition, and discrimination.

128. **The IPPF improves on the monitoring of the implementation of actions aimed at the Batwas by developing specific monitoring indicators.** It also establishes a Batwa-specific grievance redress mechanism (GRM) that fits into the overall project GRM.

129. **The Directorate of Health Promotion and Hygiene (*Direction de la Promotion de la Santé Hygiene et Assainissement*-DPSHA) of the MoH is responsible for implementing the IPPF.** The IPPF proposes that the DPSHA will implement these activities with the support of a third-party consultant and provincial and district health authorities.

130. The IPPF was disclosed in-country on December 13, 2016 and in the World Bank's InfoShop on December 14, 2016.

F. Government's Grievance Redress Mechanism and Citizen Engagement

131. **The MoH will establish a grievance redress mechanism for the KIRA Project.** Participating health units and district and provincial health administration bureaus will designate grievance officers who will be responsible for managing the grievance registers that will be opened up for community members to record any complaints linked to the project implementation in their communities. Complaints can also be made through the use of a telephone hotline that will be located

at a central level. The availability of the registers and the hotlines will be disseminated to communities so that they are aware of where to make their complaints. Where the complainant is unable to write the complaint in either Kirundi or French, he/she can be assisted by someone else to ensure that there is a written record of the complaint. All grievances must be resolved at the local level within seven days. If the grievance is satisfactorily addressed, a record of the action carried out will be recorded. In the event that the issue is not addressed within seven days, it will be escalated to the next level, either the district or province—a record of this action must be registered at the local level. If untreated within seven days at either level, records will indicate that the issue has been escalated to the DPSHA of the MoH who will resolve the issue, transmit the response to the complainant, and provide a record of the response provided. Where the DPSHA is unable to address the issue, it will escalate the matter to the ministry's administrative board or to the criminal justice system, in extreme cases. All actions must be recorded.

132. **Under the KIRA Project, communities will expand their engagement with the public health service providers, especially in the areas of nutrition and MCH care.** The KIRA Project will engage citizens through (a) consultations, (b) participation in data collection and recording, (c) capacity-building in nutrition and personal hygiene sessions, and (d) establishment of a GRM (see above). There was wide consultation during the preparation of the IPPF, and the findings from the IPPF were fed into the project design to address the specific needs of the Batwa to ensure that no citizen is left behind. Grievance redress and citizen participation in monitoring will be achieved through the setting up of a hotline by the DPSHA for complaints, recommendations, and feedback. All complaints, recommendations and feedback received through phone calls will be documented as well as the relevant action carried out to resolve complaints.

G. Environment (including Safeguards)

133. **The project is rated as Environmental Assessment category B.** Activities related to the PBF approach may lead to an increase in medical waste, which may lead to adverse environmental impacts of the project. In addition, it could also finance the rehabilitation of health infrastructures to improve the quality of health services, requiring the identification, mitigation, and monitoring of potential adverse environmental and social impacts because of the civil works.

134. **The OP/BP 4.01, Environmental Assessment, has been triggered by this project due to the potential negative environmental impacts related to the following:**

(a) **The potential negative environmental impacts during the rehabilitation of health infrastructures on its existing sites** could mainly include (i) increased levels of dust, noise, and other emissions from civil works, (ii) generation of solid wastes during the civil works; (iii) traffic disturbance and accident risks during civil works; and (iv) health and safety issues for workers.

(b) **The handling and the disposal of medical waste** (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project.

135. **In accordance with OP/BP 4.01,** these potential impacts are expected to be small to moderate, temporary, site-specific, and mostly reversible, and mitigation measures can readily be designed. Therefore, the Project Implementation Unit has prepared an Environmental and Social Management Framework (ESMF), and the Medical Waste Management Plan (MWMP) prepared for the HSDSP has been updated for the new operation. These safeguard documents, the ESMF with the MWMP, were disclosed in-country on December 13, 2016 and in the World Bank's InfoShop on December 14, 2016.

136. **The World Bank's supervision missions will include environmental and social safeguards specialists to assist the Project Implementation Unit by** (a) providing regular implementation support, (b) carrying out field reviews of safeguards implementation, and (c) monitoring safeguards implementation based on periodic progress reports.

137. **Two safeguard policies were triggered, as shown in table 5.**

Table 5. Safeguard Policies Triggered by the Project

	Yes	No
Environmental Assessment (OP/BP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Physical Cultural Resources (OP/BP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OP/BP 4.10)	[X]	[ ]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP 7.60)	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

138. Other safeguards policies triggered: None

H. World Bank Grievance Redress

139. **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 World 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.

Annex 1: Results Framework and Monitoring

Country: Burundi

Project Name: Health System Support –"KIRA" (P156012)

Results Framework

Project Development Objective

The objective of the project is to increase the use of quality Reproductive, Maternal, Neonatal, Child, and Adolescent Health services, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

PDO Indicators

Name of Indicator	Baseline	Cumulative Target Values				
		2017	2018	2019	2020	End Target (June 2021)
People who have received essential Health, Nutrition, and Population (HNP) services • Children immunized (number) • Women and children who have received basic nutrition services (number) • Deliveries attended by skilled health personnel (number) (cumulative from the second year of project implementation)	772,087 (NHIS report 2015)	799,110	1,626,189	2,482,216	3,359,643	4,259,006
Percentage of pregnant women who received four antenatal care visits within the first 28 gestational weeks	32.35 (NHIS Report 2015)	35	38	43	47	51
National quality average score of district hospitals (percentage)	80 RBF database (June 2016)	81	82	83	84	85
Contraceptive prevalence rate for modern methods (percentage)	38	39	40	41	43	45
Contraceptive prevalence rate among adolescents (percentage)	1.8 (HHS 2009) 1.3 (DHS 2010) 3.1 (HHS 2012)	5	—	9	—	12

Name of Indicator	Baseline	Cumulative Target Values				
		2017	2018	2019	2020	End Target (June 2021)
Intermediate Results indicators						
Number of visits to a health facility for children under 5 years of age	2.2 (HH Survey 2012)	2.4	2.4	2.5	2.5	2.5
Number of pregnant women who received standard antenatal care during visits to health facilities. (4 visits within first 28 gestational weeks) (cumulative from the second year of project implementation)	165,504	169,476	344,884	526,431	712,516	903,254
Coverage of births attended by qualified personnel (percentage)	77.3 (NHIS Report 2015) 78.4 (HHS 2012)	80	82	83	84	85
Number of years-protection couples for modern methods (cumulative from the second year of project implementation)	553,679 (NHIS Report 2015)	586,811	1,187,705	1,803,021	2,427,016	3,066,611
Number of pregnant women on ARV protocol for the prevention of mother-child transmission (cumulative from the second year of project implementation)	3,885 (HIV Program Annual Report)	4,300	8,700	13,200	17,780	22,430
Percentage of health centers with heads at A2 level nurse	62 (*Base de données* DRH)	70	75	80	82	83
Percentage of public health facilities that offer FHC and use RBF	97 (RBF database)	97.5	98.0	98.5	99.0	99.0
Satisfaction rate of beneficiaries on health care delivered by health centers (percentage)	58 (RBF database)	60	65	70	72	75
Number of new FP acceptors referred by the CHWs and who arrived at the health center	0 (RBF database)	158,552	240,693	324,806	410,938	499,137
Total number of children aged 6-59 months tested and referred by community health workers for malnutrition	0	17,092	110,707	344,706	787,049	1,352,334
Number of pregnant women referred for early ANC1 (TRIM1) (cumulative)	0 (RBF database)	66,944	101,626	137,140	173,506	210,745

Note: ARV = Antiretroviral; DHS = Demograhic and Health Survey; FP = Family Planning; HHS = Households;

Description of Indicators

Name of Indicator	Description/Definition	Frequency	Source	Responsibility of data Collection
PDO Indicators				
People who have received essential Health, Nutrition, and Population (HNP) services: • Children immunized (number) • Women and children who have received basic nutrition services (number) • Deliveries attended by skilled health personnel (number)	• Number of children ages 0 to 11 months who received vaccination during the year • Number of women and children who have received basic nutrition services • Number of cases of deliveries (eutocic, obstructed labor, or cesarean) made during the year with the assistance of a qualified person (of minimum A3 level)	Annual	NHIS	DGP
Percentage of pregnant women who received four antenatal care visits within the first 28 gestational weeks	Number of women who have made a fourth antenatal care visit in the first 28 weeks / pregnant woman attended to at ANC clinics × 100	Annual	NHIS	DGP
National quality average score of district hospital (percentage)	RBP quality average score of district hospitals	Annual	RBF database	RBF Technical Unit
Contraceptive prevalence rate for modern methods (percentage)	Proportion of women ages 15 to 49 years who used or whose sexual partners used any form of modern contraception during the year	Annual	Households surveys financed by the project Proxy: NHIS	DGP
Contraceptive prevalence rate among adolescents (percentage)	The number of teenage users of contraceptive methods × 100 / adolescents at risk of pregnancy	Annual	DHS/ Households surveys financed by the project	DGP
Intermediate Results Indicators				
Name of Indicator	**Description/Definition**	**Frequency**	**Source**	**Responsibility**

Name of Indicator	Description/Definition	Frequency	Source	Responsibility of data Collection
Number of visits to a health facility for children under 5 years of age	Average number of contacts per year per child under 5 years with health facilities	2–3 years	DHS	DGP
Number of pregnant women who received standard antenatal care during visits to health facilities (4 visits within first 28 gestational weeks)	Number of pregnant women with at least 4 prenatal visits in the first 28 weeks before delivery during the year	Annual	DHS/ Households surveys financed by the project	DGP
Number of year-protection couples for modern methods	Number of couples who used a modern contraceptive method during the year	Annual	HMIS	DGP
Number of pregnant women on ARV protocol for the prevention of mother-child transmission	Number of HIV+ pregnant women on ARV prophylaxis for the prevention of mother-to-child transmission during the year	Annual	National HIV/AIDS control Program Annual Report	DGP
Percentage of health centers with heads at A2 level nurse	Number of health centers managed by A2 level nurse out of total number health centers	Annual	Human resources mapping (HR Department)	DGP
Percentage of public health facilities that offer FHC and use RBF	Percentage of public health facilities that offer FHC and use RBF out of all public health facilities	Annual	RBF Technical Unit Annual Report	DGP
Satisfaction rate of beneficiaries on health care delivered by health centers	Score of quality of health services delivered by health centers as perceived by beneficiaries	Quarterly	RBF database	RBF Technical Unit
Number of new FP acceptors referred by the CHWs and who arrived at the health center	Number of new FP acceptors referred by the CHWs and who arrived at the health center during the year	Annual	RBF Technical Unit Annual Report	DGP
Total number of children aged 6-59 months tested and referred by community health workers for malnutrition	Total number of children aged 6-59 months screened with malnutrition by community health workers, referred and arrived at Health Facilities	Annual	HMIS	DGP
Number of pregnant women referred for early ANC1 (TRIM1)	Number of pregnant women referred by the CHWs for early ANC1 (Trimester 1) who arrived at the health center, during the year	Annual	RBF Annual Report	DGP

Note: ANC1 = Antenatal Consultation; ARV = Antiretroviral; FP = Family Planning; HMIS = Health Management Information System.

Annex 2: Detailed Project Description

BURUNDI: Health System Support Project ("KIRA")

Current Implementation of the FHC and RBF program in Burundi (HSDSP – P101160)

1. **The ongoing project (HSDSP - P101160) is supporting the FHC for pregnant women and children under the age of five, coupled with RBF (FHC-RBF) since 2010.** The project development objective is to "increase the use of a defined package of health services by pregnant women, children under the age of five, and couples of reproductive age." The HSDSP was approved on June 2009, and became effective on September 30, 2009. Its total funding of US$84.8 million is provided by IDA and the Health Results Innovation Trust Fund (HRITF). The original IDA grant of SDR 16.8 million (US$25 million equivalent) was followed in 2012 by a first additional HRITF grant of US$14.8 million; and in 2013 by second additional grants from IDA (SDR 16.5 million; US$25 million equivalent), and from HRITF (US$20 million). The project closing date is June 30, 2017.

2. **The results achieved make this a satisfactory project.** HSDSP has a Satisfactory Project Development Objective (PDO) ratings, and Moderately Satisfactory project ratings for other areas – including for overall implementation progress, project management, Monitoring and Evaluation (M&E), financial management (FM), procurement and safeguards.

3. **The HSDSP has a high rate of disbursement.** The initial IDA financing of US$25 million and the first additional HRITF financing of US$14.8 million were fully implemented in 2014 with a disbursement rate of 100 percent. Regarding the second additional financing, its disbursement rate as at December 31, 2016 is 83 percent. The total disbursement rate is expected to be above 99 percent by the project closing date.

Table 2.1. Disbursement Situation, December 31, 2016

Dons	Amount (US$, millions)	Status (December 31, 2016)	Approval Date	Effective Date	Closing Date	Disbursements (US$, millions)	Disbursement Rate (%)
IDA-H4880	25.0	Closed	June 9, 2009	September 30, 2009	August 31, 2014	24.6	99.9
TF-12526	14.8	Closed	July 25, 2012	October 12, 2012	August 31, 2014	14.8	100.0
IDA-H8080	22.1	Effective	October 23, 2012	April 8, 2013	June 30, 2017	19.1	86
TF-13043	20.0	Effective	December 10, 2012	April 8, 2013	June 30, 2017	15.6	78

Source: World Bank Operations Portal.

4. **The World Bank is the second largest financing source of the national FHC-RBF program after the Government.** The FHC-RBF policy in Burundi benefits from the strong ownership of the program by the Government and other stakeholders involved in the process. It is co-funded by the GoB and various international partners (World Bank, EU, Belgium Cooperation, and GAVI). Throughout the entire period of the HSDSP (up to 2017), the Government, which is

the largest contributor, is committed to allocate each year (as counterpart funds of the World Bank funding), at least 1.4 percent of its budget to finance the FHC-RBF program, by respecting the level of the said budget as stated in the Finance Law. The Government's share in financing the FHC-RBF is 45 percent against 42 percent from the World Bank and 13 percent from other development partners.

5. **Burundi is the second country in Sub-Saharan Africa, after Rwanda, to scale up RBF nationwide.** The RBF pilots which were first introduced in 2006 were implemented by the NGOs. But despite good results achieved by these pilots, there were some limitations. Surveys and evaluations showed that good results were being achieved in the areas covered by the RBF pilots, compared to elsewhere. However, there were some differences between the different RBF pilot schemes with regard to methodological approaches and parameters, and these schemes operated independently of the public system and the FHC financing mechanism. Furthermore, for some services in the RBF pilot areas, health facilities were being paid twice: by the Government through the reimbursement mechanism for the FHC policy, and at the same time, by donors financing the RBF pilot schemes. In April 2010, the RBF pilots were scaled up throughout the country. All public and most private, nonprofit health facilities in the country—HCs as well as hospitals—are covered by the national program. From the time it began in April 2010, the RBF program has been used as a mechanism to implement the Government's policy of FHC for pregnant women and under-five children. The Government funding allocated for paying health facilities for their costs incurred due to the FHC policy is channeled to health facilities on an RBF basis, with facilities paid based on their performance in relation to delivery of basic health care services to pregnant women, and under-five children (the previous system whereby health facilities were supposed to be paid based on long and detailed itemized invoices that they send to the Government—without any independent verification of the invoices—was abandoned). Instead the payments made under the FHC to health facilities are executed as part of the national RBF program, with much lower transaction costs and simpler invoicing, but with several layers of verification of the accuracy of the reported levels of services.

