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Report No: PAD2720

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED GRANT

IN THE AMOUNT OF SDR 55.7 MILLION
(US$80 MILLION EQUIVALENT)

TO THE

REPUBLIC OF BURKINA FASO

FOR A

HEALTH SERVICES REINFORCEMENT PROJECT

June 12, 2018

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2018)

Currency Unit	=	XOF
XOF 559	=	US$1
US$1	=	SDR 0.69538128

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Makhtar Diop
Country Director:	Pierre Frank Laporte
Senior Global Practice Director:	Timothy Grant Evans
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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
AWPB	Annual Work Plan and Budget
BCEAO	Central Bank of West African States (*Banque Centrale des Etats d'Afrique de l'Ouest*)
BUNEE	National agency in charge of environmental assessments (Bureau National d'Evaluation Environementale)
CAED	Center for Children in Hardship (*Centre d'accueil des enfants en difficulté*)
CAMEG	Central Medical Store (*Centrale d'Achat de Médicaments Essentiels et Génériques*)
CBHI	Community-Based Health Insurance
CERC	Contingent Emergency Response Component
CPF	Country Partnership Framework
CPR	Contraceptive Prevalence Rate
CREN	Center for Nutritional Recovery and Education (*Centre de récupération et d'éducation nutritionnelle*)
CSO	Civil Society Organization
CVA	Control and Verification Agency
DA	Designated Account
DAF	Directorate of Administration and Finance
DALY	Disability-Adjusted Life Year
DGESS	General Directorate for Statistical and Sectoral Studies (*Direction Générale de Etudes Statistiques et Sectorielles*)
DLM	Directorate for Health Promotion (*Direction de la Lutte contre la Maladie*)
DFIL	Disbursement and Financial Information Letter
DPM	Directorate of Public Procurement (*Direction de la Passation de Marché)*
DHS	Demographic and Health Survey
ECD	Early Child Development
EmONC	Emergency Obstetric and Neonatal Care
ENDOS	National Health Data Warehouse (*Entrepôt des Données Sanitaires*)
FHC	Free Health Care
FM	Financial Management
FP	Family Planning
GASPA	Groups for training and monitoring of IYCF practices (*Groupes d'Apprentissage et de Suivi des Pratiques d'ANJE*)
GAVI	Global Alliance for Vaccines and Immunization
GDPH	General Directorate of Public Health
GFF	Global Financing Facility
GHSA	Global Health Security Agenda
GIS	Geographic Information System
GNI	Gross National Income

HA	Health Accounts
HDI	Human Development Index
HRITF	Health Results Innovation Trust Fund
ICR	Implementation Completion and Results Report
IEY	Infant and Early Years
IFAC	International Federation of Accountant
IHR	International Health Regulation
IYCF (*ANJE*)	Infant and Young Child Feeding (*Alimentation du Nourrisson et du Jeune Enfant*)
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
ISR	Implementation Status and Results Report
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF (*CNAMU)*	National Health Insurance Fund (*Caisse Nationale d' Assurance Maladie Universelle*)
OH	OneHealth
OHADA	Organization for The Harmonization of Business Law In Africa
OoP	Out of Pocket Payments
PAD	Project Appraisal Document
PADS	Support Program for Health Development (*Programme d'Appui du Développement Sanitaire*)
PBF	Performance-Based Financing
PDO	Project Development Objective
PFM	Public Finance Management
PFS	Project Financial Statement
PIM	Project Implementation Manual
PHC	Primary Health Care
PHRD	Policy and Human Resources Development Fund
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PNDES	Economic and Social Development Plan (*Plan National de Développement Economique et Social)*
PNDS	National Health Development Plan (*Plan National de Développement Sanitaire*)
PPP	Purchasing Power Parity
PPSD	Project Procurement Strategy for Development
RAMU	Universal Health Insurance Scheme (*Régime d'Assurance Maladie Universelle*)

RMNCAH+N	Reproductive, maternal, newborn, child and adolescent health and Nutrition
SCD	Systematic Country Diagnostic
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SP	Strategic Purchasing
SONU	Maternal and Neonatal Emergency Care (*Soins Obstétricaux Néonataux d'Urgences*)
SRH	Sexual and Reproductive Health
TA	Technical Assistance
TS-UHC	Technical Secretariat for Universal Health Coverage
UHC	Universal Health Coverage
UHI (*AMU*)	Universal Health Insurance (*Assurance Maladie Universelle*)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Fund for Population Activities
WAEMU	West African Economic and Monetary Union
WB	World Bank
WAHO	West African Health Organization
WASH	Water, Sanitation and Hygiene
WDI	World Development Indicators
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Burkina Faso	Health Services Reinforcement Project	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P164696	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
03-Jul-2018	30-Jun-2023

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The Project Development Objective (PDO) is to increase the quality and utilization of health services with a particular focus on maternal, child and adolescent health, nutrition and disease surveillance

Components

Component Name	Cost (US$, millions)
Strengthening Health System Capacity	40.00
Strengthening Delivery of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N)	45.00
Reinforcing Health Security and Supporting Institutional Strengthening	15.00
Contingent Emergency Response	0.00

Organizations

Borrower:	Burkina Faso
Implementing Agency:	Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	80.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	80.00
IDA Grant	80.00

Non-World Bank Group Financing

Trust Funds	20.00
Global Financing Facility	20.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Total Amount
National PBA	0.00	80.00	80.00
Total	**0.00**	**80.00**	**80.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024
Annual	4.76	12.53	18.96	17.33	14.47	11.95
Cumulative	4.76	17.29	36.25	53.58	68.05	80.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Moderate

3. Sector Strategies and Policies	Substantial
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	Low
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓

Projects in Disputed Areas OP/BP 7.60	✓

Legal Covenants

Sections and Description
Schedule 2. Section I.A.2.: The Recipient shall, through the MoH, not later than 1 (one) month after the Effective Date, establish and thereafter maintain at all times during the implementation of the Project, a review committee, satisfactory to the Association, to be responsible for, inter alia: (i) providing strategic and policy guidance on matters relating to the Project; and (ii) coordinating inter-agency policies and roles, all in accordance with the provisions of the Project Operations Manual

Sections and Description
Schedule 2. Section I.A.1.(b) (ii): The Recipient shall no later than three (3) months after the Effective Date recruit and, thereafter maintain; a procurement officer, with qualifications and under terms of reference satisfactory to the Association

Sections and Description
Schedule 2. Section I.A.1.(c): The Recipient shall, not later than two (2) months after the Effective Date, install and thereafter maintain an accounting software for the Project, in a manner acceptable to the Association.

Sections and Description
Schedule 2. Section I.A.1.(d): The Recipient shall, not later than two (2) months after the Effective Date, recruit and thereafter maintain an internal auditor, with qualifications and under terms of reference satisfactory to the Association.

Sections and Description
Schedule 2. Section I.A.1.(e): The Recipient shall, not later than six (6) months after the Effective Date, recruit and thereafter maintain an external auditor, with qualifications and under terms of reference satisfactory to the Association.

