COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS) APPRAISAL STAGE

Report No.: PIDISDSA20339

Date Prepared/Updated: 25-Jan-2017

I. BASIC INFORMATION

A. Basic Project Data

Country:	Burundi	**Project ID:**	P156012
		Parent Project ID (if any):	
Project Name:	Health System Support Project ("KIRA") (P156012)		
Region:	AFRICA		
Estimated Appraisal Date:	12-Dec-2016	**Estimated Board Date:**	23-Feb-2017
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Borrower(s):	MINISTRY OF FINANCE		
Implementing Agency:	Ministry of Health, Ministry of Health, Ministry of Health, Ministry of Health		

Financing (in USD Million)

Financing Source	Amount
IDA Grant	50.00
Financing Gap	0.00
Total Project Cost	50.00

Environmental Category:	B - Partial Assessment
Appraisal Review Decision (from Decision Note):	The review did authorize the team to appraise and negotiate
Other Decision:	
Is this a Repeater project?	No

B. Introduction and Context

Country Context

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.

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.

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, and social conditions (including the health sector, see below), especially of the most vulnerable.

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. 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 km2.

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.

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.

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).

Sectoral and institutional Context

The political situation and fragile macroeconomic context have had a negative impact on the health sector. 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).

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). 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.

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.

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.

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.

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). In addition to an insufficient number of health workers, 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).

Community health is seen as a promising approach for health promotion in Burundi but not yet fully implemented. Since its official launch in 2012, the community health strategy has led to (a) the recruitment of 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 santÃ© communautaires, GCHWs) in all public health centers (HCs) (100 percent) and the training of 8,512 CHWs from 13 out of 18 health provinces. The RBF pilot took place at the community level in three provinces. An evaluation of the RBF pilot, by CORDAID, noted that the proportion of cases referred during consultations in HCs is increasing for antenatal and postnatal consultations, delivery, FP, and voluntary screening of HIV/AIDS.

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

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).

Significant results were achieved during implementation of the FHC/RBF program (households surveys PMS, 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.

The combined FHC-RBF program of Burundi is financed by different actors but the largest contributor is the GoB 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

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.

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.

Although the FHC-RBF program is not a panacea for all health system challenges, it has 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 WB 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 also committed to address malnutrition and demographic challenges as national priorities.

C. Proposed Development Objective(s)

Development Objective(s)

To increase the use of quality Reproductive, Maternal, Neonatal, Children 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.

Key Results

The proposed 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) Percentage of pregnant women who received four antenatal care visits within the first 28 gestational weeks
(c) Contraceptive prevalence rate among adolescents (percent)
(d) Total contraceptive prevalence for modern methods (percent)
(e) National quality average score of health facilities (score)

D. Project Description

The proposed KIRA Project builds on the achievements of the HSDSP while seeking to address current weaknesses and limitations of the existing FHC-RBF program. A contingency emergency response component (CERC) is included under component 4 of the proposed project.

Component 1: Use of performance-based payments to support the Recipient➢(s Free Health Care Program - US$ 40.60 million

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.

Component 2: Implementation support for the Free Health Care Program-related activities - US$ 8.40 million

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

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

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, 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, umbrellas, boots, medicine boxes, gears, hats, and white coats.

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

A CERC will be included under the proposed 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.

Component Name

Use of performance-based payments to support the Recipient➢(s Free Health Care Program

Comments (optional)

Component Name

Implementation support for the Free Health Care Program-related activities

Comments (optional)

Component Name

Strengthening of Newly Integrated FHC Program Service Providers through financing of minor investments/renovations works for CHWs and nursing training schools

Comments (optional)

Component Name

Contingency Emergency Response Component (CERC)

Comments (optional)

E. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

At the National level, the project will target the health facilities at the different level..

F. Environmental and Social Safeguards Specialists

Ishanlosen Odiaua (GEN05)

Paul-Jean Feno (GEN07)

II. Implementation

Institutional and Implementation Arrangements

The proposed KIRA Project will build on the successful implementation experience of the HSDSP project. Institutional arrangements and implementation as well as FM, procurement, and safeguard issues, among others, enabled the HSDSP to achieve a good performance, as reported in supervision missions➢(aide memoirs and Implementation Status and Results Reports (ISRs). Throughout the HSDSP, the implementation performance has been Moderately Satisfactory or Satisfactory despite the difficult context. These implementation set-up also played a positive role in the resilience of the HSDSP and the FHC-RBF program. Therefore, the proposed KIRA Project will maintain these arrangements with slight modifications as captured in the following paragraphs.