6. **Through joint efforts from the Government and its development partners, the FHC-RBF program has achieved impressive results.** The use of health services by pregnant women and children under the age of five has increased significantly since the beginning of the HSDSP, with the exception of 2015, because of the adverse political situation. For example, between 2011 and 2015 (the project started effectively in April 2010), deliveries attended by skilled personnel increased by 22 percent, contraceptive prevalence rose by more than 60 percent, and consultations of children under the age of five increased by 29 percent. The key HSDSP indicators exceeded targets that have been reviewed upward several times during the two additional financings.

7. **Prior to the 2015 political crisis, the international community considered the FHC-RBF program in Burundi as a success story.** A number of countries (including those from Asia) visited Burundi to gain exposure to its RBF experience. Countries were interested in the fact that a very poor country can significantly improve the performance of its health system (especially RMNCH), thanks mainly to smart policies such as FHC and RBF, as well as decentralization and autonomy of health facilities.

8. **The project is in line with the new vision of the health sector in Burundi (2016–25 National Health Policy) that promotes a second-generation FHC-RBF program.** The idea of the second generation originated from observations made during supervision missions of the HSDSP and discussions between the MoH and the World Bank with stakeholders from the project and the overall health sector. Thus, it was found that some performance indicators from health facilities had started to stagnate even though factors impacting on these indicators were sometimes outside the control of these facilities (see the section on the background of the health sector). PBF in its current form is unable to remove these bottlenecks; hence, the idea to extend its coverage beyond the support to health facilities. This would include expanding PBF to community level and central MoH strategic departments, nursing schools, and support functions for PBF (verification/counter-verification, project management, and communication activities to promote health service utilization by vulnerable groups).

9. **Development partners in Burundi's health sector have aligned their activities with the FHC-RBF program.** In addition to the government participation in the payment of PBF to health facilities and the verification process, other international partners support public health programs. These include GAVI, which supports the Expanded Program on Immunization, and the Global Fund, which supports the HIV/AIDS, tuberculosis, and malaria control program. The Belgian Cooperation also provides assistance and payment for performance to paramedical training schools. In addition, the Global Fund, UNICEF, and other partners provide support to community outreach through PBF payments to the CHWs.

10. **The KIRA Project will support a second generation of FHC-RBF** that puts more emphasis on quality, strengthens verification, and reinforces the cost containment. The project will give more importance to the following: (i) the quality aspects in hospitals because, apart from care services related to RMNCH (FHC), all other services will be paid according to their performance in purely qualitative terms; (ii) a strengthened verification process to better manage abuses and errors, on one hand, and put more resources on checking the quality of all health facilities (HCs and hospitals), on the other hand; and (iii) the definition and implementation of strategic activities to enable the FHC-RBF program to better control its costs.

11. **The KIRA Project builds on the achievements of the HSDSP while seeking to address current weaknesses and limitations of the existing FHC-RBF program.** Through component 1, the project will support the continued implementation of the FHC-RBF program through provision of facility-based performance based payments, while also expanding RBF to community level. The project will also help address higher level system constraints through provision of incentive payments to nursing schools and MoH strategic departments. Under component 2, the project will finance support functions for the implementation process of the FHC-RBF program. This includes verification/counter-verification activities, capacity building of MoH and project management support, and promotion of demand for health care services especially for the vulnerable groups through communication activities. Component 3 supports financing of very small investments/equipment for CHWs and nursing schools. A contingency emergency response component (CERC) is included under component 4 of the project.

<u>Component 1</u>: Use of Performance-based Payments to Support the Recipient's Free Health Care (FHC) Program - US$40.60 million

12. **This is the most important component of the project for which the bulk of the funding is allocated (81 percent).** This component will pay health providers and other health entities according to their performance. This includes health facilities; community health workers; FHC-RBF claims and administration/verification departments; MoH central strategic departments; and nursing schools.

Subcomponent 1.A: Payment of FHC-RBF to health facilities (US$29.3 million)

13. **Reimbursement of the FHC and the RBF payments will be done nationwide in favor of public health facilities, non-profit health providers, and some private health facilities according to a standard national procedure.** FHC is well defined by the law (Presidential Decree No. 100/38 of March 16, 2010) and RBF is applied according to the unique RBF Procedures Manual. Performance services and indicators are clearly defined by the manual that differentiates the list of MPA in HCs and the list of CPA, in hospitals (see MPA and CPA lists in annex 6).

14. **Payment to health facilities will be based on their performance in delivering a coherent package of health services.** The package of services to HCs and hospitals (may be revised/adjusted as the program evolves) are described in the following table and include those related to nutrition activities; prevention; maternal, neonatal, adolescent, infant, and child health; malaria; HIV/AIDS; tuberculosis; and family planning.

Table 2.2 MPA and CPA

MPA (HCs)
1. New curative care consultations for those of age over 5
2. New curative care consultations for those of age 5 or less
3. Days of hospitalization for those of age over 5
4. Days of hospitalization for those of age 5 or less
5. Children completely vaccinated
6. Antitetanus vaccinations for pregnant women
7. New curative care consultations for pregnant women
8. Uncomplicated (eutocic) childbirth deliveries
9. Standard prenatal consultations (4x)
10. Postnatal consultations
11. Minor surgery
12. Patient referral and arrival to hospital
13. Cases treated for STI
14. HIV voluntary testing
15. HIV+ pregnant women under ARV prophylaxis protocol
16. Number of new patients under ARV treatment

17. Number of patients under ARV treatment followed up by semester
18. Health care to new born babies from HIV+ women
19. Positive tuberculosis cases screened per month
20. Number of tuberculosis cases treated and cured
21. FP: Implants et DIU
22. FP: Total new + ancient acceptors
23. Screening and treatment of moderate acute malnutrition of children under 5 (HC with nutritional supplement service-SSN)
24. Screening and treatment of severe acute malnutrition of children under 5 (HC with ambulatory therapeutic service-STA)
25. Screening and referral acute malnutrition cases (moderate and severe) of children under 5 (HC without SSN and/or STA)
26. Growth monitoring and promotion for children under 5 (measuring of weight/age)
CPA (Hospitals)
1. New curative care consultations by doctors for those aged 5 or less
2. New curative care consultations for pregnant woman
3. Counter-referral case arrived to HC
4. Uncomplicated (eutocic) childbirth deliveries
5. Caesarean childbirth deliveries
6. Complicated (dystocic) childbirth deliveries, aside from caesarians
7. Day of hospitalization for those aged 5 or less
8. Standard prenatal consultations (4x)
9. Postnatal consultations
10. Minor surgery for children under 5
11. Major surgery for children under 5
12. FP: Implants and intra uterine device
13. FP: Total new + ancient acceptors
14. Surgical contraception
15. New curative consultation for severe acute malnutrition with medical complications of children under 5
16. Day of hospitalization for severe acute malnutrition with medical complications of children under 5

Note: ARV = Antiretroviral; NSS = Nutritional Supplement Services; ATS = Ambulatory Therapeutic Services;

15. **Payment of RBF to health facilities will be directly linked to predefined quantity and quality indicators**. However, the second generation RBF will put more emphasis on quality. Indeed, the quality of care, despite an improvement, is still insufficient, and major efforts must be made at this level. Hence to contribute to further improvement of the quality of services and health care, the MoH, with support from its international partners, is reviewing the RBF at the level of the health facilities to focus on the quality of care. At the level of hospitals, the RBF quantity component will be limited only to reimbursement of services related to FHC. All other quantity indicators will be removed. At the hospitals level, focus will be on improving the quality of care. Thus, a maximum RBF quality ceiling is to be determined for each hospital and quarterly evaluations of the technical quality (by peers) and biannual perceived quality (by the community)

will continue. The ceiling should be substantial enough to encourage hospitals to improve the quality of their services.

16. **For HCs, the quantity and quality aspect will be maintained** because, at this level, performance with regard to utilization of health services (quantities) and improving the quality of care is still awaited. However, the weight of the quality component will be revised upward to encourage HCs to further improve the quality of health services and the rate of the 'quantity' indicators will be revised downward, except indicators pertaining to FHC.

17. **Additional activities will accompany this quality promotion process.** These activities will be supported through funds from the KIRA Project and also by additional technical assistance (from the World Bank and other partners). Two activities will be implemented by the MoH. Quality competitions will be organized between health facilities of the same level (HCs, hospitals) to further increase quality of services, and prizes will be awarded to the best HCs and hospitals. This is intended as a first step towards a more institutionalized quality assurance mechanism in the health facilities with the development of policy documents and a quality strategy, the development of quality and referential standards, and the establishment of a gradual system of accreditation of health facilities by moving toward a certification process.

Subcomponent 1.B: Performance based payments to community health workers cooperatives (US$4.2 million)

18. **The project will gradually implement this component before scaling it up because it concerns a very large number of the CHWs (about 12,000).** These agents are grouped into 860 cooperatives called GCHWs. Each GCHW comprises between 10 and 15 agents. Implementation will be gradual and will first involve areas where pilot projects have taken place and where the approach and community culture are highly developed, owing to the various partner programs such as UNICEF and the Global Fund.

Community Health Workers Cooperatives or Groups GCHWs (Groupements d'Agents de Santé Communautaire – GASC) are local non-governmental organizations. The *Commune Administration* officially approves their legal status. There are 863 GASCs and more than 12,000 CHWs (in average each GASC is composed of 14 CHWs). Every single GASC is working with one HC and technically coached by a HC staff (Health Promotion Technician). All active CHWs have been trained to deliver health promotion activities, prevention and very basic health services at community level.

Development Partners and Income Generating Activities are the main sources of funds. Under the RBF program, and based on contracts signed with the CPVV, GASCs will receive their payment directly from the project designated accounts to their bank accounts. 70% of this payment will be allocated individually to CHWs according to their performance. The remaining 30% will be used for income generating activities and overheads.

19. **Payments will be made directly to the GCHWs (like for health facilities), each with a bank account, according to a list of predefined services and indicators by the national RBF Procedures Manual.** Each month, the performance of the CHWs will be consolidated at the GCHW to which they belong. Payment of the performance will be done in one operation directly to the GCHW. Performance is linked to predefined activities on (a) health promotion and prevention, (b) referral services to appropriate HCs, and (c) community-based distribution of some inputs (nutritional ingredients, condoms, nets, and so on). The performance of GCHWs will be assessed through a double evaluation grid to measure both the quantity and quality of services provided by the CHWs.

Subcomponent 1.C: Performance Based Payments to FHC-RBF claims and administration/verification departments (US$5.0 million)

20. **Performance based payments to FHC-RBF claims and administration/verification departments will be made according to their performance.** These comprise the National Technical Unit in charge of the coordination of the FHC-RBF program, the verification and validation provincial committees (CPVVs), the PHOs, DHOs, and the Department in Charge of Resource Management (Direction Générale des Ressources, DGR). These entities play a key role in the RBF operations and success of the program. They will receive performance payments according to rules defined by the RBF Procedures Manual used under the HSDSP.

Subcomponent 1.D: Performance Based Payments to MoH strategic departments supporting health facilities (US$2.1 million)

21. **This subcomponent will support central MoH strategic departments** to strengthen their performance culture and thus improve their support for the smooth functioning of health facilities. These comprise: (a) the public health programs in charge of nutrition and reproductive health; (b) the National Health Information System (*Système National d'Information Sanitaire*, NHIS); and (c) regulatory units in charge of drugs and human resources. These performance based payments will be used to improve both their operations (for example, purchase of small equipment, office furniture, computers, and so on) and the motivation of their staff.

MoH Strategic Departments

22. **Reproductive health and nutrition programs will be included in the RBF.** These two programs will receive payments based on their performance specifically in supporting the operational level (health districts, hospitals, and HCs). These performance based payments will be used (a) to motivate the staff of both programs and (b) to improve their operations.

23. **The Department of National Health Information System will be included in the RBF program.** To enhance decision-making and evidence-based planning and budgeting, the MoH in collaboration with its partners, implemented policies and strategies to improve the NHIS. The NHIS is experiencing difficulties with producing timely data needed for decision making and meeting reporting requirements (planning, management, and response to emergencies). Several factors contribute to this NHIS situation: (a) the current system does not include the community CHW component; (b) difficulties in coordinating subsystems; (c) inadequate monitoring of data quality; (d) stock-out of data collection tools; (e) lack of data validation mechanisms; (f) poorly

motivated staff; (g) irregular investigations which limit the availability of updated information; and (h) lack of data on the private sector. RBF is expected to improve the NHIS performance and remove various bottlenecks. Performance payments are intended for staff motivation and to improve the NHIS operations.

24. **The KIRA Project proposes to contract-in all regulatory departments (in particular, human resources, drugs regulation).** This approach has the advantage of enabling the smooth functioning of the structures to improve the working atmosphere and enable the central level to contribute effectively to the performance of operational and intermediate levels. Regulatory units' performance will be analyzed mainly through their support to health facilities.

25. **In 2013, experience in contracting-in regulatory departments (for example, human resources, drugs regulation) started with the financial support of the Belgian Cooperation.** This contracting-in was related to Service Units (SU) (departments in charge of regulation). SUs are designed as teams with a maximum of 10 to 20 people. An SU is understood as "a team that has the same outcome requirement and whose members are under the same authority." Under the Belgian Cooperation project, an SU used up to 65 percent of the amount received for staff bonuses. The remaining 35 percent was used to support operating costs (purchase of office equipment, computers, software, furniture, and other small equipment). This process improved the performance of regulatory agencies and strengthened their support at the operational level. This approach, however, ended in 2015 because of the political crisis in the country.

Support to Nursing Schools

26. **Rationale for support to nursing schools**. Based on the analysis of the current human resource development strategy, the following bottlenecks were identified: (a) the production of human resources for health is not in line, in quantity and with regard to profiles, with the needs to achieve the priority goals of the national health policy; (b) qualifications of nurses at the HCs are not adapted with a predominance of low qualification profiles (at A3 level); (c) lack of some essential human resources to achieve health policy goals; and (d) not sufficiently motivated teaching staff. The MoH, with the support of its partners, has undertaken a reform to improve the quality of nursing training. Training of nurses at the A3 level was abandoned in favor of nurses at the A2 level.

27. **The KIRA Project will continue the contracting-in of nursing schools started with the support of the Belgian Cooperation while improving the existing mechanism**. The ministry of health, with the support of the Belgian Cooperation, implemented a contracting approach for nursing schools according to the RBF approach with a focus on technical and administrative activities. It is important to ensure continuity of this program, given the good results: improved quality of training of A2 level paramedic nursing staff, better supervision of internships, better technical and pedagogic guidance to teachers, incentives for underpaid schools staff, and strengthened management. Support from the Belgian Cooperation will end in March 2017. Performance payments to these schools will serve to improve their operations and motivate staff and teachers. Only public schools and non-profit schools are included.

28. **Nursing schools are assessed quarterly by peers (other nursing schools) facilitated by the RBF Technical Unit and the MoH department in charge of nursing.** Schools are assessed based on criteria such as (a) number of students in the first year, (b) number of permanent teachers, (c) delivery of lectures, (d) educational support, (e) supervision of interns in the field at health facilities that meet the required standards, (f) educational/pedagogic sessions, and (g) management committee sessions. A quarterly ceiling (if the performance is 100 percent) is allocated to each school based on the score obtained and a budget is assigned to each nursing school. A proportion of these funds is used for staff motivation and another to support nursing schools functioning.

Component 2: Implementation Support for the FHC Program-related actvities - US$8.40 million

29. **This component is strategic even though its financial cost does not exceed 17 percent.** The component is important for the success of the KIRA Project as well as the national FHC-RBF program. It will support (a) the verification and counter-verification process and (b) the MoH capacity building, (c) the KIRA Project's management, (d) promotion of health care services demand, and (e) social and environmental safeguards activities.