Conditions

Type	Description
Effectiveness	For IDA and GFF, the Recipient shall designate and/or recruit and, thereafter maintain an accountant and a finance officer, both with qualifications and under terms of reference satisfactory to the Association
Effectiveness	For IDA and GFF, the Recipient shall prepare and adopt the Project Operations Manual, with terms and conditions satisfactory to the Association
Effectiveness	For GFF, the execution and delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental actions

Type	Description
Disbursement	For IDA, notwithstanding the provisions of Part A of Schedule 2 of the Financing Agreement, no withdrawal shall be made: (a) payments made prior to the Signature Date; except that withdrawals up to an aggregate amount not to exceed $2,000,000 may be made for payments made prior to this date but on or after May 1, 2018, for Eligible Expenditures under Category (2); (b) Under Category (3), no withdrawal shall be made until the amounts allocated under the GFF Grant Agreement has been disbursed or committed in full
Type	Description
Disbursement	For IDA under Category (3) and for GFF under Category (2), no withdrawal shall be made until the Association has received at least one Health Service Provider Agreement in form and substance satisfactory to the Association
Type	Description
Disbursement	For IDA under category (4) and GFF under Category (3), no withdrawal shall be made, for Emergency Expenditures under Part 4 of the Project unless and until the Association is satisfied that all the following conditions have been met in respect of the said activities: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the CERC Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section C of Schedule 2 to the Financing Agreement; (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section C of Schedule 2 to the Financing Agreement, for the purposes of said activities; and (iv) the Recipient has adopted a CERC Operations Manual in form, substance and manner acceptable to the Association and the provisions of the CERC Operations Manual remain - or have been updated in accordance with the provisions of Section C of Schedule 2 to the Financing Agreement so as to be appropriate for the inclusion and implementation of said activities under the CERC Part

I. STRATEGIC CONTEXT

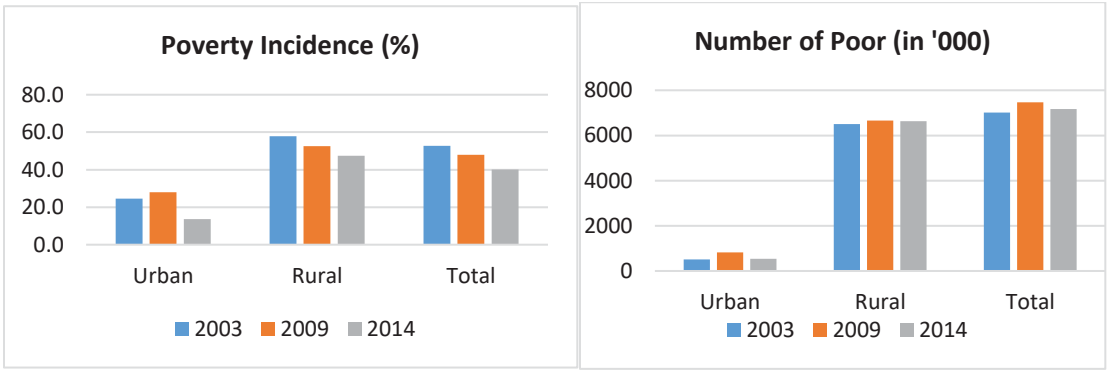
A. Country Context

1. **Burkina Faso is a poor country**. Despite Gross Domestic Product (GDP) growth of 5.6 percent per annum, Gross National Income (GNI) per capita is still low (US$650 in 2016), and the poverty incidence still high although it declined from 46.7 percent in 2009 to 40.1 percent in 2014 (INSD-Burkina Faso). Although Burkina Faso's Human Development Index (HDI) rose by 5 percent over the period 2000-2006 to 0.420 in 2015, the country is currently ranked 185thout of 188.

2. **Burkina Faso is an arid, land-locked country.** Access to the ocean, 1000km south, depends on neighboring poor countries who suffer from weak governance and occasional conflicts. It is a Sahelian country, but without the advantage of a major river for irrigation. Climate change increases the risk of natural hazards (limited and unreliable rainfall, increased frequency of droughts and floods) while compounding the vulnerability of key economic and social development sectors, especially agriculture. It is estimated that 34 percent of the country's land area – or more than nine million hectares of arable land - has already been degraded due to climate change and desertification, with an annual progression of around 105,000 ha to 250,000 ha[1].

3. **Despite significant declines in the poverty rate between 2003 and 2014, given the country's rapid population growth rate, the absolute number of people living in poverty remained roughly the same between the two periods, at around seven million (out of a total population of 18 million).** Due to the high population growth rate, Burkina Faso's average annual per capita GNI increased by only 2.6 percent between 2006 and 2013, below the global and African average rate for the same period. In addition, a significant proportion of households are clustered around the poverty line, meaning that small variations in earnings can lead to either significant increases or decreases to the number of people living in poverty. It is estimated that about eight out of ten citizens live on less than US$3 per day. Poverty is largely a rural phenomenon, with approximately 90 percent of the poor living in rural areas[2].

Figure 1: Poverty Incidence (in percentage) and Number of Poor (in '000)



Source. QUIBB-2003, EICVM-2009, EMC-2014

[1] Second Report on the State of Environment in Burkina Faso (REEB2), Government of Burkina Faso, 2011
[2] Burkina Faso SCD, 2017

4. **After 24 years of relative stability, the political and security situation gradually worsened starting in 2011.** The political and security crisis culminated in widespread population protests that led to a Government change in October 2014, marking a historic turning point for the country. Main causes included, among others, the high cost of living; regional disparities in basic social services; unequal redistribution of resources; youth unemployment; perceived lack of accountability, impunity and monopolization of political power. More recently, security threats from Islamic extremist groups in the Sahel, have been dampening investment, tourism and confidence in the State. Attacks on expatriate-frequented sites also occurred in Ouagadougou, including a hotel and restaurants in January 2016 and August 2017, as well as most recently in several key locations throughout the capital, including army headquarters and the French Embassy, in March 2018.

B. Sectoral and Institutional Context

Persisting health and demographic challenges

5. **Although noteworthy progress was achieved for several key health outcomes between 2010 and 2015[3], Burkina Faso did not meet the Millennium Development Goals (MDGs).** The under-five mortality rate decreased from 129 to 82 deaths per 1,000 live births; neonatal mortality dropped from 28 to 23 deaths per 1,000 live births; the maternal mortality ratio fell slightly from 341 to 330 deaths per 100,000 live births, and the total fertility rate went from 6 to 5.4 children per woman [4]. Coverage of essential services has improved as well: the number of new contacts per capita per year for under-five children increased between 2010 and 2016 from 1.4 to 2.5; 86 percent of children aged 12-23 months were completely immunized, compared to 39 percent in 2003, and 84 percent of pregnant women delivered in health facilities in 2015, compared to 66 percent in 2010.

6. **Despite relative progress, infant and maternal malnutrition continues to contribute significantly to morbidity and mortality in Burkina Faso**[5]. The prevalence of stunting was 27 percent in 2016 versus 32 percent in 2009 while the rate of acute malnutrition decreased from 11.3 percent to 7.6 percent between 2009 and 2016. The prevalence of HIV remains relatively low at 0.8 percent nationally, with 0.9 percent for women and 0.7 percent for men (DHS IV-MICS, 2017).

7. **The main drivers for poor child health outcomes remain communicable diseases and poor nutritional status.** According to Burkina Faso's annual Health Statistics Report (2016), deaths among children under five years are mainly due to malaria (41 percent), infection of the newborn (12 percent), malnutrition (9 percent), and acute respiratory infections (23 percent). Poor infant feeding practices, high disease burden, and limited access to nutritious food all contribute to impaired cognitive development, which impedes the country's productivity.

8. **In Burkina Faso, the national stunting prevalence in children under five is currently 21.2 percent (SMART 2017), which significantly masks the disparity of undernutrition across some regions.** Sahel, Est, Sud-Ouest, and Cascades are the most affected regions with stunting rates of 38.9 percent, 34.5 percent, 34.2 percent, and 30.5 percent, respectively. However, only 5.8 percent of children in Centre region are stunted. Across

[3] EMP PNDS 2015 – 2020 and EMD 2015
[4] INSD 2015
[5] *Global burden of disease* report 2015

much of the country, wasting prevalence is consistently high. With a national wasting prevalence of 8.6 percent in children, regions like Sahel experience extremely high rates at 13.6 percent. Ensuring optimum nutrition—particularly during the 1,000-day period from pregnancy to a child's second birthday—can alter an individual's development trajectory and maximize her or his productive potential. Importantly, chronic undernutrition can be transmitted through an inter-generational cycle, where malnourished mothers are more likely to have stunted children, who in turn perpetuate this cycle. Accelerating the reduction of stunting in Burkina Faso, within the integrated RMNCHA+N package, will be essential for maximizing the return on investments in early childhood development, in education, and more broadly in policies aimed at fostering and enhancing human capital accumulation and job creation.