The proposed KIRA activities will continue to be embedded within the MoH and aligned with its functions. 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 proposed KIRA Project related to the CHWs, nursing schools, and so on. 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:

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

The Department in charge of Health Services (DGS) will ensure the overall coordination of the proposed 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 proposed KIRA 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.

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

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 proposed KIRA Project, which offers new activities (such as nursing schools and the CHWs) will require a strengthening of the ministry. Two additional experts in procurement and community health will be recruited by the ministry and funded by the proposed project. The procurement expert will be made available to the DGR, and the community health expert will be assigned to the CT-FBP. The

proposed KIRA Project will also finance local or overseas training to build the capacities of senior staff members and experts responsible for its implementation.

All FHC-RBF implementation modalities that the proposed KIRA Project is financing will be included in the RBF Procedures Manual. The CT-FBP-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 CT-FBP 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.

Under the FHC-RBF program, funds are channeled from the Designated Accounts directly to health services/providers. The claims process started at facilities and goes up to the Provincial Verification Committee (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 WB teams (Disbursement and Task Team) receive SOEs from the DGR, review them and provide Non Objection (NO). Once the NO is provided, the MoH transfer funds from the Designated Accounts directly to health facilities or services bank accounts.

III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The RBF interventions will increase quality of health services and population access to health in general; delivery of an essential package like immunizations, vitamin supplementation to both pregnant women and children with procurement and delivery of relevant health commodities (drugs); delivery of essential package of equipment to health facilities to improve the service to a minimum acceptable standard; and support to community nutrition activities; rehabilitation/renovating existing health facilities. In view of the above, no major civil works that could lead to potential negative environmental and social impacts will be undertaken in the proposed operation. However, it is possible that, during implementation some repairs/rehabilitation of existing facilities and construction of fences may be undertaken. It is therefore expected that with improvements in health services delivery, the production of both medical and pharmaceutical waste in the various care centers and pharmacies in the country would ultimately increase accordingly. The Borrower has prepared an Environmental and Social Management Framework (ESMF) and Medical Waste Management Plan (MWMP) and these were approved by the Bank.
Natural Habitats OP/ BP 4.04	No	OP 4.04 is not triggered on this project because the activities are focused with existing health centers to improve quality of health services and population access to the health in general.

Forests OP/BP 4.36	No	The project will not be concerned with the management of forests.
Pest Management OP 4.09	No	The project will not be concerned with the purchase of pests and pesticides. The project has developed a Medical Waste Management Plan in compliance with OP 4.01.
Physical Cultural Resources OP/BP 4.11	No	The project focuses on existing health centers to improve quality of health services and population access to the health in general. No environmental risks are foreseen on Physical Cultural Resources.
Indigenous Peoples OP/BP 4.10	Yes	A national Indigenous Peoples Plan (IPP) has been prepared for the KIRA project. It builds upon the indigenous peoples instrument that was prepared and implemented under the current HSDSP project (P101160). The recommendations of the KIRA IPP include specific actions to address health needs of the Batwa and improve their access to public health services through the acquisition of medical assistance cards. It also specifies increased outreach to Batwa who did not benefit from the previous HSDSP project activities. Batwa health care workers, coopted into local health committees under the HSDSP project will assist in the implementation of the Batwa-specific activities, especially with the specific health concerns expressed by the Batwa at the consultations held during the preparation of the IPP.
Involuntary Resettlement OP/BP 4.12	No	This Policy is not triggered, as KIRA activities ➢(results based financing payments, support to the RBF process and increase health services demand and Financial support to newly integrated activities and entities in the RBF-FHC - have no potential for land acquisition or economic displacement. In addition, any renovation works to be financed under component C will be limited to existing buildings.
Safety of Dams OP/ BP 4.37	No	This policy is not expected to be triggered by any of the project activities as the project will not be financing any activities related to dams.
Projects on International Waterways OP/BP 7.50	No	This policy is not expected to be triggered by any of the project activities.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not expected to be triggered by any of the project activities.