Subcomponent 2.A: Support to verification and counter verification processes (US$5 million)

30. **Funding will be allocated to verification activities to enhance their quality and effectiveness while containing their operating costs.** There are two components in verification: the ex-ante verification is done before the payment is made and counter verification or ex-post verification is done once the payment is made. Currently (in the HSDSP), verification is provided by (a) the CPVV team that deals with the quantitative verification; (b) the PHOs and the DHOs evaluate the quality of services provided by HCs; (c) peers assess the quality at hospitals; (d) local organizations (community-based) are in charge of community verification (accuracy of health services provided); and (e) counter verification is undertaken by contracted out independent entities. The KIRA Project will continue to finance this process. However, it will introduce some changes that are described in the following paragraphs.

31. **A change is needed because of very high verification costs.** From 2010 to 2013, the evaluations of the technical quality in the HCs were conducted by the PHOs in collaboration with the DHOs. From 2014, the MoH decided to entrust this evaluation to independent NGOs. However, it was noted that the evaluation made by the PHOs and the DHOs was to a certain extent a conflict of interest because the latter are supposed to supervise the HCs. Moreover, complacency was observed in the quality scores assigned to the HCs. At the hospital level, peer review was maintained with the participation of independent NGOs. However, the evaluation of the technical quality by independent entities/NGOs was conducted only in 6 of the 18 provinces, because of insufficient financial resources. The evaluations of the technical quality of the HCs by independent NGOs, their participation in quality evaluation by peers at hospitals, as well as their contribution to the quantitative monthly evaluations would cost about US$3 million per year for the 18 provinces.

32. **To strengthen verification while containing costs, the KIRA Project proposes the following changes:** recruitment of contracted workers who will receive a monthly salary **and** would be made available to the CPVVs. The latter would then have the mission of verifying

quantitative services in the health facilities (HCs and hospitals) and assessing the technical quality at the HCs. Assessing the technical quality in hospitals by peers will continue. Thus, the CPVVs will be composed of civil servants and contracted workers and will be dealing with the following tasks: (a) assessing the technical quality of HCs at the end of each quarter; (b) participating in the evaluation of the technical quality of district hospitals by peers; and (c) participating in monthly evaluations of quantitative services at the HCs and hospitals. For the national hospital, an enlarged team of the RBF National Technical Unit will participate in evaluations of the technical quality by the peers. This change will lead to a reduction of approximately 35 percent of the current verification cost. The KIRA Project will finance the salaries of contracted workers in charge of assessing the quality and quantity as well as performance payments of the CPVVs' civil servants. The Government will finance the operational costs as well as the salaries of the CPVVs' civil servants.

Subcomponent 2.B: Supporting project management (US$2.9 million)

33. **Various capacity-building activities of the MoH will be financed by the KIRA Project.** These activities cover various areas including monitoring and evaluation, FM, social and environmental safeguards, management and coordination of the project, communication, and so on. Financial audits and ad hoc surveys will also be financed.

34. **Support to the management of the KIRA project.** Similar to the HSDSP, it will be done through financial support to the RBF National Technical Unit and experts in charge of management of the KIRA Project, within the MoH.

Subcomponent 2.C: Supporting the promotion of demand at community level and social and environmental safeguards activities (US$0.5 million)

35. **The KIRA Project will provide funding to the same community activities under the HSDSP to increase the demand for health care, promote healthy behavior, especially assisting vulnerable groups, notably the Batwa, to have access to health services.** This includes capacity building and training of community-based actors, and the use of media, public awareness campaigns, and various communication activities.

36. **The project will also support the implementation of social and environmental safeguards activities** notably assistance to the Batwa population to better access health services and setting up an additional number of Montfort-type incinerators to improve biomedical waste management.

<u>Component 3</u>: Strengthening of newly integrated FHC Service Providers through financing of minor investments/renovations works for Community Health Workers (CHWs) and nurse training - US$1.00 million

37. **This support concerns nursing training schools and the CHWs.** A lump sum will be allocated to each school to finance small investments (technical equipment, computers, software, library supplies, very small renovation works, and so on) focusing on small-scale upgrading. Renovation works will be limited to improvement works on existing buildings. Support to the CHWs consists of providing them with a kit that includes, among others, bicycles (bikes), umbrellas, boots, medicines boxes, gears, hats, and white coats.

<u>Component 4</u>: Contingency Emergency Response Component (CERC) - US$0.00

38. **A CERC will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints.** This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

Annex 3: Implementation Arrangements

BURUNDI: Health System Support Project ("KIRA")

1. **The KIRA Project will use the ongoing HSDSP implementation arrangements with minor modifications.** Institutional arrangements and implementation as well as FM, procurement, and safeguards issues, among others, enabled the HSDSP to achieve a good performance (reported in supervision missions' aide mémoirs and ISRs). Throughout the project, the implementation rate has been Moderately Satisfactory or Satisfactory despite the difficult circumstances that the country went through. These measures also played a positive role in the resilience of the project and the FHC-RBF program. Therefore, the KIRA Project will maintain these arrangements with slight modifications.

Institutional and Implementation Arrangements

2. **The KIRA Project will build on the successful implementation experience of the HSDSP project.** Throughout the HSDSP, the implementation performance has been Moderately Satisfactory or Satisfactory despite the difficult context. The institutional and implementation arrangements including the FM, procurement, and safeguards, enabled the HSDSP to achieve a good performance, as reported in supervision missions' aide mémoires and Implementation Status and Results Reports (ISRs). As these implementation arrangements also played a positive role in the resilience of the HSDSP and the FHC-RBF program, the KIRA Project will maintain them with slight modifications as captured in the following paragraphs.

3. **The project's activities will continue to be embedded within the MoH and aligned with its functions because the Ministry has extensive experience in project management with the World Bank** (three projects since 2009: HSDSP, East Africa Public Health Laboratory Networking Project and the Great Lakes Emergency Sexual and Gender-based Violence and Women's Health Project). The Ministry of Health has shown a high degree of leadership and ownership of the programs supported by the projects that it manages. Throughout the life of health projects managed directly by the ministry, financial management and procurement were transparent and effective. The alternative of creating a project management unit has been discussed and rejected, as it does not guarantee a better project funds management. This alternative is also technically risky because it could demotivate the MoH staff and gradually jeopardize the investment made in terms of MoH management capacities.

4. **Similar to the HSDSP, no Project Implementation Unit will be created.** Different departments of the ministry will continue to ensure the same responsibilities with some changes, as described in the following paragraphs, due to additional subcomponents of the Project related to the CHWs, nursing schools, and so on.

5. **This integration within the MoH will be maintained while some other DPs are looking for non-government alternative mechanisms to** channel their financial support to Burundi. The project is maintaining these arrangements for the following reasons:

- All DPs involved in supporting FHC-RBF program use the same single and unified claims system (verification, counter-verification and validation). This includes the European

Union, GAVI, Belgian Cooperation and Global Fund to fight against AIDS, tuberculosis and malaria;

- The core team in charge of day-to-day management of the FHC-RBF program is composed of high level civil servants selected on a competitive basis with a prior approval from IDA;
- The existing competencies within various departments of the ministry are complemented by highly skilled staff recruited by the project to provide technical support in various areas such as financial management, procurement, social and environmental safeguards, among others.

6. **The DGS will ensure the overall coordination of the KIRA Project.** It will be responsible also for the implementation of some subcomponents of the project. Two other MoH departments: the DGR and the DGP will be responsible for implementing the remaining KIRA Project activities. The DGR will also assume the role of deputy coordinator in charge of fiduciary aspects of the project. In the absence of the head of the DGS, the DGR director will assume the function of acting KIRA Project coordinator.

7. **The role of the DGS.** In addition to its function as general coordinator of the KIRA Project, the DGS will have other responsibilities such as the following:

(a) Supervise the RBF Technical Unit in all activities related to results based payments to health facilities;

(b) Supervise the RBF Technical Unit in all activities related to RBF payments to public health programs and the CHWs;

(c) Implement and monitor activities related to environmental and social safeguards issues.

8. **The role of the DGR** will assume the function of the deputy coordinator and will be charged with the following responsibilities:

(a) FM and procurement;

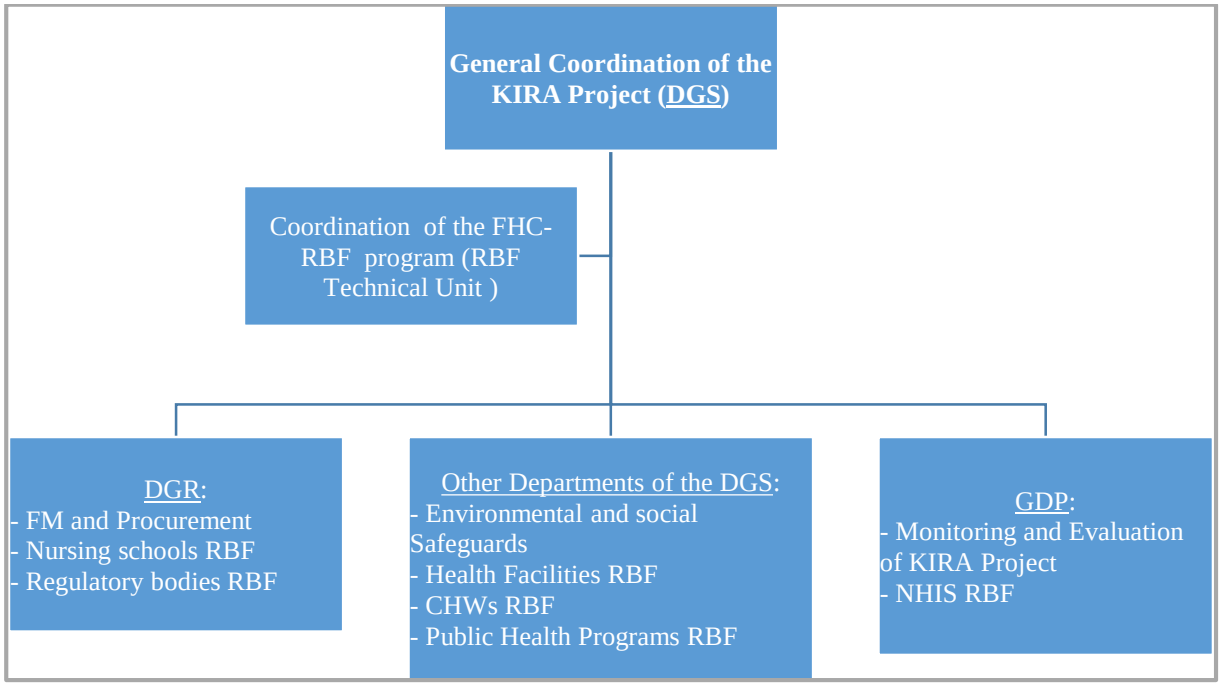
(b) KIRA Project Technical Focal Point for the Ministry of Finance;

(c) Co-implementer, with the RBF Technical Unit, of all activities related to the results based payments to nursing schools and regulatory bodies.

9. **The role of the DGP.** The DGP will be in charge of (a) KIRA Project monitoring and evaluation and (b) co-implementation, with the RBF Technical Unit, of all activities pertaining to results based payments to the NHIS.

10. **The role of RBF Technical Unit.** This unit will coordinate, implement, and monitor the FHC-RBF program. Hence, the RBF Technical Unit will continue to be the technical focal point for the World Bank team in charge of the KIRA Project. Although other departments are co-responsible for the implementation of various KIRA results based payment subcomponents, the ultimate responsibility of RBF implementation is assumed by the RBF Technical Unit.

Figure 3.1. Health System Support "KIRA" Project: Coordination and Distribution of Responsibilities



11. **The KIRA Project will continue to support the MoH with regard to local expertise**. Like the HSDSP, the KIRA project will continue to make available some local experts to the ministry (experts in FM/accounting, procurement, monitoring and evaluation, environmental and social safeguards, information technology/online databases, and communication).

12. **Because of the extension of the RBF program, it is necessary to further strengthen the capacity of the MoH.** Through the HSDSP experience, it appears that the MoH has enough senior staff members and experts in the departments mentioned earlier. However, the implementation of the KIRA Project which offers new activities (nursing schools, CHWs, and so on) will require a strengthening of the ministry. One additional expert in procurement will be recruited and funded by the project and one community health specialist will be appointed by the Ministry of Health. The first will be made available to the DGR, and the second will be assigned to the RBF Technical Unit. Secondly, the KIRA Project will finance local or overseas training to build the capacities of senior staff members and experts responsible for its implementation.

13. **Separation of functions is one of the RBF fundamental principles to prevent possible conflicts of interest and improve governance.** However, the principle does not necessarily indicate the need of one different actor for each function, to the extent that some functions can be compatible without prejudice. For the Burundi FHC-RBF program implementation, eight main functions have been defined:

(a) The provision of care is provided by hospitals and public, confessional, and private HCs, and also the CHWs:

(b) Verification of services is provided by:

(i) the CPVVs teams for quantitative verification of all contracted providers (the CHWs, HCs, and hospitals);

(ii) peers for quality evaluation in hospitals;

(iii) the CPVVs for assessing the quality in HCs and services provided by the CHWs;

(iv) local organizations (community-based) that are in charge of community verification (accuracy of services);

(v) RBF Technical Unit senior staff members and the central administration, who will handle the performance of nursing schools, public health programs, regulatory bodies, and the NHIS.

(c) Counter verification, which will focus on the quality of health facilities services and the performance of the (i) CHWs, (ii) PHOs, (iii) DHOs, and (iv) CPVVs. It will be undertaken once every six months by an independent external body and by local associations that conduct community surveys (perceived quality of health care).

(d) Purchasing of services from the CHWs, HCs, and district and regional hospitals is handled by the CPVV validation departments, while this function is managed by the MoH central level for national hospitals.

(e) Financing of the FHC-RBF program is ensured by the Ministry of Finance at the government side and international partners.

(f) The technical coordination of the FHC-RBF program at all levels is entrusted to the CT-RBF (as mentioned earlier).

(g) Regulation is ensured by the MoH central services and the PHOs.

(h) The voice of the population will be ensured through health committees involved in HCs management as well as the above mentioned local organizations used in verification and in users' satisfaction surveys.

14. **The RBF verification process will be modified to give more importance to quality.** At the hospitals level, the RBF quantity component will be limited only to reimbursement of the services related to FHC. All other indicators related to quantity will be removed. At this level, focus will be on improving the quality of care. Thus, a maximum RBF quality ceiling is to be determined for each hospital and quarterly evaluations of the technical quality and semiannual evaluations of the quality perceived will continue. At HCs, the two components 'quantity and quality' should be maintained because, at this level, performance with regard to health coverage and improving the quality of care is still expected. However, the weight of the quality component will be revised upward to encourage HCs to further improve the quality of health services, and the price of quantity indicators will be revised downward, except for indicators related to FHC.