9. **Several factors constrained the achievement of MDGs 4 and 5.** Firstly, population growth is a pressing issue in Burkina Faso, which has one of the highest total fertility rates in the world, 5.4 births per woman and 107 per 1000 women age 15-19. High fertility is reflected in the low prevalence of modern contraceptive methods (31.7 percent). These low Contraceptive Prevalence Rates (CPR) can be explained by a weak capacity on the supply-side and a weakness of the demand-side factors demonstrated by a low percentage of satisfied demand for family planning services that is only 55.3 percent (49.6 percent in rural areas and 75.3 percent in urban areas).

10. **High fertility is fundamentally driven by the high rate of child mortality, in line with the theory of demographic transition postulating a relationship between the reduction of infant mortality and the decline in fertility.** Demand-side factors include: (i) low level of education, especially for girls: only 40 percent of girls were registered in secondary schools in 2014, with most of them unable to complete; (ii) sexual behaviors: many adolescents have sex early (approximately one out of four girls aged between 15 and 19 years has already given birth); a large number of pregnancies in school with more than six thousand cases of pregnancies in schools, most in post-primary level over 2012 to 2016; and (iii) location: The fertility rate is higher in rural areas (5.8 children per woman) than in cities (3.7 children per women); social and cultural factors linked to religion and ethnicity that can lead to the early marriage of children at 17.8 years and the early year of the first birth of 19.8 years; and the low levels of education (especially for girls).

11. **While Burkina Faso's rapid population growth creates risks, it could also generate a demographic dividend if the nation's youth were able to find productive jobs to ensure that the workforce has a paid job and a high purchasing power.** The window of opportunity for demographic dividend has been open since 1996; if adequate policies are implemented, the structure of the population could therefore contribute to boosting economic growth.

12. **Burkina Faso, like other countries of the sub-region, is marked by the persistence of communicable disease; in particular it has experienced measles, meningitis and dengue fever outbreaks regularly over the past year**. The most recent outbreak of dengue fever in September 2017, occurred mainly in urban areas and has caused about 18 deaths. It has highlighted (i) the weakness of the surveillance, detection and response of the health system, particularly by the public health system; (ii) the important role played by the private health sector in the appropriate response of the disease; and (iii) the need to take into account national multi-sectoral cooperation, coordination and communication, particularly with the private sector for an effective control of infectious diseases and a strengthened health system and preparedness.

Table 1: Key demographic and health indicators in Burkina Faso

Life expectancy (2015, years)	56.3	Antenatal care, 4+ visits (2015)	47%
Total fertility rate (2016, children per woman)	5.4	Skilled birth attendance (2015)	80%
Maternal mortality ratio (per 100,000 live births, 2015)	371	Stunting (2016)	27%
Child mortality rate (per 1,000 live births between 0 and 5 years, 2016)	85	Wasting (2016)	7.6%
Contraceptive prevalence rate, modern methods (2018)	30.1%	Exclusive breastfeeding (2016)	55%
Unmet need for family planning (2016)	29%	Early initiation of breastfeeding (2016)	42%

Source: World Development Indicators, 2018

Inadequacy of current service delivery and health financing models

13. **As far as service delivery is concerned, access to essential health care in general, and obstetrical, prenatal and neonatal services in particular, constitute a persisting policy challenge.** Access is hampered by geographical factors (distance to health facilities, transport costs) as well as socio-cultural factors (high confidence in traditional consultation, the social representation of disease, women's need to ask their husbands for permission to go to the medical center, for example). Finally, social and cultural pressure remain important factors that impact negatively on health. The lack of a comprehensive civil registration and vital statistics system inhibits the planning for maternal and child health services as well as the positive identification of children to ensure that they obtain access to such services.

14. **Provision of high quality health services is still a challenge.** For instance, only 47 percent of children with acute respiratory infection (pneumonia) who use health centers for treatment receive antibiotics; management and planning skills at the health facility level (especially primary) remain weak; resources for investments in improving quality (equipment, infrastructure, goods, staff) continue to be insufficient; health information systems are under performing; inequity and discrimination in availability of services is prevalent; community participation is almost absent; transparency and accountability have to be improved; essential medicines are often out of stock, due to both poor planning at the facility level and the declining performance of the central medical store (*Centrale d'Achat de Médicaments Essentiels et Génériques*, CAMEG). In addition, coaching and supervision by district and regional teams are insufficient, both in terms of quality and quantity, and management capacity needs to be improved.

15. **Weak delivery of services is a pervasive issue for all human development outcomes, and the health sector is not an exception.** While Burkina Faso has recorded progress in terms of access to social services over the past decade, it still lags behind comparator countries in the sub-Saharan African region in terms of almost all indicators related to human capital development. For example, in 2014 the literacy rate in Burkina Faso was 28.7 percent, while the average for Sub-Saharan Africa was 60.4 percent. Primary completion and secondary enrollment rates were also lower than the region average (62.7 percent vs 69.1 percent and 21.7 percent vs. 33.7 percent, respectively).

16. **As far as health financing policy is concerned, on the revenue mobilization front, financial resources for the health sector have increased in the recent past,** with the Government's health budget increasing from approximately 9 percent of the total Government spending in 2006 to 12 percent in 2016. Nevertheless, private out-of-pocket health expenditures remain relatively high at 39 percent of total health expenditures despite slight increases in public spending and decreases in out of pocket expenditures over the past years.

17. **Pressures on insufficient public financing of the health and nutrition sectors are exacerbated by the pressure created by the rapidly growing population, spending inefficiency, and government commitment with respect to Universal Health Coverage (UHC**). While the budget allocation for the Ministry of Heath has increased to 12 percent of total public expenditures over the past few years, it still remains lower than the level of 15 percent committed to in the Abuja Declaration[6]. The 2016 budget financed the following categories of expenditures: infrastructure and equipment (11.7 percent), salaries (35.1 percent), and operating costs (53.2 percent). Furthermore, both allocative and financial efficiency of the sector are weak. In addition, financial pressures will become even more intense in the near future given the Government's commitment with respect to providing universal health coverage in the coming years. In addition to the insufficient availability of funds, the allocative and financial efficiency of the sector is weak.

18. **Protection against financial risk is therefore weak.** A very small proportion of the population benefits from health coverage; less than 1 percent[7] is enrolled in health insurance and 55 percent of the poorest quintile of the population do not use formal care in case of illness[8]. On average, households spend more than 30 percent of their budget on health-related expenses, the second highest category after food[9]. The proportion of people who fall into poverty as a result of health care expenditure is higher among the poorest of the population; who are subjected more to catastrophic expenditure (Figure 2). [10]

19. **Significant issues related to fragmentation of health financing policies and initiatives still prevail**, with a variety of health financing mechanisms and funds that are not always aligned, and even sometimes contradictory. The management of these programs is not straightforward, and at times poorly coordinated, thus limiting their efficiency. This is particularly true for the funding of RMNCAH which is often channeled through disease-specific priorities programs. The multiplicity of funding through various channels, usually targeted and without good coordination, makes it difficult to obtain a global view of all actors and their interventions, and thus leads to gaps and/or overlaps. These have a negative impact on health financing governance and contribute to weaken the country's leadership when it comes to piloting and financing UHC. The challenge is about aligning and harmonizing them, especially in a context where each donor has its own procedures and requirements. To help solve this issue, the country has begun developing a national health financing strategy, which is an opportunity to reform the overall structure of the health financing system and its institutional arrangements.