IV. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
Increasing the quality of health services and population access to health in general will involve

delivery of an essential package like immunizations, medicines, and vitamin supplementation; provision of essential package of equipment to health facilities; and support to rehabilitate/ renovate existing health facilities. These initiatives could involve various kinds of risks associated with the inappropriate handling and disposal of infected materials that could therefore increase the environmental pollution. These risks primarily affect personnel in medical facilities in charge of handling the proper disposal of medical waste, families whose basic income derive from the triage of waste, notwithstanding the general public, to the extent that waste is not disposed of on-site nor safely contained in protected areas. In addition the rehabilitation/renovation of existing health centers could involve negative impacts and risks like the increased levels of dust, noise, and other emissions from civil works, the generation of solid wastes during the civil works; the traffic disturbance and accident risks during civil works; and health and safety issues for workers. However, the environmental and social impacts of anticipated activities are expected to be moderate, site-specific, and manageable to an acceptable level, and the proposed project requires no exceptions to the World Bank➢(s policies on environmental and social safeguards.

Therefore, the Project 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 two environmental and social Safeguard Policies triggered by this operation are: OP 4.01 (Environmental Assessment), and OP 4.10 Indigenous People.

Since the health facilities to be financed by the project will not yet be defined before appraisal and the RBF approach is to provide financing based on activities implemented in the existing health facilities, the Ministry of Health in Burundi has already prepared an Environmental and Social Management Framework (ESMF); a Medical Waste Management Plan including the expired pharmaceutical products (MWMP) and an update of current Indigenous Peoples Planning Framework (IPPF) for Batwa group.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The types of rehabilitation/renovation on the existing health facilities and the risks from the medical waste are site specific and whose potential environmental and social effects are well understood, unlikely to be significant, and readily manageable.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

The only feasible project alternative is the presently chosen project design.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The Batwas, who make up approximately 1% of the population, are amongst the most vulnerable groups in Burundian society. This group is recognized as an indigenous group in Burundi. .Despite constitutional provisions for Batwa representation in the national parliament, there is limited impact on the lives of most Batwa 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 under the previous Bank-financed HSDSP -IPP, the Ministry of Health 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, civic registration of marriages and births in order 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 services. Batwa representation in local health committees, at management and implementation levels has also increased. Batwas also make up just over 5% of the 12,000 community health workers nationwide.

The Indigenous Peoples policy (OP/BP 4.10) is triggered and ensures the inclusiveness of the Batwas, present in the project area. The Ministry of Health prepared a national Indigenous Peoples Plan (IPP) for the KIRA project. The national IPP focuses on the acquisition of 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 ➢(Gitega, Karusi, Kirundo and Ruyigi - in September 2016, relate to personal hygiene, sexual and reproductive health, early pregnancy and sexual violence towards Batwa women. Other issues that came out during the consultations regard access to education and employment opportunities, child nutrition and discrimination. The IPP improves on the implementation 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.

The Direction de la Promotion de la Sante Hygiene et Assainissement (DPSHA) of the Ministry of Health is responsible for implementing the IPP. The IPP proposes that the DPSHA will implement these activities with the support of a third party consultant, provincial and district health authorities.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

During the preparation of this proposed project, intensive public consultations and participation have been held in the samples of health centers and Batwas groups. These safeguard documents ESMF, MWMP and IPPF were disclosed in-country on December 13, 2016 and at Bank InfoShop on December 14, 2016

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	17-Oct-2016
Date of submission to InfoShop	14-Dec-2016
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Burundi	13-Dec-2016
Comments:	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	17-Oct-2016
Date of submission to InfoShop	14-Dec-2016
"In country" Disclosure	
Burundi	13-Dec-2016

Comments:
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.
If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes [×] No [ ] NA [ ]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [×] No [ ] NA [ ]
OP/BP 4.10 - Indigenous Peoples	
Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?	Yes [×] No [ ] NA [ ]
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?	Yes [×] No [ ] NA [ ]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?	Yes [×] No [ ] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

V. Contact point

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