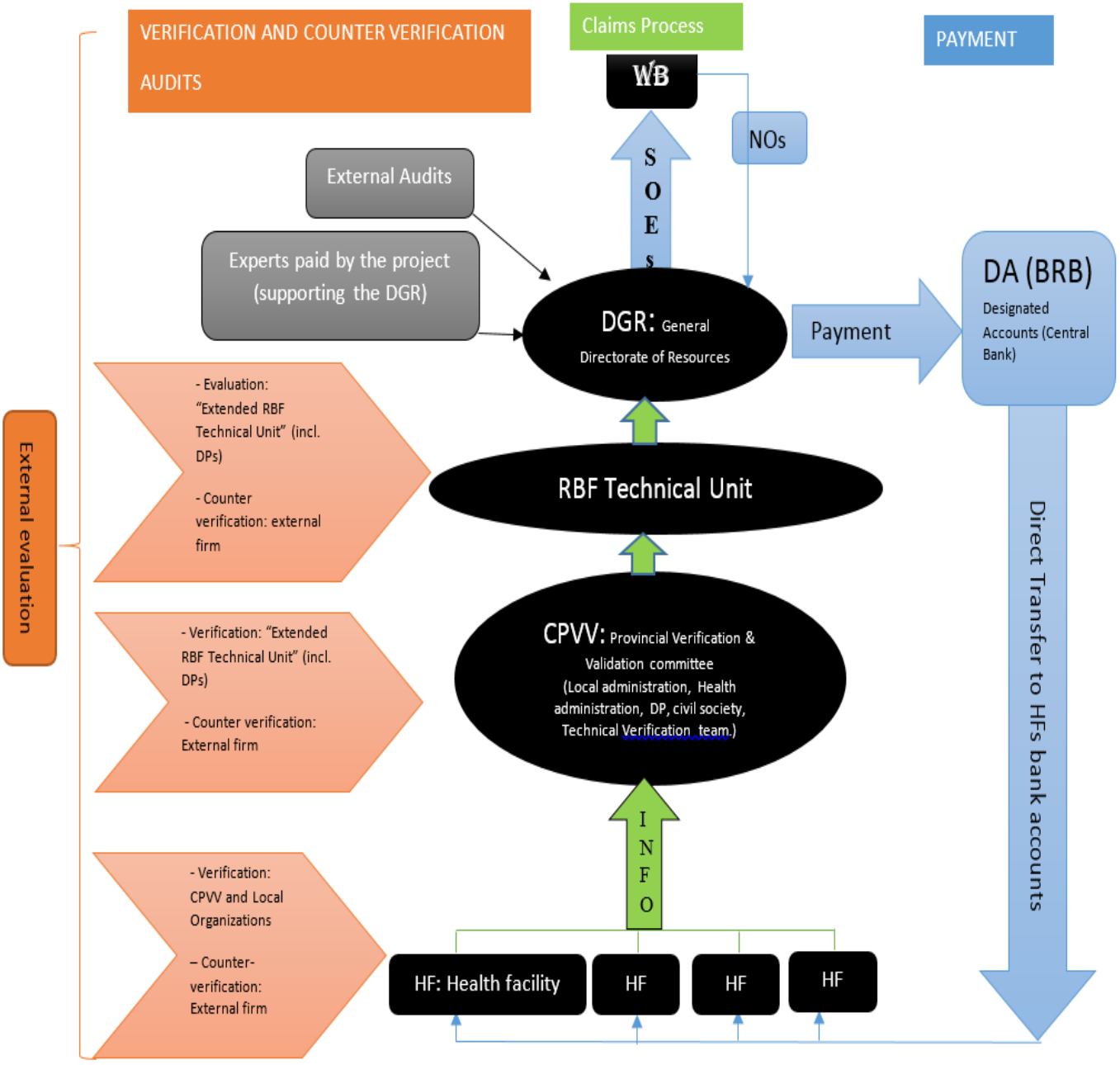
15. **Evaluation of the quality of HCs will be done by the CPVVs to achieve greater efficiency and to contain costs.** As part of the HSDSP, this evaluation is done either by independent NGOs (6 provinces) or by the provinces and districts (12 provinces). In the latter case, this evaluation is to some extent a conflict of interest because provincial and district offices are supposed to supervise the majority of HCs. Evaluations of the HCs' technical quality by the NGOs in all provinces will be too costly (US$3 million per year; US$12 million for four years). That is why the KIRA Project will recruit contracted workers who will receive monthly salaries and would be made available to the CPVVs. These would then (a) handle the quantitative verification task of services provided by the CHWs and health facilities (HCs and hospitals) and (b) assess the technical quality of the HCs. At district and regional hospitals, evaluation of the technical quality by peers will continue. For national hospitals, an enlarged team of the RBF Technical Unit will oversee the assessment of the technical quality by peers.

16. **All FHC-RBF implementation modalities that the KIRA Project is financing will be included in the Procedures Manual.** The RBF Technical Unit has the responsibility to produce and update the Procedures Manual which is the most important tool for implementing the FHC-RBF. This unit is also in charge of preparing the FHC-RBF annual reports (technical and financial reports). Finally, the RBF Technical Unit will improve the RBF database to include the new components of the program pertaining to the CHWs, nursing schools, regulatory bodies, public health programs, and the NHIS.

17. **The Ministry of Finance plays a very important role in the KIRA Project.** During the HSDSP (including 2015), the Government has always respected its commitment to allocate 1.4 percent of its annual general budget to the FHC-PBF program as a precondition for disbursement of IDA/HRITF financing (agreement condition for the HSDSP financing). However, to reinforce its commitment to support FHC-RBF and to ensure greater financial sustainability of the program, the GoB is committed to increase its contribution by 0.1 percent annually to reach 1.5 percent in 2017, 1.6 percent in 2018, 1.7 percent in 2019, 1.8 percent in 2020, and 1.9 percent in 2021.

18. **Under FHC-RBF program, funds are channeled from the Designated Accounts directly to health services/providers**. As shown in the figure below, the claims process starts at facilities and goes up to the CPVV for verification and validation, and then claims are transmitted to the RBF technical unit for an additional validation. For payment, claims are transmitted to the DGR (supported by experts paid by the project) for a final validation at the MoH level. The World Bank teams (Disbursement and Task Team) receive Statement of Expenses (SOEs) from the DGR, review them and provide Non Objection (NO). Once the NO is provided, the MoH transfers funds from the Designated Accounts directly to health facilities or services bank accounts.

Figure 3.2 KIRA FHC-RBF Claims and Payment Cycle



Notes:

- Involved health facilities (643 health centers and 54 hospitals) are public and private across the country;
- More than 600 local NGOs are involved in the verification and counter-verification;
- External evaluation and counter-verification carried by international NGOs, such as COPED, Catholic CORAID, CORDAID, HealthNet TPO;
- Public health centers are managed by a management committee composed of civil servants and elected community representatives
- Each health facility (public and private) has a private bank account with a commercial bank.

Financial Management, Disbursements and Procurement

Financial Management

19. **As part of KIRA Project preparation, an FM assessment of three General Directorates (DGS, DGR, and DGP) of the MoH was carried out in accordance with the Financial Management Manual for World Bank-Financed Investment Operations that became effective on March 1, 2010.** The objective of the FM assessment was to determine whether the FM arrangements (a) are adequate and capable of correctly and completely recording all transactions and balances relating to the project activities; (b) facilitate the preparation of regular, accurate, reliable, and timely financial statements; (c) safeguard the project's entity assets; and (d) are subject to audit arrangements acceptable to the World Bank.

20. **The MoH has been identified by the World Bank and the GoB to manage this new project.** To meet the World Bank's minimum requirements, the existing FM system applied by the ongoing HSDSP will be maintained.

Staffing

21. **It has been agreed that the existing MoH fiduciary team which is well experienced in World Bank fiduciary procedures** will have the overall responsibility of handling the FM aspects of this project, including budgeting, disbursement, book keeping, reporting, supervision, management of the DA, and auditing.

22. **The financial team will be composed of one FM expert, one chief accountant, and two accountants who will be working fully on the project.** They have been handling the FM aspects of the HSDSP and have been producing unqualified audit reports and timely quarterly Interim Unaudited Financial Reports. Training on fiduciary procedures will be conducted for all FM staff throughout the life of the project.

Planning and Budgeting

23. **The Annual Work Plan and Budget (AWPB), along with the disbursement forecast will be prepared by the CT-FPB unit in coordination with the DPSHA and the fiduciary team within the project** and will be submitted to the MoH for approval. Thereafter, it will be submitted to IDA for a no objection no later than November 31 of the year preceding the year the work plan should be implemented, except for year 2017, for which such deadline would be three months after the project's effectiveness. The fiduciary unit of the HSDSP will monitor its execution with the accounting software in accordance with the budgeting procedures specified in the Procedures Manual as well as in the Financial Regulation and Rules. The budgeting system should forecast for each fiscal year the origin and use of funds under the project. Only budgeted expenditures would be committed and incurred so as to ensure that the resources are used within the agreed upon allocations and for the intended purposes. The quarterly Interim Unaudited Financial Reports will be used to monitor the execution of the AWPB.

Accounting System

24. **Project accounting, policies, and procedures will be documented in the FM section of the manual.** The accounting software TOM2PRO used by the ongoing HSDSP and set under its multi-project version will be customized to record all the project's transactions following World Bank guidelines and to prepare the financial statements for the project. The accounting team is familiar with handling accounting and reporting activities through the software consistent with World Bank procedures.

Internal Control and Financial, Administrative, and Accounting Manual

25. **The existing Financial Management Manual which details out key internal control procedures** from transaction initiation, review, approval recording, and reporting will continue to be implemented with slight modifications, if need be, to comply with the project objectives. There will be a clear separation of duties within the FM unit.

Reporting Arrangements

26. **The KIRA Project will record and report on project transactions and submit to the World Bank Interim Financial Reports (IFRs) no later than 45 days after the end of each calendar quarter.** At a minimum, the financial reports must include the following tables with appropriate comments: (a) sources and uses of funds; (b) uses of funds by project activity/component and comparison between actual expenditures and budget; (c) special account activity statement; and (d) notes to the IFR. At the end of each fiscal year, the project will issue the project financial statements comprising: (a) a balance sheet; (b) a statement of sources and uses of funds; (c) accounting policies and procedures; and (d) notes related to significant accounting policies and accounting standards adopted by management and underlying the preparation of financial statements. These project financial statements will be subject to annual external audits as described in the following paragraphs.

External Auditing Arrangements

27. **A qualified, experienced, and independent external auditor will be recruited on approved terms of reference three months after project effectiveness.** The external audit will be carried out according to International Standards on Auditing and will cover all aspects of project activities implemented and include verification of expenditures eligibility and physical verification of goods and services acquired. The report will also include specific controls such as compliance with procurement procedures and financial reporting requirements and consistency between financial statements and management reports and field visits (for example, physical verification). The external auditors will prepare a Management Letter giving observations and comments, providing recommendations for improvements in accounting records, systems, controls, and compliance with financial covenants in the Financial Agreement. The audit period will be on annual basis and the reports including the project financial statements submitted to IDA and to the auditors six months after the end of each fiscal year.

28. **The project will comply with the World Bank disclosure policy of audit reports (for example, making them publicly available), promptly after receipt of all final financial audit reports** (including qualified audit reports), and place the information provided on its official website within one month of the report being accepted as final by the team.

Governance and Accountability

29. **The risk of fraud and corruption within project activities is Substantial, given the country context.** However, the effective implementation of the fiduciary mitigation measures should contribute to strengthen the control environment. Also, appropriate representation in the RBF Technical Unit, transparency in implementation of project activities, as well as sound communication to and with stakeholders and to the wider public, should constitute a strong starting point to tackle governance and corruption issues during project implementation.

Disbursements

30. **The basis of disbursements for the project will be the SOEs. An SOE will summarize eligible expenditures incurred during the period.** The expenditures will be normally grouped by expenditure category or detailed statement that lists all expenditures incurred during the reporting period. When the SOEs are used as supporting documentation for disbursements, the GoB will still be required to provide the IFRs to IDA in accordance with the requirements of the legal agreement.

Results-based Financing

31. **Subcomponents 1.A, 1.B, and 1.D will use results-based disbursements.** Thus, the disbursements will be made against evidence of outputs delivered, which will not be directly tied to specific individual contracts. A clear set of 26 services in the HCs and 16 services in hospitals (which together make up the FHC-RBF package) have since been defined and will be the basis of disbursements upon verification. The unit costs of such services were evaluated at appraisal. The setting of the unit costs used various sources of information collected over a period of time on similar schemes being run by the GoB and financed by various donors. The tariffs' estimation has been made and evaluated to ensure that disbursement of funds made is for the services identified and not for other purposes. All the SOEs used for executing disbursements or advances for the RBF will include confirmation of production and delivery of final services to the population as defined in the existing menu as well as their unit costs, and any other information deemed necessary to meet project FM arrangements. When requesting disbursements from IDA, the GoB will submit to the task team leader and to the Financing and Accounting Department (WFA), a schedule of the different services so far defined and rendered and the associated tariffs for each, to justify the aggregate disbursement amount. IDA will finance 100 percent of the tariffs defined.

32. **An arrangement will be made to regularly adjust tariffs during implementation.** By doing so, prospective unit costs of the defined service packages will progressively converge toward actual expenditures and satisfy the principle of applying the project funds efficiently toward the purposes intended.

Bank Account

33. **Two DAs will be opened at the central bank, the Bank of the Republic of Burundi on terms and conditions acceptable to IDA under the fiduciary responsibility of the MoH.** (a) One DA will be used for the IDA funds for activities under Component 1 which uses RBF and (b) the second account will be used to finance all other activities of the project under Components 2 and 3. Both accounts will be managed by the DGR of the MoH and the ceiling of those DAs are set (DA-A: USD$3,000,000; DA-B: USD$1,000,000). Replenishments to those DAs will be made on a monthly basis against Withdrawal Applications (WAs) supported by the SOEs or records and other documents as specified in the Disbursement Letter.

34. **The appropriate designated personnel at the MoH will carry out monthly bank reconciliations of the two DAs.** Bank reconciliations will be reviewed and approved by senior officials within the MoH.

35. **Just before the project becomes effective, the GoB will designate signatories for the project's DAs.** The names of these signatories will be sent to IDA with specimen signatures before funds can be drawn from the grant. The existing AAMP and RPM define the positions of those authorized as account signatories.

Funds Flow: IDA and Counterpart Funds

Initial Advance and Other Disbursement Methods

36. **Upon grant effectiveness, IDA will make an initial advance (reimbursement method) from the proceeds of the grant by depositing it into the borrower's DAs opened in the central bank, Bank of the Republic of Burundi under terms and conditions acceptable to IDA.** The ceiling for DA A, in which IDA resources for Component 1 will be deposited, will be equal to 50 percent of the cash forecast as shown in the AWPB. Regarding, the DA B (for Components 2 and 3), the ceiling will be US$1 million. Actual expenditure of goods and services will be reimbursed (reimbursement method) after the submission to IDA of the WAs and against the SOEs that will be prepared and approved in accordance with the RMP for expenditures under Component 1 and the AAMP for expenditures under Components 2 and 3. The direct payment method, whereby IDA may send payments directly to a third party for eligible expenditures at the recipient's request supported by records of eligible expenditures (such as copies of receipts and supplier invoices), will also be used as a disbursement method. The IDA Disbursement Letter will stipulate the minimum application value for direct payments and special commitment procedures as well as detailed procedures to be complied with under these disbursement arrangements.

37. **The project will sign and submit WAs electronically** using the e-Signatures module accessible from the World Bank's Client Connection website.

38. **For the Contingent Emergency Response Component, the existing flexibility in OP 12.00 Disbursement would be used to provide significant advances in order to provide the necessary liquidity for fast response.** The level of the advance needed for the CERC would be established independently of any existing advances for the project components and recorded in the revised Disbursement Letter. The advances for the CERC would be deposited in separate Designated Account established for the purpose.

39. **If ineligible expenditures are found to have been made from the DAs, the borrower will be obligated to refund the same.** If the project accounts remain inactive for more than six months, IDA may reduce the amount advanced. IDA will have the right (reflected in the terms of the funding agreement) to suspend the disbursement of the funds if the borrower fails to comply with significant conditions, including reporting requirements.

40. **All documents that support the reported expenditures, such as invoices, statements, and bills of lading, should be maintained by the implementing entities** and made available for review by auditors as set out in the Financing Agreement.