[6] In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support.
[7] National health account report 2012
[8] EMS 2015
[9] SCD 2017
[10] INSD, Analysis of catastrophic expenditure and the impact of direct payments on household impairment

Recent policy responses requiring support

20. **The Government developed a new five-year health plan (*Plan National de Développement Sanitaire*, PNDS,2016-2020), which is composed of eight strategic objectives.** These include: i) Development of health sector leadership and governance; ii) Strengthening the delivery of health services for universal access to quality services; iii) Development of human resources for health; iv) Promotion of health and the fight against communicable and non-communicable disease; v) Development of infrastructure, equipment and health products; vi) Improvement of the management of the health information system; vii) Promotion of health research; and viii) Increasing of health financing and improvement of financial accessibility of the population to health services. Each objective is accompanied by a set of supporting sub-objectives and key interventions which aim to improve the health sector performance.

21. **The Government of Burkina Faso had previously made several important commitments to achieve Universal Health Coverage (UHC) over the past few years**. In September 2015, the Universal Health Insurance (UHI, *Assurance Maladie Universelle/AMU*) law was approved/adopted, establishing the National Health Insurance Fund (NHIF, *Caisse Nationale d'Assurance Maladie Universelle, CNAMU*). To ensure the operationalization of the NHIF, the Government set up the technical secretariat in charge of UHC (ST-CSU) and conducted various analytical and advisory services. Pilot projects of the NHIF scheme implementation have been conducted in three health districts since 2015. The path proposed for the development of the coverage of the informal sector is a subsidized Community-Based Health Insurance (CBHI) approach, managed, together with coverage scheme for the formal sector, under the same NHIF umbrella.

22. **This political will to move towards UHC was further reinforced in April 2016 when the Government adopted, financed and progressively implemented free targeted health care for women and children**. The policy was expanded nationwide in June 2016 and remains fully financed directly from the public health budget. By October 2017, the Government developed its first National Health Financing for UHC Strategy (2017-2030) which is currently at the final stage of being adopted. The strategy includes several key objectives, including (i) reducing fragmentation of health financing; (ii) increasing fiscal space for health through domestic revenue mobilization and efficiency gains; (iii) improving quality and coverage of health services through strategic purchasing; and (iv) improving financial protection through the rollout of the national health insurance scheme.

23. **In recent years, the World Bank has contributed to the shaping of current health financing and service delivery strategies through the piloting of Performance Based Financing (PBF).** Since 2011, the World Bank has supported the Government of Burkina Faso to pilot, roll out and expand progressively PBF in the health sector, which currently covers 25 percent of the national population. A community-based targeting approach was used to identify the poorest 20 percent of households, who benefited from user fee exemptions that were subsidized through PBF payments. So far, the PBF in Burkina Faso has shown promising results as a mechanism to improve access to essential health services by rural populations, minimizing barriers to care while improving quality (Figures 2 and 3).

Figure 2: Evolution of average quality scores in PBF districts, 2014-2017

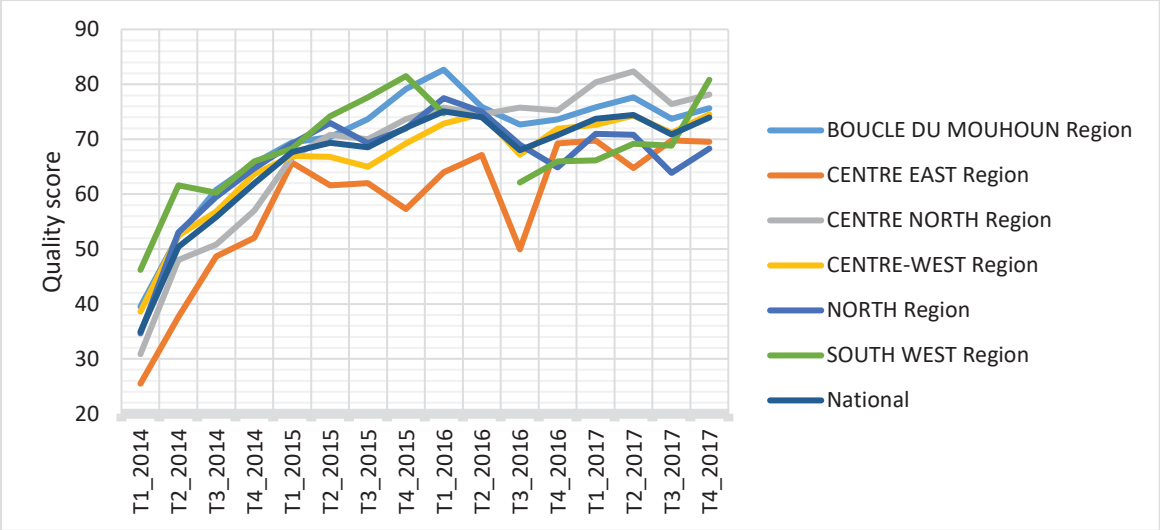
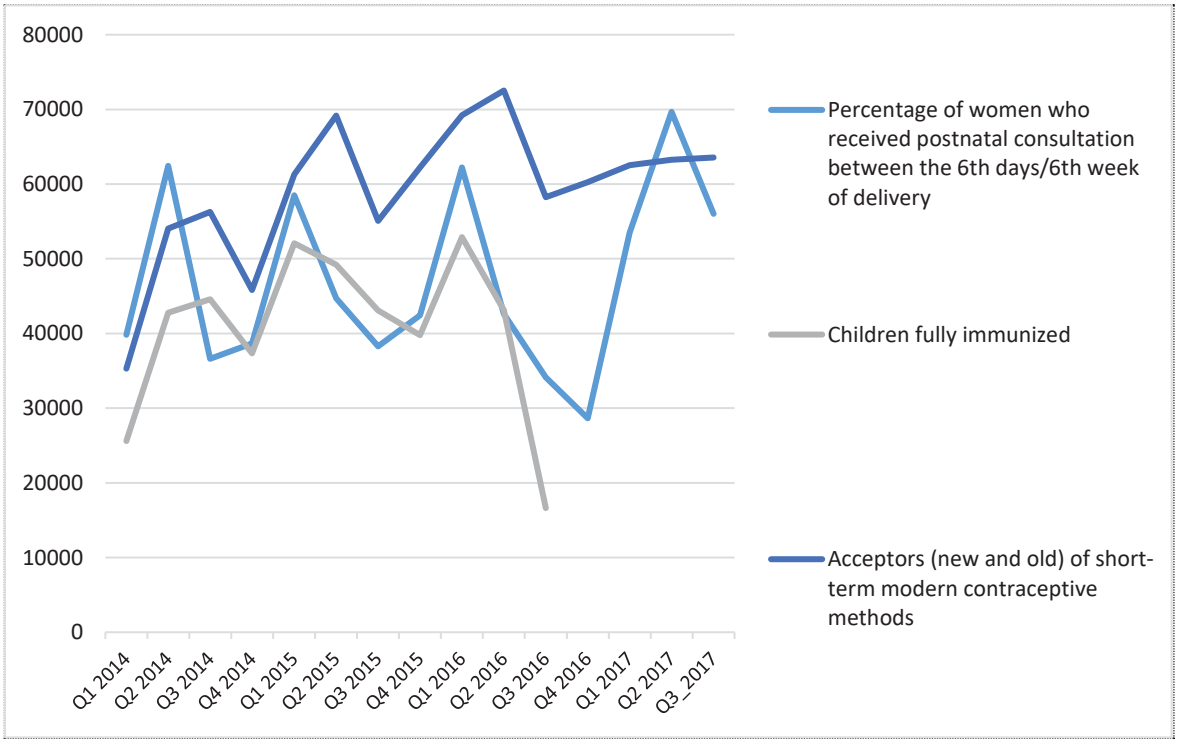


Figure 3: Evolution of key maternal and child health services in PBF facilities, 2014-2017



24. **An experimental impact evaluation of PBF, financed by the Health Results Innovation Trust Fund, was included in the pilot.** Preliminary results show significant improvements in the coverage of essential maternal health services (4.4 percentage point increase in assisted deliveries, three postnatal care visits within six weeks after delivery), quality of care (satisfaction with working environment, 15 percent increase in facilities with permanent availability of power and safe water), and other key outcomes. The results will be finalized in mid-2018 and inform design elements of the national strategic purchasing strategy under development. Preliminary results on key indicators are presented in Table 2.