41. **DAs A and B will be audited according to World Bank procedures.** After the initial advance, disbursements to the DAs will be based on the submission of SOEs. Subsequent replenishments will be based on a review by IDA of monthly financial and physical progress reports accompanied with adequate supporting documents.

42. **All project payments regardless of currency will be done through the bank** and converted at the day's mean exchange rate.

Use of SOEs

43. **Disbursements for all expenditures under the components of the project will be made against full documentation against detailed SOEs.** All supporting documentation for SOEs will be retained by the MoH/DGR to be readily available for review by periodic IDA supervision missions and internal and external auditors.

44. **Payments for RBF activities will be reported to IDA on a semi-annually basis** using a specific SOE format annexed to the Disbursement Letter.

45. **IDA will have the right to suspend disbursements should the recipient fail to comply** with the reporting requirements specified in the Financing Agreement.

46. **Disbursements by category.** The table below sets out the expenditure categories to be financed out of the Grants and Credits. This table takes into account the prevailing Country Financing for all participating Countries in setting out the financing levels.

Category	Amount of the Grant Allocated (expressed in USD)	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Results-Based Payments under Component 1 of the Project.	40,600,000	30,200,000	100%
(2) Minor works, goods, non-consulting services and consultants' services, Training and Operating Costs under Component 2 and 3 of the Project	9,400,000	7,000,000	100%
(3) Emergency Expenditures under Components 4 of the Project	0	0	100%
TOTAL AMOUNT	50,000,000	37,200,000	

Supervision Plan

47. **The FM risk of the ongoing project (HSDSP) is assessed as Moderate, due to the country's fragility context.** The FM supervision will be undertaken twice a year by IDA FM staff. The supervision will review the project's FM systems and capacity, in accordance with AAMF and RPM, including but not limited to the operation of the DAs, evaluation of the quality of budgets, financial reports, assessment of the relevance of these manuals, SOEs, internal controls, reporting, and follow up of audit and mission findings. Intensity of supervision will be reassessed after the first year of implementation. The objective of the supervision missions will be to ensure that strong FM systems are maintained for the grant throughout the life of the project. Reviews will be carried out regularly to ensure that expenditures incurred by the DGR remain eligible for IDA funding. The ISR will be updated after every FM supervision.

Procurement Arrangements

48. ***Applicable guidelines***. **Procurement under the Project will be carried out in accordance with the World Bank's** (i) "Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (revised in July 2014); (ii) "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 (revised in July 2014); and (iii) "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2008 (revised in January 2011) and as of July 1, 2016.

49. **The general description of various items under different expenditure categories is presented below under Scope of procurement.** For each contract, the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame are agreed between the Borrower and the World Bank in the

Procurement Plan. The Procurement Plan will be updated at least annually, or as required, to reflect the actual project implementation needs and improvements in institutional capacity.

50. **In addition to prior review of contracts by the World Bank as indicated in the Procurement Plan,** the procurement capacity assessment recommends at least one supervision mission each year and to carry out post-review of procurement actions.

51. **Advertising procedures.** In order to get the broadest attention from eligible bidders and consultants, a General Procurement Notice (GPN) will be prepared by the implementing entity and published in the United Nations Development Business online (UNDB online), on the World Bank's external website and in at least one newspaper of national circulation in the Borrower's country, or in the official gazette, or a widely used website or electronic portal with free national and international access. The Borrower will keep record of the responses received from potential bidders/consultants interested in the contracts and send them the Specific Procurement Notices.

52. **Specific Procurement.** Notices for all goods and non-consulting services to be procured under International Competitive Bidding (ICB) will be published in the UNDB online and in at least one newspaper of national circulation in the Borrower's country, or in the official gazette, or a widely used website or electronic portal with free national and international access. Specific Procurement Notices (SPN) for goods and non-consulting services to be procured using National Competitive Bidding (NCB) will be published in at least one newspaper of national circulation in the Borrower's country.

53. **Procurement documents**. Procurement would be carried out using the Wrold Bank's Standard Bidding Documents (SBD) for all International Competitive Bidding (ICB) for goods and Standard Request for Proposal (RFP) for the selection of consultants through competitive procedures. For National Competitive Bidding (NCB), the Borrower will continue building on the World Bank's SBD and use this type of document throughout the project implementation.

54. **Fraud and Corruption.** All procurement entities as well as bidders and service providers (i.e., suppliers, service providers, and consultants) shall observe the highest standard of ethics during the procurement and execution of contracts financed under the Project in accordance with paragraphs 1.16 and 1.17 (Fraud and Corruption) of the Procurement Guidelines and paragraph 1.23 and 1.24 (Fraud and Corruption) of the Consultants Guidelines, and the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2008 and revised in January 2011 and as of July 1, 2016.

Scope of Procurement

55. **Procurement of Works.** Works to be procured will include construction of incinerators and other small works and rehabilitations. Contracts with an amount lower than US$7,000,000, but equal to or above US$200,000 may be procured through NCB. Contracts with an amount below US$200,000 may be procured using shopping procedures.

56. **Procurement of Goods.** Goods to be procured under the Project will include office furniture, IT equipment and community health toolkits. Contracts with an amount equal or above US$3,000,000 equivalent shall be procured through ICB. Goods orders shall be grouped into larger contracts wherever possible to achieve greater economies of scale. Contracts with an amount lower than US$3,000,000, but equal to or above US$100,000 may be procured through NCB. Contracts

with an amount below US$100,000 may be procured using shopping procedures in accordance with paragraph 3.5 of the Procurement Guidelines and based on a model request for quotations satisfactory to the World Bank. Shopping consists of the comparison of at least three price quotations in response to a written request. Direct contracting may be used in exceptional circumstances in accordance with paragraph 3.7 and 3.8 of the Procurement Guidelines.

57. **Procurement of non-consulting services.** Procurement of non-consulting services, such as **services** for organizing workshops, training, data collection, transport services and maintenance of office equipment, will follow procurement procedures similar to those stipulated for the procurement of goods, depending on their nature.

58. **Selection of Consultants.** Services of both national and international consultants will be required under the Project, as related to the PBF verification, surveys, technical assistance, additional staff and financial auditing. Selection of consultants will be carried out in compliance with the Consultant Guidelines. The provisions vary for consulting services provided by firms and individual consultants as follows:

i. Firm. Selection of consulting firms will include launching a Request for Expressions of Interest, preparing short-lists and issuing a Request for Proposal using World Banks' standard formats, when and as required by the World Bank's Guidelines. The selection method shall be chosen among the following: Quality and Cost Based Selection (QCBS) whenever possible; Quality Based Selection (QBS); Selection under a Fixed Budget (FBS); Least Cost Selection (LCS); Single Source Selection (SSS) as appropriate; Consultant's Qualifications (CQS) for consultancy services estimated to cost less than US$200,000 equivalent. The shortlist of firms for assignments estimated to cost less than US$200,000 equivalent per contract may be composed entirely of national firms in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines, provided that a sufficient number of qualified national firms are available and no foreign consultant desiring to participate is barred.

ii. Individual Consultants. Individual consultants will be selected by comparing qualifications of at least three candidates and hired in accordance with the provisions of Section V. of the Consultant Guidelines.

59. **Single-Source Selection (SSS)** may be used for consulting assignments that meet the requirements of paragraphs 3.8 - 3.11 of the Consultant Guidelines and will require full World Bank's prior review for contracts in amount above US$100,000. Procedures of Selection of Individual Consultants (IC) will apply to assignments which meet the requirements of paragraphs 5.1 and 5.6 of the Consultant Guidelines.

60. **Procurement from United Nations Agencies.** There may be situations in which **procurement** directly from agencies of the United Nations (UN), following their own procurement procedures may be the most appropriate methods. In such circumstances the Recipient shall submit to the World Bank for its no objection a full justification and the draft form of agreement with UN agency.

61. **Terms of reference (ToRs)** for the selection of firms and individual consultants, will be subject to World Bank's review and clearance.

62. **The recruitment of civil servants** as individual consultants or as part of the team of consulting firms will follow the provisions of paragraphs 1.9 to 1.13 of the Consultants Guidelines.

63. **Training activities** would comprise workshops, seminars and conferences, based on individual needs, as well as group requirements, on-the-job training, and hiring consultants for developing training materials and conducting training. Selection of consultants for training services follows the requirements for selection of consultants above.

64. **Operating Costs.** Operating Costs are incremental expenses arising under the Project and based on Annual Work Plans and Budgets approved by the World Bank pursuant to the Financing Agreements. They are incurred based on eligible expenses as defined in the Financing Agreement and cannot include salaries of the Borrower's civil and public servants. The procedures for managing these expenditures will follow the procedures agreed in the implementation manual, acceptable to the Bank.

65. **Record Keeping and Filing.** To ensure transparency in the procurement process, the Project will document all steps in the process for each contract. These procurement documents will be filed in a manner that will facilitate retrieval in the event of audits or reviews. Procurement record-keeping will be the responsibility of the Procurement Unit.

66. **Procurement risks and mitigation measures.** The table below summarizes procurement risks and their proposed mitigation measures. The overall project risk for procurement is Substantial at this stage and would be updated during implementation.

Table 3.1: Procurement Risk assessment and Mitigation Measures

Risk	Action	Completion Date	Responsible Entity
Accountability for Procurement Decisions in the Ministry	Prepare a project specific manual as part of project preparation and ensure the procurement decision making is fully covered in the Manual and available/known to staff.	Before effectiveness	MoH
Procurement staff overloaded	Hire one additional procurement officer and involve the Ministry procurement unit members in project implementation for their inner capacity building and training.	At least 3 months after effectiveness	MoH
Procurement planning	Develop and maintain procurement planning that minimize variances between planned and actuals in cost and schedule – Intensify supervision.	Throughout project implementation	MoH

67. **Frequency of procurement supervision.** In addition to the prior-review supervision conducted from World Bank offices, the World Bank will carry out annual supervision missions to conduct post review of procurement actions and contracts under prior review thresholds on basis of a sample of about 20 percent of contracts within review period.

68. **Prior review thresholds.** The prior review thresholds are based on project actual risk and will be reflected in the procurement plan.

69. **Procurement plan.** The Borrower, at appraisal, developed a procurement plan that project management will use during project implementation. This plan was agreed between the Recipient and the World Bank Team on January 13, 2017. It will be available in the Project's database and on the World Bank's external website. The Procurement Plan will be updated annually, in agreement with the Project Team, or as required to reflect actual project implementation needs and improvements in institutional capacity.

70. The following tables 3.2 and 3.3 provide the details of the procurement arrangements involving major contracts foreseen for the first 18 months, as identified during appraisal.

Table 3.2: List of Major Contracts for Works, Goods and Non-Consulting Services

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost (US$ millions.)**	**Procurement Method**	**Prequalification (yes/no)**	**Domestic Preference (yes/no)**	**Review by World Bank (Prior/Post)**	**Expected Bid-Opening Date**	**Comments**
1	Construction of Incinerators	112	NCB	No	No	Post	Nov. 2017	
2	Community health toolkit	277	NCB	No	No	Post	Nov. 2017	

Table 3.3: List of Consulting Assignments

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost (US$'000)**	**Selection Method**	**Review by World Bank (Prior/Post)**	**Expected Proposals Submission Date**	**Comments**
1	PBF counter-verification	280	QCBS	Post	Feb. 2018	
2	Ministry of health performance evaluation	200	QCBS	Post	Oct. 2017	
3	Facility Survey (HC/SARA)	230	LCS	Post	May 2018	
4	Household survey	250	LCS	Post	Aug. 2018	
5	Technical assistance for Batwa	200	QCBS	Post	May 2018	
6	Financial audit	30	LCS	Post	Aug. 2017	
7	PBF verification	840	IC	Prior	Oct. 2017	4 individual consultants per provincial committee of verification and validation to be hired
8	Additional procurement officer	54	IC	Prior	Aug. 2017	
9	Additional community health expert	54	IC	Prior	Aug. 2017	

Environmental and Social (including Safeguards)

71. **Activities related to the PBF approach may lead to an increase in medical waste, which may lead to adverse environmental impacts of the project.** In addition, it could also finance the rehabilitation of health infrastructure to improve the quality of health services, requiring the identification, mitigation, and monitoring of potential adverse environmental and social impacts due to the civil works. These potential impacts are expected to be small to moderate, temporary, site-specific, and mostly reversible and mitigation measures can readily be designed. Therefore, the PBF program is classified as category B in the World Bank's Environmental Assessment classification due to the low size and site-specific nature of its foreseen social and environmental risks and impacts. The environmental and social safeguard policies triggered by this operation are listed in the following paragraphs.

72. The environmental and social category of the project is category B and the following safeguard policies are triggered: Environmental Assessment (OP/BP 4.01) and Indigenous Peoples (OP/BP 4.10). OP 4.01 will address issues linked to the increased generation of infectious and hazardous health care waste, while OP 4.10 will ensure the inclusiveness of the indigenous peoples, the Batwas, present in the project area.

73. **OP 4.12, on Involuntary Resettlement, is not triggered and the project will not finance any activities that will require land acquisition or economic displacement.** Visits to sample sites during the pre-appraisal mission revealed that the extent of works from the ongoing HSDSP project, upon which the KIRA Project builds, did not include any major works. All activities that will require land acquisition or involve economic displacement will be excluded from funding through the application of the ESMF screening form.

Social (including Safeguards)

74. **The World Bank operational policy on Indigenous Peoples, OP 4.10, has been triggered for this project on account of the presence of the Batwa people across the country and the project's national coverage, and an IPPF has been prepared.** The IPPF builds primarily on the achievements of the previous IPP that was prepared and implemented for the HSDSP in 2009.

75. **The project's primary beneficiaries will be the poor and vulnerable groups such as the Batwa. Given** the results-based outlook of the project, there will be increased focus on building the capacity of provincial and communal stakeholders to better address the specific needs of these vulnerable populations, including the Batwas.

76. **The Constitution of Burundi accords specific Batwa representation in the Senate and the National Assembly, in accordance with the electoral code.** Batwas are recognized as an indigenous group in Burundi, and make up an estimated 1 percent of the national population. The highest concentrations of Batwa are in Cibitoke, Kirundo, and Ngozi provinces. Lowest concentrations are in Ruyigi, Bujumbura Mairie, and Cankuzo. As part of the implementation of the HSDSP-IPP, the MoH has carried out various activities targeted at improving Batwas' access to public health care. This has been achieved through targeted sensitization and mobilization activities focused on health, nutrition, personal hygiene, and civic registration of marriages and

births to facilitate acquisition of relevant documentation to access health care. Through these activities, 6,000 Batwas obtained medical assistance cards, which enables them to gain access to public health care, especially for pregnant women and children under five, and Batwa representation in local health committees, at management and implementation levels. Batwas make up over 5 percent of the 12,000 community health assistants nationwide.

77. **Under the KIRA Project, the focus will be on increasing the number of Batwas that own medical assistance cards and increasing outreach to those who did not benefit from the HSDSP activities.** To this end, the assistance of the Batwas already engaged in the public health services will be solicited to ensure that the specific needs of the community are addressed. These specific needs, as expressed during consultations in four provinces in September 2016, relate to personal hygiene, sexual and reproductive health, early pregnancy, and sexual violence toward Batwa women.

78. **While some of these issues can be addressed under the KIRA Project, an approach to ensuring long-term sustainability and ensuring continued access to health care services is to create a synergy with the World Bank-financed Social Safety Net Project which focuses on vulnerable people, including the Batwas.** Some of the proposed activities, especially money transfer and income-generating activities, are in the provinces of Gitega, Ruyigi, Karusi, and Kirundo. The SSNP is a response to the policy thrust of the National Social Protection Policy. This connection to social protection activities is critical to ensuring sustainability as continued access to public medical services will require annual renewal of the medical assistance card and 20 percent contribution to the cost of each medical treatment. A regular source of income thus becomes indispensable to ensure sustainability beyond project cycles.

79. **The institutional arrangements for implementing the IPPF will be anchored in the DPSHA of the MoH. Under the HSDSP, the ministry has recruited an NGO to implement the IPPF with the support of the Batwa nursing assistants and those within the provincial and local health committees.** The implementation performance of this NGO will be independently evaluated at the end of the HSDSP. Under the KIRA Project, the MoH will recruit, through a competitive process, a consultant to implement the IPPF. The ministry will recruit a consultant to monitor and evaluate the implementation progress of the IPPF, midcycle on the basis of the indicators established in the IPPF and by the MoH. The results of the assessment will enable any necessary adjustments to be made to ensure maximum positive impact on the Batwas. The IPPF has been prepared, approved by the World Bank, and disclosed in the country on December 13, 2016 and in the World Bank's InfoShop on December 14, 2016.

Environment (including Safeguards)

80. **OP/BP 4.01 Environmental Assessment** has been triggered by this project because of the potential **negative** environmental effects related to such effects during the rehabilitation of health facilities infrastructures on the existing sites and the handling and the disposal of medical waste (such as placentas, syringes and material used for the delivery of pregnant women) in health facilities covered by the project.

81. **Potential negative environmental impacts with the PBF program.** The potential negative environmental effects during the rehabilitation of existing health facilities infrastructures are mainly (a) increased levels of dust, noise, and other emissions; (b) generation of solid wastes

during civil works; (c) health services disturbance and accident risks during the civil works; and (d) health and safety issues for workers and community. In addition, the RBF program could increase the handling and the disposal of medical waste (such as placentas, syringes, delivery material…) in health facilities covered by the project. Therefore, the borrower has prepared an ESMF, and the MWMP prepared for the original project has been updated for the new operation.

82. **ESMF.** The borrower has prepared an ESMF that included a well-costed Environmental and Social Management Plan in compliance with the Environmental Law in Burundi and OP 4.01, Environmental Assessment. The ESMF establishes the screening process or mechanism for the subprojects and includes an environmental and social-screening form and a set of social and environmental clauses for contractors, meant to establish a mechanism and/or a process of (a) determining and assessing the future potential environmental and social risks and/or impacts of the health facilities to be rehabilitated under the proposed RBF program and (b) ensuring that contractors comply with the basic core requirement of the triggered policy. It has provided a specific guideline to mitigate these negative impacts. The main mitigation measures applicable for the key type of health facilities rehabilitation have been provided in its annex. This will help eliminate or minimize adverse environmental and social impacts to acceptable levels. Therefore, all these mitigation measures and plans have been budgeted for in the project financing. The ESMF has considered the key steps and due diligence to identify ineligible activities including the following: (a) a detailed review of range of activities classified as category A, according to World Bank OP 4.01; (b) all activities/subprojects that could trigger World Bank OP 4.12 on Involuntary Resettlement; and (c) the construction or extension of new HCs.

83. **MWMP.** The borrower has updated the MWMP for the previous project due to the potential risk in ineffective medical waste management in the medical facilities. The updated MWMP presents the strategic objectives of the MoH to improve medical waste management in the national health facilities. Within this framework, the PBF program will finance (a) containers for syringes, trash bins, boots, gloves, and masks for the maintenance personnel for onsite sanitary pits; (b) the incinerator construction; (c) the training for healthcare personnel for each HC; (d) development of a monitoring mechanism and management tools and instruments on medical waste management in the health sector; and (e) public awareness campaigns regarding the dangers of unsafe medical waste management. The ESMF with the MWMP has been prepared, approved by the World Bank, and disclosed in the country on December 13, 2016 and in the World Bank's InfoShop on December 14, 2016.

Role of Partners

84. **In addition to the Government and the KIRA Project, international partners will support FHC-RBF activities.** Along with the government participation in the payment of RBF bonuses to health facilities and the verification process, other international partners support public health programs. These include GAVI that supports the Expanded Immunization Program and the Global Fund that supports the HIV/AIDS, tuberculosis, and malaria control programs. The Belgian Cooperation also provides assistance and performance payment to nursing schools. Again, the Global Fund, UNICEF, USAID, and other partners provide support to the CAMEBU and for community outreach through payment of the CHWs through the RBF program.

Monitoring and Evaluation

85. **All activities related to monitoring and evaluation will be undertaken by the DGP.** These activities include the reporting, mainly using the Health Management Information System (HMIS) annual report.

86. **A recent independent assessment done by the IHP+ Results Group awarded Burundi the highest rating for the HMIS: "HMIS results are reliable, although attention needs to be paid to certain data, which can sometimes be inaccurate."** One area where the HMIS system has improved substantially is with regard to the indicators included in the FHC-RBF (which includes key indicators related to communicable diseases like malaria, HIV/AIDS, and tuberculosis). The experience of other countries shows that RBF contributes to substantially strengthen the accuracy and completeness of the HMIS system, since health facilities are obliged to report data on the RBF services on a timely basis, and there is a solid system of independent verification of the reported results (as is the case in Burundi). Furthermore, monthly routine reporting to the HMIS by health facilities has improved, as it is one of key conditions of eligibility for monthly RBF payment because only verified data are reported. Moreover, according to the HMIS assessment carried out in March 2014, through 'Performance of Routine Information System Management,' which is a conceptual framework for strengthening routine health information systems, the Burundi HMIS data quality was qualified as fairly good.

87. **Through the national RBF system, data are now available for each health facility** on a monthly basis on quantities produced, and on a quarterly basis on all quality indicators. These data are available on a public website (http://www.fbpsanteburundi.bi). Three years ago, an RBF dashboard was added to the website.

88. **However, the HMIS should be strengthened and fully harmonized with the FHC-RBF database. Several** development partners are supporting the Government to improve the HMIS, including the World Bank. The KIRA Project will not only include the HMIS in the RBF program, but will also support strong harmonization between the two programs. The two general directorates concerned by this harmonization are the DGS (FHC-RBF) and the DGP (HMIS).

89. **The DGP that is leading the KIRA Project monitoring and evaluation will also be in charge of surveys and relevant health system evaluations, assessments, and studies. In effect, the MoH will undertake household and facility surveys twice.** The ministry will also be supported by the World Bank team to conduct a study on equity. In parallel, the DGP will work with the RBF Technical Unit to improve the quality of the FHC-RBF annual report to transform it into a systemic report that can be used internally for planning and budgeting, but also externally by other ministries and other countries (as a knowledge sharing process).

90. **The DGP will also be leading the preparation and the monitoring of the KIRA Project's Annual Costed Plan. Every year, the MoH will prepare an ACP.** This plan should be monitored by the DGP with contributions from all other departments involved in the KIRA Project's activities. Every quarter and/or semester, the DGP is in charge of alerting the coordinator (DGS) in case of significant delays or implementation bottlenecks.

Annex 4: Implementation Support Plan

BURUNDI: Health System Support Project ("KIRA")

Strategy and Approach for Implementation Support

1. **The proposed implementation plan is consistent with the current FHC-RBF operation.** The KIRA Project will be using the MoH entities for implementation of its activities. The procurement, FM, safeguards, and technical capacity (especially on the community component of RBF) will continue to be strengthened. Program implementation rests under the responsibility of the MoH with targeted and continuous implementation support and technical advice from the World Bank and development partners involved (GAVI, Global Fund, and UNICEF). The World Bank's implementation support will broadly consist of the following:

- Capacity-building activities to strengthen the national and local levels' ability to implement the program, covering the technical, fiduciary, and social and environmental dimensions;
- Provision of technical advice and implementation support geared to the attainment of the program's development objectives;
- Ongoing monitoring of implementation progress, including regularly reviewing key outcome and intermediate indicators, and identification of bottlenecks;
- Monitoring risks and identification of corresponding mitigation measures; and
- Close coordination with other donors and development partners to leverage resources, ensure coordination of efforts, and avoid duplication.

2. **Further, implementation support will include the provision of capacity strengthening in procurement, FM, governance, and anticorruption.** An annual fiduciary review will be conducted for the program; adequate budget will need to be allocated for this review. This review will be supplemented by onsite visits by the World Bank's fiduciary staff at least twice a year. Reliance will also be placed on the annual audit reports. In addition, desk reviews will be done for audit, financial, procurement, and any other reports received during the financial year. In-depth reviews may also be commissioned by the World Bank whenever deemed necessary.

Table 4.1. Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate (US$)
First 12 months	Capacity building for the CHWs PBF	PBF expert	200,000 (IDA)
	Capacity building on FM, procurement, internal audit, and safeguard implementation and compliance	FM, procurement, and safeguards staff and consultants	
12–48 months	Implementation support	Same as above	150,000 each subsequent year

Table 4.2. Skills Mix Required

Skills Needed	Number of Staff Weeks (Annually)	Number of Trips (Annually)	Comments
Task team leader	15	Field trips as required	Washington-based
Public Health and Co-TTL	15	Field trips as required	Washington- and CO-based
Procurement	5	Field trips as required	CO-based
FM Specialist	5	Field trips as required	CO-based
Nutrition Specialist	5	Field trips as required	Washington-based
Environment specialist	4	Field trips as required	Regional hub
Indigenous Peoples and Health Specialist	4	Field trips as required	Washington/regional hub
PBF Specialist	4	Field trips as required	Washington-based
Community Health Specialist	4	Field trips as required	International
Governance Specialist	2	Field trips as required	Washington-based
Administrative Support	10	Field trips as required	Washington- and CO-based

Note: CO = Country Office.

Annex 5: Economic and Financial Analysis

BURUNDI: Health System Support Project ("KIRA")

1. **The KIRA Project aims to increase the use of quality Reproductive, Maternal, Neonatal, Child, and Adolescent Health Services.** The KIRA Project will build on project activities and achievements of the ongoing project (HSDSP), which constitute a solid foundation, while trying to increase the impact on the performance of the health system. It will not only maintain the good results already achieved (maternity services), but also (a) improve other strategic programs focusing on immunization, family planning, tuberculosis, malaria, and HIV/AIDS; (b) foster efforts against malnutrition; and (c) boost the quality of health services at the primary level of care and in hospitals.

2. **The KIRA Project has the double objective of building on progress achieved through the ongoing HSDSP and addressing weaknesses and issues of the FHC-RBF program in Burundi.** The end goal is to strengthen health system performance by supporting the FHC-RBF program. In addition to the direct support to health facilities (HCs and hospitals as in the current project), the KIRA Project will also target the CHWs; nursing schools; the National Reproductive Health Program; the National Nutrition Program; the HMIS; and the regulatory bodies at the central and provincial levels.

Project Development Impact

3. **The project will contribute to Burundi's development through the following pathways:** improving mother and child survival and reducing mortality related to communicable diseases; saving unnecessary health care and social care costs; increasing the productive labor force; promoting equity and shared prosperity; and improving health system efficiency.

4. **The project will contribute to improving mother and child survival and reducing mortality related to communicable diseases** by promoting interventions that address malnutrition; increasing the coverage of effective mother and child health interventions such as family planning, assisted deliveries, pre- and post-natal care, and integrated management of childhood illnesses; promoting preventive care and vaccination; and improving the management and treatment of communicable diseases, in particular HIV/AIDS, tuberculosis, and malaria. According to WHO, more than half of under-five child deaths are due to diseases that are preventable and treatable through simple, affordable interventions. Strengthening health systems to provide such interventions to all children will save many young lives. Further, malnourished children, particularly those with severe acute malnutrition, have a higher risk of death from common childhood illness such as diarrhea, pneumonia, and malaria. Nutrition-related factors contribute to about 45 percent of deaths in children under five years of age. Similarly, most complications during and following pregnancy and childbirth are preventable or treatable. The major complications that account for nearly 75 percent of all maternal deaths are severe bleeding (mostly bleeding after childbirth); infections (usually after childbirth); high blood pressure during pregnancy (pre-eclampsia and eclampsia); complications from delivery; and unsafe abortion. The project will contribute to maternal mortality reduction by addressing barriers that limit access to quality maternal health services, in particular, through addressing inequalities in access to quality reproductive, maternal, and newborn health care services; ensuring universal health coverage for

comprehensive reproductive, maternal, and newborn health care; strengthening the health system to respond to the needs and priorities of women and girls, and ensuring accountability to improve quality of care and equity.

5. **The project will contribute to saving health care costs related to disease treatment** by focusing on cost-effective preventive and curative measures and saving the social economic burden that is related to extra care needed for children who are stunted and who suffer from preventable diseases. It will also reduce costs related to unsafe delivery that can have lifelong consequences. Family planning can also save infant lives by spacing planned births and limiting unintended births. It also saves maternal lives by reducing exposure to the risks of pregnancy and childbirth, including recourse to unsafe abortion.

6. **This project will generate long-term economic benefit by increasing active and productive labor force who can potentially contribute to economic growth and poverty elimination.** With improved health and nutrition status, more children will survive into adulthood and work more productively as a result of better cognitive development. Women who are saved from maternal deaths will contribute directly to productive activities or relieve household members who would have had to provide child care without their presence. A recent study on the impact of MCH on economic growth found a bidirectional relationship in Burundi between mortality and changes in the GDP, meaning that changes in the GDP have an impact on under-five and maternal mortality and vice versa. The study further demonstrates that the effect of marginal health investments on health outcomes is higher at low levels of the GDP, that is, in countries where the level of health investments is generally lower, such as Burundi.[3] A study on WHO African countries also found that maternal mortality of a single person reduces per capita GDP by US$0.36 per year.[4]

7. **This project will promote equity and shared prosperity by targeting the most vulnerable populations, that is to say, mother and children under five.** The FHC policy will also prevent households and individuals from catastrophic or impoverishing expenditures by granting them access to basic health services free of charge. In many countries, the cost of health care is the primary reason for not seeking care and results in inequalities in access to health care with the better-off seeking more care than the poor. Although other barriers to access health care services may exist (geographic and social barriers, and so on), the project will significantly help address a significant barrier to health care services. A review of the literature on user fee abolition indeed reports that in all cases (20 studies), the number of visits increased after the abolition of user fees.[5]

8. **The project will contribute to improved technical efficiency in the health service delivery system.** It will support the MoH and other entities involved in RBF, including the National Technical Unit in charge of the coordination of the FHC-RBF program, CPVVs, PHOs,

[3] Amiri, A. and U.G. Gerdtham. 2013. “Impact of maternal and child health on economic growth: New evidence based granger causality and DEA analysis.” *Newborn and Child Health,* study commissioned by the Partnership for Maternal, Lund University, Sweden.

[4] Kirigia, J.M., D. Oluwole, G.M. Mwabu, D. Gatwiri, and L.H. Kainyu. 2006. “Effects of Maternal Mortality on Gross Domestic Product (GDP) in the WHO African Region.” *African Journal of Health Sciences*, 12 (3): 55–64.

[5] Ridde, Valéry and Florence Morestin. 2011. "A scoping review of the literature on the abolition of user fees in health care services in Africa." *Health Policy and Planning* 26 (1): 1–11.

DHOs, and DGR. By strengthening institutional capacity and improving availability and quality of key inputs, more facilities will be pushed to the production function frontier, and therefore, deliver better services to the extent possible at a given cost.

9. **The project will also contribute to improved allocative efficiency at health facilities and community levels.** Indeed, the project focuses on primary health care and community-based activities, which are the most cost-effective modalities to provide a defined package of high-impact services. It will support the Burundi health system to be more results-focused and to get value from the money invested by supporting the RBF approach. It will enable decision makers and managers at all levels to be more evidence-based in policy analysis, planning, and budgeting by supporting the country's monitoring and evaluation system, analytics, and capacity building in evidence-based decision making. In addition, it will facilitate efficiency improvements by allocating resources to where marginal benefits and utility are highest and by focusing on areas that are lagging behind. For example, this project aims to strengthen human resources for health by supporting the nursing schools and addressing issues related to the quality of training, shortage of nurses, and lack of motivation. The use of RBF for nursing schools is expected to address bottlenecks related to the quality and quantity of nurses in the country and, ultimately, to motivate them to deliver better services to the population.