Table 2: Preliminary results of the Burkina PBF impact evaluation on key maternal and child health indicators, PBF vs. full control (difference-in-difference results)

Indicator Label	PBF vs. full control
Satisfaction with the physical working environment (score min 0, max 10)	0.500*
Intrinsic motivation (score min 0, max 10)	0.125
Proportion of facilities with permanent availability of power and safe water in last 7 days	0.150**
Proportion of observed Antenatal Care (ANC) cases having received all three key routine ANC services	0.16
Proportion of recently pregnant women with ANC visit within first four months of pregnancy	0.057
Proportion of recently pregnant women who have delivered in an official health facility	0.044**
Proportion of recently pregnant women with at least three Postnatal Care (PNC) visits within 6 weeks after delivery	0.066**
Proportion of non-pregnant women aged 15-49 who use modern family planning methods	0.019
Number of children aged 0-11 months fully immunized	2.017
Number of patients under age 5 having sought curative services	80.471

*Note: * 5% significance level, ** 10% significance level.*

25. **Since 2007, Burkina Faso subscribed to the international health regulation (IHR) and the "OneHealth" approach.** A country-led self-assessment in 2014 on disease surveillance, preparedness and response capacity revealed some key weaknesses in the health systems in terms of infectious disease surveillance and epidemics. These include: (i) a fit for purpose health workforce for disease surveillance, preparedness and response is lacking at each level of the health pyramid; (ii) community engagement and community level surveillance and response structures either do not exist or need significant improvement; (iii) limited availability of laboratory infrastructure in place for timely and quality diagnosis of epidemic-prone diseases; (iv) lack of interoperability of different information systems hampers analysis and utilization of information for decision making and disease mitigation measures; (v) infection prevention and control standards, infrastructure and practices are generally inadequate; (vi) management of the supply chain system is weak and inefficient; and (vii) there are significant gaps in regional level surge capacity for outbreak response, stockpiling of essential goods, information sharing and collaboration.

26. **In September 2016, the country joined the Global Health Security Agenda (GHSA) and thus aims to prevent, detect, and respond to epidemics**. Therefore, a plan of basic capacity building in the implementation of the International Health Regulation (IHR) accompanied by a budgeted roadmap of activities have been adopted. The country is in the process of fund mobilization, but important financial gaps remain, which require the support of the international community.

27. **In conclusion, although some significant progress has been achieved in the health conditions of the population in Burkina Faso thanks to the implementation of ambitious policies, numerous challenges remain and can only be tackled through a better integration of existing policies and further innovation.** Health strengthening efforts which have proven effective at bringing positive change are still at a pilot stage (especially those influencing quality of care), and some promising, large scale policies have been enacted but require additional effort and resources to be implemented (specifically those promoting equity). A specific effort is also needed on surveillance, preparedness and response to public health crises, to make sure that this progress is not jeopardized.

28. **The proposed operation aims to support these scaling-up, strengthening and integration efforts.** In doing so, World Bank support has a catalytic dimension: in helping to set up a solid foundation for the system of social protection in health and for the national service delivery model, it contributes to making future domestic investment in health as well as future international support, more effective. The multi-sectoral nature of the World Bank's mandate is a comparative advantage, to promote changes which require the commitment of governmental actors far beyond the boundaries of the health sector.

C. Relevance to Higher Level Objectives

29. **The proposed project aims to contribute to multiple Sustainable Development Goals (SDG) targets.** Various project activities will support improving access of the population of Burkina Faso to the health services they need, of good quality and without facing financial hardship. In doing so, the project contributes to SDG 3.8 which aims to reach UHC in 2030. The proposed project also directly contributes to the attainment of SDG targets 3.1 (reduction of maternal mortality), 3.2 (end preventable death of newborns and children under five years of age), 3.7 (ensure universal access to sexual and reproductive healthcare services including for family planning, information and education) and 3.d (Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks). The nutrition related activities contribute directly to SDG 2.

30. **Better health and nutrition status improves human capital and produces more productive individuals who are better off economically.** In addition, the project will have a particular focus on improving access to and utilization of health services among the poor and vulnerable, leading to improvements in health and development outcomes of at-risk and vulnerable populations. Furthermore, by improving the level of financial risk protection in health, the project will contribute to tackle a major risk of impoverishment in the country. In doing so, the proposed project will fully contribute to the World Bank's twin goals of eliminating extreme poverty and boosting shared prosperity by improving the health status and human capital especially among vulnerable segments of the population, which in turn will increase productivity.

31. **The proposed project also contributes to the World Bank's Africa Strategy as follows:** In the medium to long term, it would contribute to Pillar 1 – Competitiveness and Employment – as family planning would help space births and reduce population growth. As a result, the country would benefit from a higher GDP per capita which would result in increased opportunities for employment. It would also contribute directly to Pillar 2 – Vulnerability and Resilience – by helping to improve female reproductive health and reducing maternal mortality and decrease vulnerability through high health insurance coverage.

32. **Investment in human capital and social protection systems is moreover a key priority for the Government as reflected in the Country Partnersip Strategy (CPS) 2018-2023 and the proposed project is one of the most important priorities in focus area 2.** It directly contributed to achieving the CPS objective 2.2: Expand access to reproductive health and nutrition. The CPS (2018-2023) makes gender a key cross-cutting area for Burkina Faso. By reducing gender bias against women particularly in their access to quality health care and by tackling the high rate of fertility with a well-functioning family planning system, it will improve their socio-economic conditions.

33. **Finally, the proposed intervention comes as a complement and/or strengthening of the World Bank's existing technical and financial support to the Government of Burkina Faso in the health sector through**: (i) two regional operations: the Sahelian Women Empowerment and Dividend Demographic (SWEDD, P154549) **and** the Sahel Malaria and Neglected Tropical Diseases (Malaria/MTD, P149526) projects, and the (ii) Reproductive Health Project (P119917).

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

34. The Project Development Objective (PDO) is to increase the quality and utilization of health services with a particular focus on maternal, child and adolescent health, nutrition and disease surveillance.

35. The PDO Level Indicators are the following:
    a. People who have received essential health, nutrition, and population (HNP) services (Number)
    b. Number of women and children who have received basic nutrition services (Number)
    c. Average score of the quality of care checklist (Number)
    d. Multi-hazard national public health emergency preparedness and response plan is implemented (Number)

36. **The PDO will be achieved through the project's support to the NHIF and the free health care scheme will contribute to improving financial access and utilization of essential health and nutrition services, with a particular focus on vulnerable groups.** Support to the scale up of PBF and the provision of critical inputs will contribute to improving the quality of these services. The project's support will also contribute to strengthening the health system's ability to prevent, detect and respond to public health emergencies.

B. Project Components

37. **In line with the SDGs, the proposed project intends to support Burkina Faso in its march towards Universal Health Coverage (UHC), ensuring that all people have access to needed health services of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.** The project's three components are designed to mutually support health system improvements and the move towards UHC in a synergistic way.

38. **Component 1 will finance and provide technical assistance to the rollout of various health financing and provider payment mechanisms that contribute to UHC.** Through its support to the NHIF, the project aims on the one hand to assist in the development of a system of financial risk protection for members of the informal sector, including the poor, which would incentivize greater utilization from these groups. As a complement, by supporting the rationalization of the free healthcare scheme and moving from a reimbursement to tariff-based payment system, the project will contribute to ensuring that essential services are effectively delivered free of charge and that provider payment reforms introduced through the project lead to efficiency gains in health financing. Finally, through the improvement and scale-up of PBF, and specific interventions the project incentivizes providers to deliver services with greater quality.

39. **Component 2 will complement improvements on the health financing side supported by Component 1 through support for service delivery improvements in the key areas of reproductive, maternal, newborn, child and adolescent health and nutrition.** Guided by the RMNCAH+N Investment Case that is currently under development with support from the Global Financing Facility (GFF), the component will finance activities that either scale-up innovative service delivery models (such as decision -support systems for child illness and family planning, or build capacity for the delivery of high quality services through training and essential commodity procurement. The prioritization of these investments will be guided by the various targeting mechanisms agreed upon in the national Investment Case, that seek to improve health outcomes among the worst-off and most vulnerable.

40. **Component 1 serves to reinforce the primary objective of Component 2 by promoting the PBF platform to incentivize quality improvement at community, primary and secondary care levels.** Moreover, the quality checklists for PBF will be reviewed and revised to improve existing and/or add new indicators that will significantly contribute to monitoring and improving quality of care around the services targeted in Component 2. The results-based approach of PBF inherently necessitates a stronger culture of data review and feedback and supportive supervision that will also help to improve quality of care under Component 2.

41. **Component 3 will finance investments to strengthen disease surveillance and response systems, which are essential health system strengthening measures.** Investing in activities that will strengthen mechanisms related to health security will be complementary to the investments under the other two components that have a specific focus on improving access to quality health services.

42. **Component 4 will allow the project to be agile in providing support to the Government to rapidly respond to emergencies, whether they be disease related or otherwise.** This component is complementary to the other components, in particular Component 3, which aims to improve the capacity of the Government of Burkina Faso to detect and respond to emergency health security threats.

Component 1: Strengthening Health System Capacity (US$30 million equivalent IDA, US$10 million GFF)

43. **Component 1 aims to support the strengthening and integration of several pre-existing and planned health financing policies, namely the launch of the national health insurance scheme and optimization of strategic purchasing mechanisms already in place, such as free care for women and children and PBF.** This intervention is fully in line with the national health financing strategy and subsequent documents such as the national orientation on strategic purchasing, which aims to move towards a purchaser/provider split through the establishment of a National Health Insurance Fund (NHIF - *CNAMU*) as a pool covering the entire

population. As a strategic purchaser, the NHIF will eventually manage the free healthcare scheme focused on essential health services for mothers and children below age five (*gratuité*) and a scaled up PBF program, as the main mechanism for improving quality of care, with a focus on primary and secondary care levels.

44. **Prior to the effective operationalization of the NHIF, which will lead to a clearer purchaser-provider split, the Ministry of Health will continue to finance both the free care and PBF purchasing mechanisms, but with project support, through one integrated purchasing mechanism**. It is worth noting that this component is multi-sectoral by nature, as apart from the Ministry of Health, the Ministry of Civil Service and Social Welfare, and Ministry of the Women, Family and National Solidarity are also responsible for achieving a greater level of social protection in health.

45. **Subcomponent 1.1:** *Establishment of the National Health Insurance Fund (US$5 million IDA).* Subcomponent 1.1 will support the establishment and operationalization of the NHIF, which was officially instated in March 2018. This subcomponent aims at strengthening the pooling function of the health financing system, hence bringing more equity in access through increased financial risk protection, especially of the poor. The NHIF will be in charge of providing insurance coverage of both formal and informal sectors of the population, and will progressively take on the role of strategic purchaser. The NHIF will also, once operational, take over the management of the free healthcare scheme. The fund is meant to be fully operational after two years following its creation.

46. **World Bank support will be focused on the extension of social protection in health to the informal sector, and especially to the poorest.** National plans envisage achieving coverage of the informal sector through the scale-up of ongoing CBHI (*mutuelles*) experiments. However, based on the outcomes of these national experiments and examination of international best practice[11], the national health financing strategy introduced a significant departure from the "traditional" CBHI model by moving towards mandatory enrolment, and subsidization of this enrolment, at least for the poor.

47. **Subcomponent 1.1 will finance technical assistance for the following activities:** (i) the design of the mechanisms of mandatory enrolment of the informal sector; (ii) the mechanisms targeting of the poor and of subsidization of their enrolment; (iii) the determination of the package of care (it is envisaged, as a trade-off between population and services covered, to limit coverage of the new CBHI scheme under the NHIF to PHC, while aiming to cover the whole population within the informal sector); (v) management of informal and formal sector coverage mechanisms; and (iv) other studies and technical assistance related to the design and rollout of the NHIF.

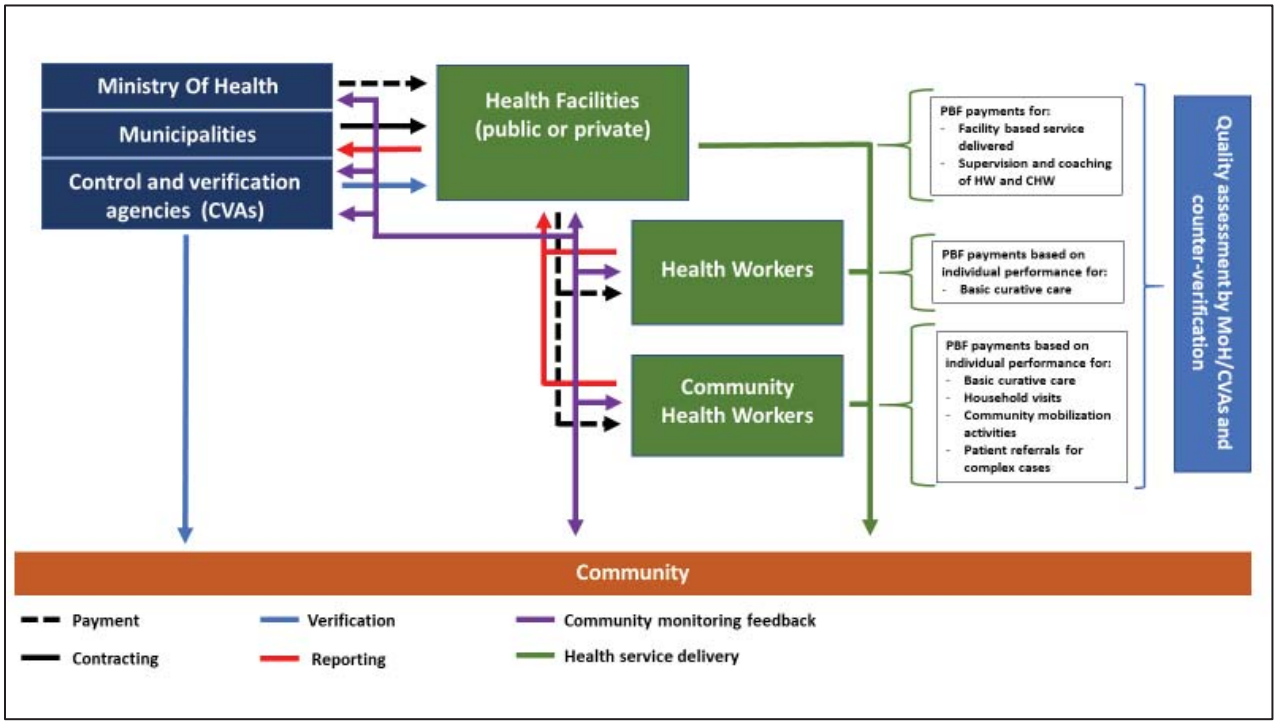
48. **This subcomponent will also finance activities supporting the design and set-up of the NHIF's information system.** Specifically, the activities to be financed under this subcomponent include: (i) the development of the enrolment system for the insured and their dependents; (ii) the tracking system for the payment of contributions; claims management; (iii) the control and liquidation system, and (iv) the tracking system of claim reimbursement to the insured and to facilities. Operational costs (consultants, goods, services) related to the operationalization of these systems will also be financed by this subcomponent.