Rationale for Working with Public Sector

10. **Public sector engagement is justified by the critical role of the Government in regulating the health sector, and by the project's economic and social goals.** Investments funded through the project will strengthen health service delivery and improve institutional capacity. Public sector intervention is critical to promote good health in the general population, making sure that no one is left behind. Public sector investments are key to provide and promote preventive health services and support equity improvements to access good quality RMNCAH services. These interventions also have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which advocate for public sector intervention.

Value Added of the World Bank Support

11. **The value added of the World Bank support to Burundi on RBF and FHC is** (a) its technical input based on international experience on health systems strengthening and specifically on RBF and capacity to mobilize a wide-range of technical expertise to support key strategies and reforms and (b) its convening role in Burundi (since 2010) to support the mobilization of additional resources for innovative health interventions in the country. Furthermore, the ongoing HSDSP has been successful in supporting the Government to implement key reforms such as the PBF and FHC.

Cost-effectiveness Analysis

Justification

12. **Economic analysis aims to assess whether the dollar benefits of a program outweigh its dollar costs.** Cost benefit-analysis allows comparing the pros and cons of policies and programs to help policy makers identify the most valuable options to pursue. Cost-benefit analysis monetizes

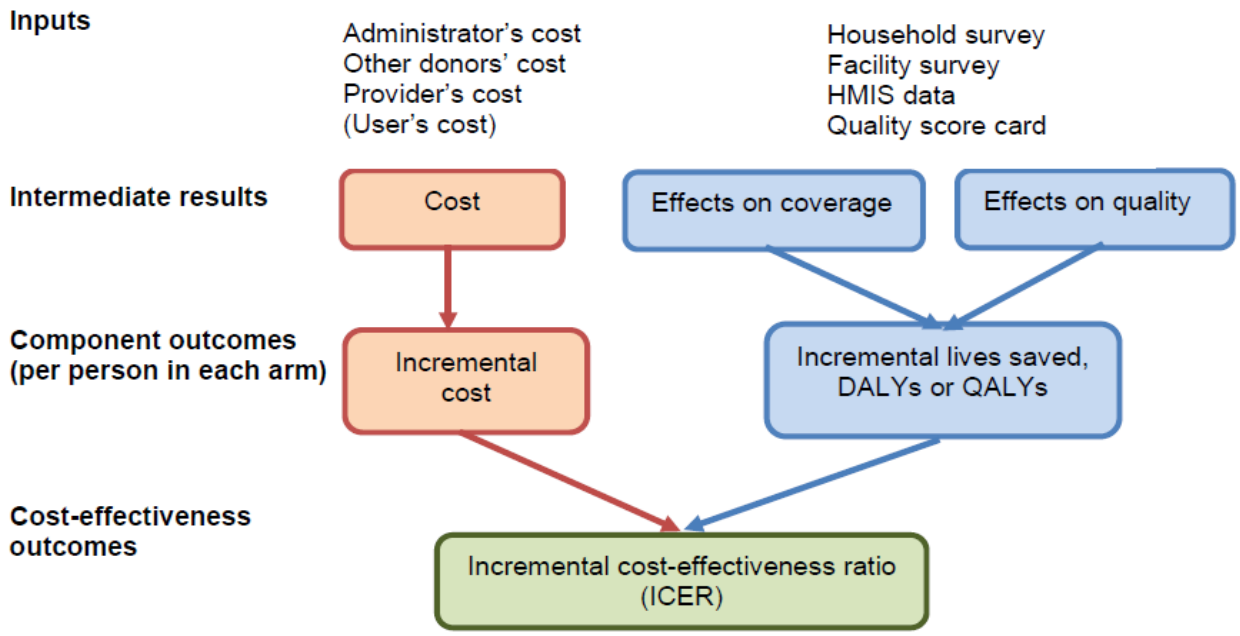
all major benefits and all costs associated with a project so that they can be directly compared with each other. Although this approach is considered as the gold standard, it is difficult to use in practice, in particular, with soft investment projects like health projects that do not involve any infrastructure development. The Cost-effectiveness Analysis (CEA) allows to weigh the effectiveness of the project against its cost. It is similar in many ways to the cost-benefit analysis, but it does not attempt to monetize all anticipated benefits derived from the project.

13. **As RBF is the major component of the KIRA Project, the recently developed methodology for conducting CEA of RBF projects is used.**[6] Conducting a CEA requires data on a variety of inputs on costs and effectiveness. Costs include RBF program costs (that is, incentives, costs of monitoring and evaluation), costs of consumables, and other costs above the facility level. Effectiveness includes information on improvement in use of selected health services, which must be translated to the number of lives saved, Quality Adjusted Life Years (QALYs), or Disability Adjusted Life Years (DALYs) for a CEA. A health CEA generally compares an intervention approach (such as RBF or another innovation) with the existing approach. In other words, the project is compared to the business-as-usual model.

Methodology

14. **The final output of a CEA is the ICER.** The ICER is defined as the change in cost (with and without the intervention), divided by the change in effectiveness (with versus without the intervention). Figure 5.1 shows a general schema for a CEA of health programs in general, which can apply specifically to a CEA in RBF programs.

Figure 5.1. Schema for CEA of Health Programs



Source: Shepherd, D., W. Zeng, and H. Nguyen. 2015. CEA of results-based financing programs: A toolkit. World Bank. Washington DC.

[6] Shepherd, D, W. Zeng, and H. Nguyen. 2015. *Cost-effectiveness analysis of results-based financing programs: A toolkit.* World Bank. Washington DC.

Assessing Program Costs

15. **The first step in a CEA is to estimate the costs of the RBF interventions. Incremental costs for the project are used, that is, the difference in costs between the program and business-as-usual.** The reference is the status quo (not the KIRA Project) and the new program is the addition of the KIRA Project. The incremental costs thus measure the costs of adding the program onto the existing health system. Costs include financial expenditures such as the RBF bonuses, payment of FHC, training of health workers and managers, support to verification and counter-verification processes, and demand-side interventions. In other words, the entire project cost must be included in the analysis. Annual costs therefore amount to US$12.5 million as the project spans a period of four years.

16. **Discounting is required when costs occur in future years.** General economic principles of the CEA indicate that they should be discounted to the present value at of the start of the program. The costs should be expressed in constant prices for the year in which the program begins and then discounted with a real discount rate of 3 percent per year. The total present value of the program is thus US$47.79 million (table 5.1). These costs are the total incremental costs of the program, the counterfactual scenario being what would have happened in the absence of the KIRA Project.

Table 5.1. Discounted Program Costs (US$, millions)

Year	Actual Cost	Discount Factor	Present Value
2017–18	12.5	1.00	12.50
2018–19	12.5	0.97	12.13
2019–20	12.5	0.94	11.76
2020–21	12.5	0.91	11.41
Total	**50.0**	**—**	**47.79**

17. **As this CEA concerns the entire KIRA Project, the analysis is not disaggregated by target services.** Although RBF incentivizes a specific set of interventions and FHC only benefits children under five years and pregnant women, the decision was made to perform the CEA on the total program costs for two main reasons. First, the overall program outputs are what are of interest rather than a specific subset of outputs (for example, family planning). Limiting the analysis on a subset of interventions would not address the purpose of the CEA which is to look at the KIRA Project as a whole. Second, RBF and FHC are seen as strategies that strengthen the health system in general and major interventions implemented through the KIRA Project, such as training of health care personnel, improved management and reporting mechanisms, demand-side incentives, and so on will positively impact the health system rather than specific interventions. However, when possible, an attempt was made to disaggregate results by beneficiary groups, namely mothers and children.

Assessing Program Effectiveness

18. **The second step in a CEA is to estimate effectiveness, which is quantified with regard to lives saved, DALYs or QALYs.** The effectiveness of RBF-FHC programs is often measured as the change in utilization of health services, which is the foundation of the programs. However, measuring the effectiveness in terms of lives saved, DALYs, or QALYs can allow policy makers

to compare a program to other initiatives as this provides a standardized outcome measure. This requires the conversion of utilization of health services to lives saved.

19. **To convert coverage of services to lives saved, it is assumed that the increase in utilization of services will bring about health benefits to target populations** through preventing occurrence of diseases (that is, vaccination), effectively managing illnesses to improve the quality of life, and reducing risks of death. For that purpose, the software LiST was used. It is the most comprehensive tool available to convert coverage of a wide variety of health services to health outcomes (number of lives saved).[7] The LiST tool estimates the impact of different interventions on the MCH outcomes and requires numerous inputs to produce desired results on health outcomes. Key inputs on baseline and end-line coverage of the services were inputted in the tool to reflect the project targets as presented in the results framework. Other inputs were preloaded based on literature and country-specific statistics. More specifically, the key parameters of the LiST, as shown in the following paragraphs, were adjusted to reflect the situation of Burundi and the KIRA Project:

- **Demographics.** Burundi national population data from the UNFPA were loaded. It includes all parameters for projecting population, such as the TFR, age-specific fertility rate, sex ratio at birth, life expectancy, immigration, and baseline population size.

- **Health status.** Data on nutrition status, health status, abortion rate, and still birth rate were also loaded and mainly drawn from literature.

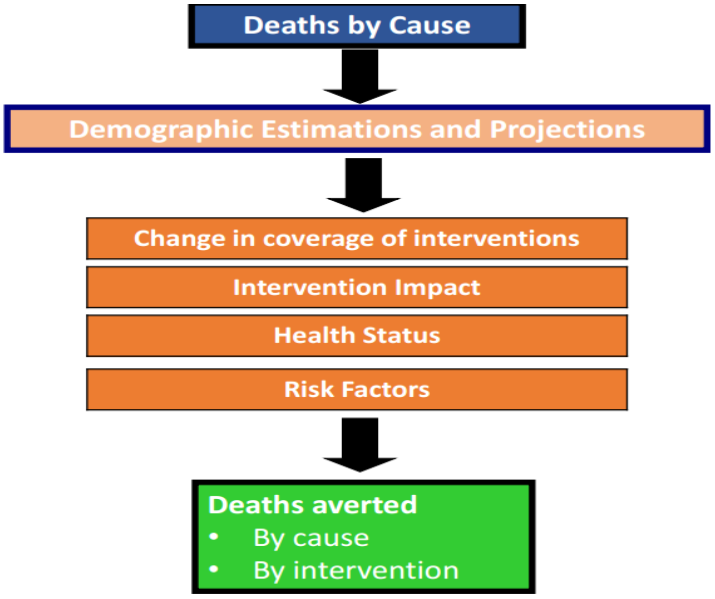
- **Mortality and causes of death.** Baseline maternal mortality and child mortality and causes of death were drawn from the latest reliable sources available.

- **Impact matrix.** The LiST tool contains a wide variety of MCH service interventions which is consistent with the FHC services and incentivized services under RBF. Baseline and target coverage levels were aligned to those presented in the results framework.

- **Effectiveness.** The LiST tool provides default values for the effectiveness of basic health services (for example, effectiveness of basic emergency obstetrical care and comprehensive emergency obstetrical care on antepartum hemorrhage).

[7] The LiST tool was developed by researchers at Johns Hopkins University and can be downloaded from http://www.avenirhealth.org/software-spectrum.

Figure 5.2. LiST Methodology



Source: http://livessavedtool.org

20. **Results from the LiST estimates show that interventions planned through the KIRA Project can save numerous children's and mothers' lives.** The incremental number of lives saved, compared to the counterfactual scenario of no program, reaches 6,357 children under five years and 374 mothers over the four-year period.

Table 5.2. Number of Lives Saved Over 4 Years (LiST Estimates)

	Averted Deaths in Children			Averted Maternal Deaths
	< 1 month	1–59 months	Total	
2017–18	278	452	729	42
2018–19	558	818	1,376	78
2019–20	837	1,047	1,884	114
2020–21	1,098	1,270	2,368	140
Total	**2,771**	**3,587**	**6,357**	**374**

Incremental Cost-Effectiveness Ratio

21. **The ICER is generated using the above cost estimations and outcome measures expressed in terms of lives saved.** The ICER is calculated for the overall program as well as for a subset of interventions, namely maternal health interventions and child health interventions. Looking at the total RBF payments for the minimum and complementary packages of services, it was estimated that about 60 percent of expenditures were related to mothers compared to 40 percent of children. This estimate, although imperfect, is used to approximate program costs for children and mothers. The ICERs presented in this section suggest that the cost of saving one life over the project period would be US$7,101, which seems like a good investment, and therefore, provides sound justification for the project.

Table 5.3. ICERs Associated with Health System Support "KIRA" Project

	Program Costs (US$, millions)			Averted Deaths			ICER (US$ per life)		
Year	**Children**	**Mothers**	**Total**	**Children**	**Mothers**	**Total**	**Children**	**Mothers**	**Total**
2017–18	5.00	7.50	12.50	729	42	771	6,859	178,571	16,213
2018–19	4.85	7.28	12.13	1,376	78	1,454	3,525	93,269	8,339
2019–20	4.70	7.06	11.76	1,884	114	1,998	2,497	61,901	5,887
2020–21	4.56	6.85	11.40	2,368	140	2,508	1,927	48,893	4,549
Total	**19.12**	**28.68**	**47.79**	**6,357**	**374**	**6,731**	**3,007**	**76,676**	**7,101**

22. **Estimated economic growth benefits related to increased productive years also demonstrate the high value of the project.** The program can help save a total of 6,731 lives which represents a significant gain for the economy. Indeed, one can estimate that the annual value of a life lost is equivalent to the GDP per capita. Using a per capita GDP of US$276 (2015 value), and taking into account only productive labor years (between 15 and 49 years), the value of benefits related to improved MCH is estimated to be US$63.16 million (Table 5.4). The net value of benefits (benefits minus project costs) is US$15.27 million (US$63.16−47.8), and the benefit-cost ratio is US$1.32 (63.16/47.8). This implies that for every US$1 invested through the project, there will be a yield of US$1.32.

Table 5.4. Estimated Economic Gains Generated from Deaths Averted through Health System Support "KIRA" Project (US$)

Years	Economic Benefit Value related to Averted Deaths (US$)		
	From Averted Children Deaths	**From Averted Maternal Deaths**	**Total**
2017–18	6,840,936	394,128	7,235,064
2018–19	12,912,384	731,952	13,644,336
2019–20	17,679,456	1,069,776	18,749,232
2020–21	22,221,312	1,313,760	23,535,072
Total	**59,654,088**	**3,509,616**	**63,163,704**

Limitations

23. **It is likely that the real cost effectiveness and benefit of the project have been underestimated in this analysis.** Lives saved were estimated using the LiST tool. However, due to data and resource constraints, some parameters inputted in the tool were default values rather than data collected for the purpose of the exercise. Furthermore, data on targets to achieve by the end of the project, was not available for all services. As a result, it is likely that gains from the project are underestimated. The exercise, however, provides a good enough indication of the positive value of the project. The CEA used life years rather than QALYs or DALYs as life years represent an intuitive and easy-to-interpret way of measuring population health. Although this measure does not allow taking into account quality aspects, it was more appropriate as it would have been difficult to compute the health-related quality of life weights. As for the cost-benefit analysis, conservative assumptions were made for the number of productive years and only

economic growth benefit related to increased productive years were considered although other benefits will be achieved, but cannot be translated easily in monetary value (for example, efficiency gains).

Financial Analysis

Macroeconomic Situation

24. **Burundi is making the transition from a post-conflict to a stable economy.** Burundi has recorded rather high and stable economic growth between 2004 and 2014 (oscillating between 4 percent and 5 percent), but the year 2015 was marked by an important negative downturn. The GDP growth is expected to recover from 2016 onward (figures 5.3 and 5.4). The economic growth, however, was outpaced by population growth and per capita GDP has been declining over the past decade. It is expected to average US$235 per capita in the next five years in constant terms (figure 5.4). Growth is supported by agriculture, particularly a rebound in coffee production, and construction of major infrastructure projects.

Figure 5.3. Annual GDP Growth: Trends and Projections

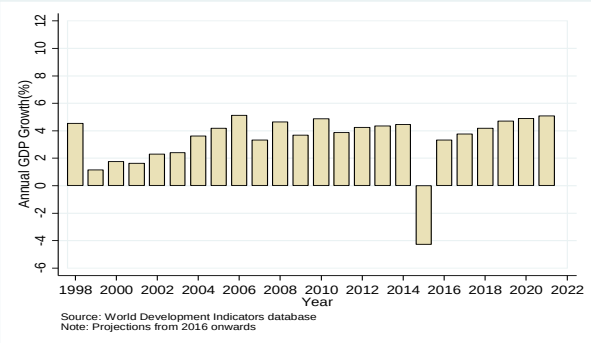
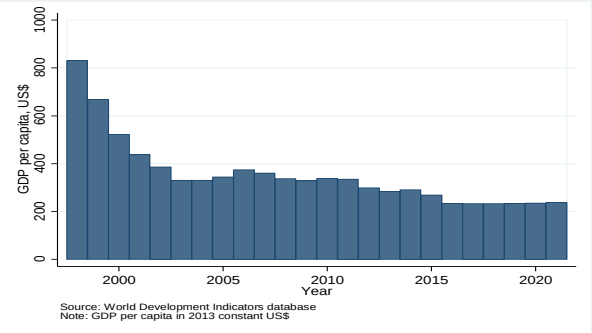


Figure 5.4. Annual GDP per capita: Trends and Projections



25. **Between 2005 and 2014 Burundi has registered lower growth rates than its neighboring countries, but the country is close to the Sub-Saharan Africa average.** In per capita terms, however, Burundi's growth has been slightly better than for Sub-Saharan Africa. Burundi also performed slightly below the low-income countries average, but its growth (prior to the 2015 crisis) has, however, been one of the most stable over the decade.

Table 5.5. Regional Comparison: GDP Growth and Growth per Capita (Average 2005–2014)

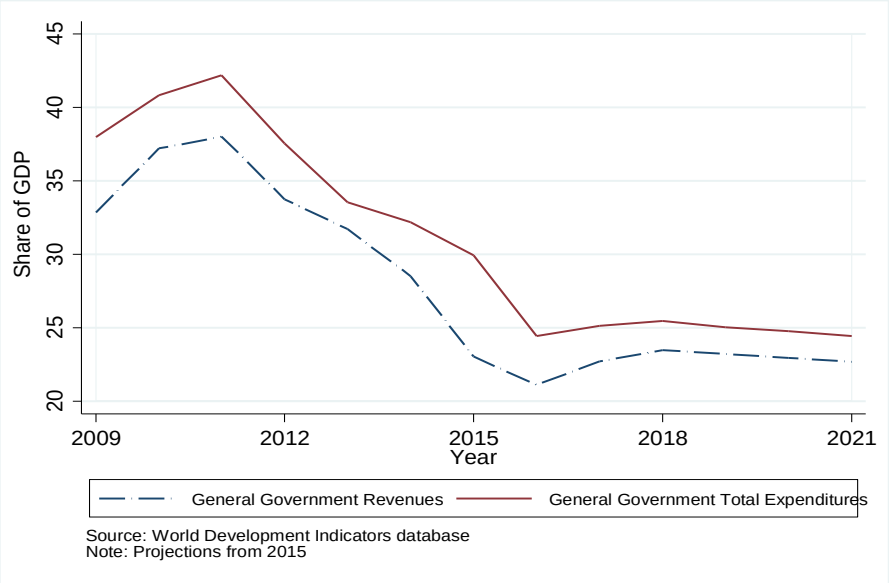
Country Name	Mean Growth	Standard Deviation Growth	Mean Growth per capita	Standard Deviation Growth per capita
Madagascar	2.75	3.39	(0.04)	3.47
South Africa	2.89	2.05	1.47	2.13
Swaziland	2.94	1.23	1.51	1.41
Mauritius	3.69	1.19	3.39	1.21
Namibia	4.14	1.70	2.83	1.77
Burundi	**4.28**	**0.55**	**2.10**	**0.57**

Country Name	Mean Growth	Standard Deviation Growth	Mean Growth per capita	Standard Deviation Growth per capita
Lesotho	4.38	0.99	4.13	0.99
Botswana	4.73	4.95	3.50	5.03
Malawi	5.44	2.10	2.82	2.09
Tanzania	6.02	1.10	3.67	1.23
Congo, Dem. Rep.	6.13	1.54	3.31	1.58
Zambia	6.88	1.50	4.11	1.60
Mozambique	7.03	0.92	4.33	0.83
Rwanda	7.33	1.55	5.14	1.58
Low–income Countries	**4.53**	**7.49**	**2.43**	**8.22**
Sub-Saharan Africa	**4.29**	**7.14**	**1.99**	**7.56**

26. **Risks to the outlook remain elevated according to the last IMF Article IV from 2014.** Major risks include a deterioration of the political and security situation; a further decline in donor support; a worsening in the terms of trade; or a protracted period of slower growth in advanced and emerging economies which could cause a slowdown in growth, reform implementation, and social unrest. Burundi's economy is handicapped by two main weaknesses: limited fiscal space and a narrow export base making both fiscal and external positions very vulnerable.

27. **Burundi's prudent fiscal policy in recent years led to an improved fiscal position, with the reduction of the deficit in the basic primary balance (IMF).** However, the Fund noted that the meager fiscal space too often led to budget adjustments at the expense of investment spending to mitigate the effects of exogenous shocks. Capital expenditure is precarious and tied to project grants, while execution continues to be highly dependent on the pace of disbursements of budget support. Total Government revenues and expenditures reached 28.5 percent and 32.2 percent of GDP, respectively in 2014, but are expected to decrease from 2015 onward.

Figure 5.5. General Government Revenues and Expenditures (2009–21)



Source: World Development Indicators database
Note: Projections from 2015

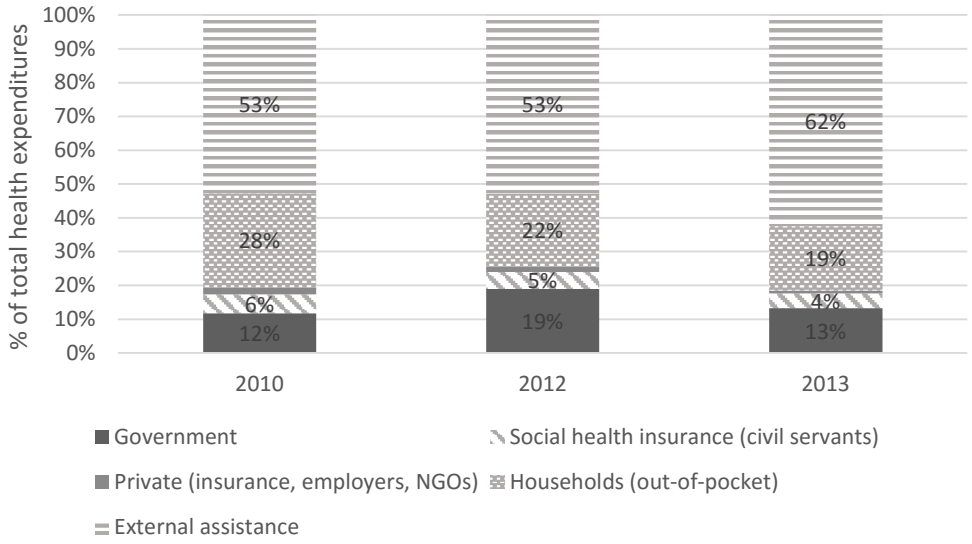
28. **According to the IMF, current health financing programs could become unsustainable as the Government may increasingly become unable to reimburse hospitals for services provided.** Indeed, while the abolition of fees for health services for children under five years and pregnant women substantially improved social inclusion, the Medical Assistance Program is not fully funded. Greater reliance on domestic revenues was recommended to reduce reliance on donor support and mitigate the impact of aid volatility. As domestically financed public investment and pro-poor spending have invariably suffered during fiscal adjustment, the IMF warned that 'quick win' social programs such as FHC for pregnant women needed to be safeguarded to ensure inclusiveness and buy-in by the population for the authorities' poverty reduction and growth strategy.

Health Sector Expenditure

29. **Health financing in Burundi is highly and increasingly reliant on external sources.** In 2013, 62 percent of total health spending was from external resources. Households, through out-of-pocket payment represented the second financing source (with 19 percent of THE in 2013). The Government was only the third financing source, representing 13 percent of total health spending. Over the period 2010 to 2013, the share of external assistance in THE increased while the share of out-of-pocket spending decreased, probably as a result of the FHC policy (2014 NHAs).

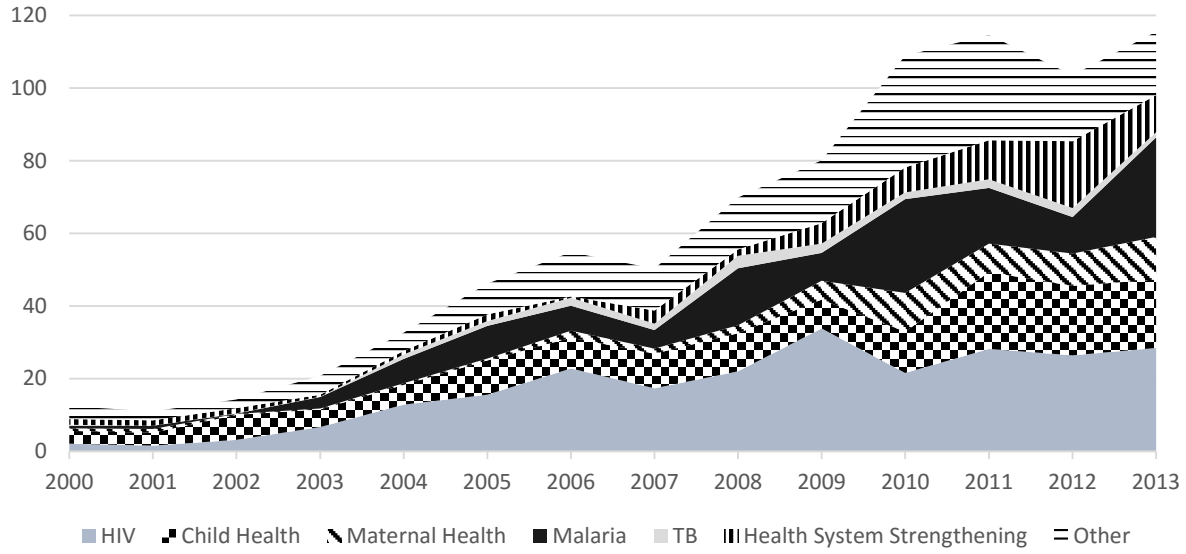
30. **Between 2000 and 2013, external assistance increased more than ten-fold in constant 2015 U.S. dollars**. External assistance on health is primarily disease-oriented. It finances mainly the MCH programs as well as HIV/AIDS and malaria programs. The share of external resources going to health systems strengthening, although limited, has been growing in recent years (figure 5.6). Fiscal space for health in Burundi critically depends on the sustainability of external funding, the extent to which additional Government and other domestic resources can be used to finance health services, and the efficient use of the money available.

Figure 5.6. Health Financing Sources (2010–13)



Source: Burundi NHAs (2014)

Figure 5.7. External Assistance on Health by Program (2000–2013) in Constant 2015 US$



Source: IHME
Note: "Other" includes other infectious diseases, noncommunicable diseases, and other.

31. **It is expected that this project will be financially sustainable, but close monitoring of the macroeconomic and budget situation will be needed.** The project investment, US$12.5 million per year over a four-year period, accounts for a significant portion of the annual Government budget on health. Taking 2013 data (latest NHA data available), the proposed annual investment of US$12.5 million is 5 percent of THE (US$250 million), but 38 percent of government spending on health. In more recent years, however, the MoH budget suffered from poor execution. In 2014, only 61 percent of credits were actually disbursed. If budget execution

does not improve, the financial sustainability of the project could be weakened. The annual project cost indeed represents 44 percent of the MoH's 2014 expenditures. 2015 execution data is not yet available but it is expected to be comparable, if not worse, due to the crisis.

32. **The MoH has been actively engaged during project preparation and is committed to contribute to US$44 million over the course of the project.** The annual country contribution would thus represent almost half of the MoH's executed budget. Besides the pressure this puts on the MoH budget and the threat it represents for other expenditures, there is also a risk that the Government will not be able to honor its commitment, if budget execution issues are not addressed. On the positive side, however, it is important to note that the ministry has strong ownership of this project which represent the core of its intervention in the sector; it is therefore expected that expenditures related to the project will be prioritized and secured.

Annex 6: Health Services Incentivized through the RBF (Verification of Quantities)

BURUNDI: Health System Support Project ("KIRA")

MPA (HCs)
1. New curative care consultations for those over 5 years
2. New curative care consultations for those of age 5 or less
3. Days of hospitalization for those over 5 years
4. Days of hospitalization for those of age 5 or less
5. Children completely vaccinated
6. Antitetanus vaccinations for pregnant women
7. New curative care consultations for pregnant women
8. Uncomplicated (eutocic) childbirth deliveries
9. Standard prenatal consultations (4x)
10. Postnatal consultations
11. Minor surgery
12. Patient referral and arrival to hospital
13. Cases treated for STI
14. HIV voluntary testing
15. HIV+ pregnant women under ARV prophylaxis protocol
16. Number of new patients under ARV treatment
17. Number of patients under ARV treatment followed up by semester
18. Health care to new born babies from HIV+ women
19. Positive tuberculosis cases screened per month
20. Number of tuberculosis cases treated and cured
21. FP: Implants et DIU
22. FP: Total new + ancient acceptors
23. Screening and treatment of moderate acute malnutrition of children under 5 (HC with nutritional supplement service-SSN)
24. Screening and treatment of severe acute malnutrition of children under 5 (HC with ambulatory therapeutic service-STA)
25. Screening and referral acute malnutrition cases (moderate and severe) of children under 5 (HC without SSN and/or STA).
26. Growth monitoring and promotion for children under 5 (measuring of weight/age)
CPA (Hospitals)
1. New curative care consultations by doctors for those of age 5 or less
2. New curative care consultations for pregnant woman
3. Counter-referral case arrived to HC
4. Uncomplicated (eutocic) childbirth deliveries
5. Caesarean childbirth deliveries
6. Complicated (dystocic) childbirth deliveries, aside from Caesarians
7. Day of hospitalization for those of age 5 or less

8. Standard prenatal consultations (4x)
9. Postnatal consultations
10. Minor surgery for children under 5
11. Major surgery for children under 5
12. FP: Implants and intra-uterine device
13. FP: Total new + ancient acceptors
14. Surgical contraception
15. New curative consultation for severe acute malnutrition with medical complications of children under 5
16. Day of hospitalization for severe acute malnutrition with medical complications of children under 5

Note: ARV = Anteretroviral; FP = Family Planning; NSS = Nutritional Supplement Services; ATS =.Ambulatory therapeutic Services; STI = Sexually Transmitted Infections.

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