[11] See for example: World Health Organization, Mathauer, Inke, Mathivet, Benoît & Kutzin, Joseph. (2017). Community based health insurance: how can it contribute to progress towards UHC? World Health Organization. http://www.who.int/iris/handle/10665/255629

49. **Subcomponent 1.2:** *Scale-up and strengthening of purchasing mechanisms (US$19 million IDA, US$10 GFF).* Subcomponent 1.2 will support the strengthening and scaling-up of purchasing mechanisms already in place such as PBF and free health care, based on experience gathered at national level and international best practice. Recent national documents (especially the national document on strategic purchasing) highlight the key role of PBF as a principal means to incentivize providers for improving quality of care, especially at the primary care level, while the free healthcare scheme appears as the most pragmatic mechanism for reimbursing quantity, although management needs to be strengthened to ensure effective and efficient operations.

50. **Under the strategic purchasing approach**, **as described in Figure 4, health facilities will be contracted by municipalities and paid by the MoH to deliver a predefined package of essential health services that follows national guidelines and standards.** On a quarterly basis, health facilities will submit declared performance to municipalities. Control and verification agencies will oversee the effectiveness of the service delivered. Quality assessment will be conducted jointly by MoH and CVAs (Control and Verification Agencies). In order to ensure community participation, a mechanism of community monitoring and feedback will be put in place. Eventually, payment and verification functions will be transferred to the NHIF.

Figure 4: Strategic purchasing service delivery, contracting and information flowchart



51. **This subcomponent will support the geographic scale-up of quality measurement, verification and payment mechanisms of the current PBF program.** Technical modifications will be introduced based on lessons learned from the PBF pilot to date. Further scale up from the existing 19 PBF districts located in six regions (North, North-Center, East-Center, West-Center, South-West and Boucle du Mouhoun and Hauts-Bassins) will be done in phases. In year one of the scale-up, the remaining 18 districts in the six regions currently in the PBF program

that are not currently covered will be included, leading to an increase from 25 percent of the total population to 47 percent of the population. During the second year of the scale-up, the selection of regions and districts will be based on the results of the prioritization process of the Investment Case, based on population health needs for RMNCAH+N. Preliminary analytical work suggests that these regions will include Sahel and Cascades.

52. **Project financing will support purchasing quality of care through defined measurement mechanisms, purchasing services not covered by the free care scheme for women and children (for which governmental financing is already assured), and ensuring robust verification mechanisms are in place for both quality and quantity elements of the strategy.** The specific set of services, prices, quality measurements and verification measures will be defined in the national strategy purchasing orientation document under finalization. Based on PBF disbursements from the Reproductive Health Project (P119917), approximately US$1 million is spent annually on subsidies for nutrition-sensitive services such as moderate and acute severe malnutrition and growth monitoring and promotion. With the scale-up supported by this project, it is estimated that a minimum of US$5 million will be spent on supporting nutrition services through the strategic purchasing mechanisms.

53. **Specifically, the subcomponent will finance:** (i) the "quality subsidies" to be paid to service providers based on the quarterly evaluations measuring their levels of quality of care; (ii) the "quantity subsidies" for services not covered by the free care scheme, as well as payments for services provided at the community level (Community PBF); and (iii) subsidies to regional and district health teams for results achieved related to coaching and supervision activities.

54. **The strategic purchasing mechanism will also be strengthened, through the inclusion of community health workers and the improvement of the individual incentivization mechanism.** Community health workers represent a key asset for the delivery of primary health care and are also key actors of social mobilization in health. To maximize their engagement and performance in delivering the package of services, and having stronger emphasis on improving quality, it is therefore relevant to include them in the PBF incentive mechanism. Under these conditions, they can also be a crucial asset to help the service delivery system cope with the significant increases in utilization observed following the introduction of the free healthcare scheme.

55. **Subcomponent 1.3:** *Verification and cross-cutting interventions in health financing (US$6 million IDA).* The third subcomponent will be dedicated to supporting cross-cutting interventions, benefiting both the enhanced coverage and purchasing components above. Specifically, the subcomponent will finance: (i) costs related to coaching, verification and community mobilization within the strategic purchasing approach, and (ii) technical support to developing and piloting innovative strategies to measure, incentivize and purchase quality health services, enhance provider autonomy, and (iii) support to the production of evidence to sustain evidence-based health financing policy formulation.

56. **Adequate verification coaching and supervision at the local level, as well as social mobilization to sustain implementation of both the PBF and CBHI component of NHIF will be crucial to the long-term success of UHC.** This sub-component will therefore support the development and delivery of verification, coaching and supervision capacity building activities to providers and relevant municipal staff as well as social mobilization activities. In a context of decentralization, the role of municipalities in this matter will be strengthened, as well as the role of community health workers.

57. **This subcomponent will support the operational costs of regional CVAs to provide enhanced verification measures to counter-verify results declared by service providers (both quantity from the free care payment mechanism and quality through the PBF mechanism).** Each region implementing the strategic purchasing scheme (as described under subcomponent 1.2) will have one CVA who will verify quarterly both at the facility and community level the quantity and quality of services declared by contracted providers.

58. **Subcomponent 1.3 will also finance technical assistance to improve the efficiency and effectiveness of the free healthcare scheme**. Free healthcare policies have been implemented in many countries as a first step to fund basic services for selected population groups and they often succeeded in boosting utilization of these services. Yet their impact has often been undermined by insufficient funding and inadequate provision of inputs[12], and Burkina Faso is no exception. The project will provide technical assistance to streamline processes at both purchaser (as part of the transition of the scheme to the NHIF) and provider level, as well as capacity building to effectively plan for and ensure the availability of necessary financing and inputs. Special attention will be given to the alignment of PBF and free-healthcare policies, as they are in essence, complementary and interdependent; the former purchases quality while the later purchases quantity. The longer-term objective, as presented in the national health financing strategy, is the full integration of the free-healthcare scheme in the NHIF benefit package.

59. **Health provider autonomy is a crucial enabler of the strategic purchasing efforts.** Support in this area will be delivered in the form of technical assistance and capacity building activities for facility-level managers based on international best practice as well as feedback from the original PBF project. This support will be articulated around the key dimensions of providers autonomy for health financing policy. NGOs and/or private companies will be contracted to coach facilities managers on such practices as financial management, social marketing, etc.

60. **Generation of evidence on health financing policy, its analysis and its dissemination in a manner which will facilitate its straightforward translation into decisions, will be crucial for the further design, implementation and continuous improvement of health financing policies**. It is therefore planned, within this project to provide advice and capacity building opportunities to such institutions as the MoH unit on Performance Monitoring and "*Résultologie*", MoH Unit of Knowledge Translation and MoH General Directorate of Studies and Sectoral Statistics (DGESS) as well as relevant NHIF teams. They will also be supported in the delivery of their respective flagship products (for instance National Health Accounts for DGESS).

Component 2: Strengthening Delivery of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) (US$35 million equivalent IDA, US$10 million GFF)

61. **Component 2 aims to promote UHC and enable the acceleration of the demographic transition to maximize human capital and economic growth through a comprehensive approach to Reproductive, Maternal, Newborn, Child and Adolescent Health and nutrition (RMNCAH+N).** This component is aligned with Axis 2 ("Developing Human Capital") of the Economic and Social Development Plan (PNDES 2016-2020), the reference document for the development of Burkina Faso. The component will finance a set of interventions that will (i) invest in the capacity of service providers to provide quality services; and (ii) pilot and/or scale-up innovative and effective tools to improve coverage and quality of RMHCAH+N services.

[12] See for instance Mathauer, Inke, Mathivet, Benoit, Kutzin, Joe & World Health Organization. (2017). Free health care policies: opportunities and risks for moving towards UHC. World Health Organization. http://www.who.int/iris/handle/10665/255588

62. **The Government of Burkina Faso, as a recipient of investments from the Global Financing Facility (GFF) for Every Woman Every Child, is also leading a participatory process to develop an investment case to identify priorities and actions in support of RMNCAH+N**. The Investment Case is supported by a GFF Exploratory Grant and GFF preparation trust fund, and involves an exhaustive resource mapping which will identify current and planned donor, private sector and public-sector investments in RMNCAH+N; their geographic coverage; interventions and implementing partners; and financial envelopes. Gaps in coverage will be flagged along with evidence-based identification of underserved priorities and populations. These will feed into an Investment Case and action plan for RMNCAH+N in Burkina Faso that will be discussed and jointly agreed through a government-led consultative process inclusive of civil society, private sector and development partners. This process began in early 2018 and the Investment Case is expected to be completed by November 2018. Half of the Global Financing Facility's (GFF) investment in Burkina Faso will be allocated to prioritized interventions outlined in the investment case, supporting improvements in the quality of RMNCAH+N services.

63. **The activities to be financed under this component will broadly fit into four subcomponents:** (i) Strengthening RMNCAH service delivery; (ii) Investing in the Early Years and nutrition; (iii) Support to the national census and to civil registration and vital statistics (CRVS) and, (iv) Strengthening multi-sectoral coordination for RMNCAH+N. Geographic targeting for this component will be articulated as a result of the resource mapping. As the RNMCAH+N investment case is still under finalization, the specific geographical coverage of the interventions to be financed by this component will be decided in consultation with the government and other partners supporting these efforts, to ensure harmonization, coordination and avoidance of duplication in efforts (as per the GFF objectives to support smart, sustainable and scalable investments).

64. **For nutrition interventions, geographical targeting will be used to identify populations with the greatest nutrition needs, such as the Sahel, East, South-West and Cascades regions (SMART, 2017) which have the highest stunting rates, and the Sahel region which has the highest rate of wasting.** As part of the GFF-supported process that will ensure alignment and coordination between partners, the specific districts will be selected in consultation with other partners investing in nutrition, to avoid overlap and duplication in financial and technical support. The same approach will be used for interventions aimed at improving maternal, child, reproductive, and adolescent health needs.

Table 3: Nutrition indicators by region, Burkina Faso

Regions	Stunting prevalence (SMART 2017)	Wasting prevalence (SMART 2017)	Exclusive Breastfeeding (SMART 2017)	Complementary Feeding Practices (MAD) (SMART 2017)	Vitamin A Supplementation (SMART 2017)	Intermittent Presumptive Treatment of Malaria in Pregnancy (MICS, 2014)
National	21.2	8.6	47.8	17.5	76.1	21.5
Boucle du Mouhoun	22.4	8.4	39.3	11.5	90.6	21.7
Cascades	30.5	6.5	43.7	25.4	76.0	26.0
Centre	5.8	7.0	26.9	25.4	62.7	17.0
Centre Est	24.4	6.8	47.6	19.2	81.8	49.3

Centre Nord	26.5	9.4	69.6	9.0	75.7	33.1
Centre Ouest	24.5	9.0	67.5	10.8	87.2	18.9
Centre Sud	18.4	7.5	66.4	5.3	88.1	32.9
Est	34.3	10.8	60.5	18.0	76.9	8.8
Hauts Bassins	21.0	5.9	43.8	15.5	75.8	4.7
Nord	22.6	11.3	57.9	15.5	76.5	19.3
Plateau Central	24.9	8.5	57.0	11.6	82.5	18.2
Sahel	38.9	13.6	46.7	25.6	87.2	24.9
Sud Ouest	34.2	8.9	46.3	6.8	86.8	18.2

Note: Iron and Folic Acid Supplementation in pregnancy is estimated at 66.7 percent nationally, estimated not available by region, (PMA2020, 2017)

65. **Subcomponent 2.1:** *Strengthening maternal, newborn, child and adolescent health service delivery (US$5 million IDA, US$8 million GFF).*

66. ***Subcomponent 2.1.1: Strengthening capacity to address obstetric and neonatal emergencies.*** The project will seek to bolster the capacity of the health system to provide comprehensive Emergency Obstetric and Newborn Care (EmONC) and to increase access to these services. While the GFF resource mapping and investment case will provide a much clearer analysis, in general, the subcomponent will finance the following activities: (i) the provision of commodities and equipment necessary for EmONC, including for post-abortion care; (ii) assess training needs of providers at different levels of the system, including to perform emergency obstetric surgical interventions, and finance the resulting in-service training and supervision plan; (iii) assess the pre-service curriculum for EmONC skills of a range of provider cadres and develop a plan to address deficiencies through curriculum revision; (iv) assess the adequacy of the referral system including communications, transport and continuity of care from community level to tertiary care and develop a remedial action plan; (v) assess awareness of maternal and newborn danger signs at the community level and promote care-seeking behavior for emergency services as needed through Social and Behavior Change Communications. (SBCC); and (vi) train and strengthen Maternal and Perinatal Death Audit Committees. Supportive supervision and quality improvement of EmONC services will be further promoted through linking with the planned strategic purchasing platform for secondary and tertiary care. The resource mapping should identify deficits in coverage for EmONC availability to ensure equity in access across the country.

67. ***Sub-component 2.1.2: Promoting family planning with a focus on adolescent health and well-being.*** Family planning (FP) is an effective way to accelerate the demographic transition to enable a potential demographic dividend. To ensure wide access to quality family planning services, this subcomponent will finance: (i) training of facility providers in quality FP counseling and service provision, including post-partum FP services; (ii) training of community health workers (CHW) in SBCC around FP and in provision of a limited range of FP commodities and the scaling-up of this activity; (iii) analytical work to design strategies to improve the effectiveness of messages to the population and in turn increase demand for family planning within priority population groups; and (iv) providing TA to the Government to strengthen linkages to programs working with adolescents (for example the SWEDD project, P154549) in improve access to sexual and reproductive health services for youth. Again, the strategic purchasing platform supported under Component 1 will contribute to

improvement of quality of FP counseling, postpartum FP and adolescent services through the in-built system of results monitoring, supervision and feedback, as well as through incentivized CHWs.

68. ***Subcomponent 2.1.3: Strengthening primary care services for women and children*.** While the PBF platform will enable closer attention to improving quality of care at facilities under Component 1, this component will complement the strategic purchasing approach by financing the following activities: (i) an assessment on the training needs of staff at facilities and enable in-service training on Prevention of Mother-to-Child Transmission (PMTCT), antenatal care, normal labor and delivery, postnatal care and Integrated Management of Childhood Illness (IMCI); (ii) purchasing of commodities and equipment to provide these services; (iii) training for district and regional teams to strengthen supportive supervision for maternal and child health services, in order to improve care at the community, primary and secondary care levels, and (iv) training of service providers, in particular at the community level, to promote IMCI and create demand for primary care services at the household level. The RMNCAN+N Investment Case will present specific gaps in these areas, including geographic coverage and service-specific deficiencies, that will provide the orientation for prioritizing targeting of training and capacity building efforts under this subcomponent.

69. **The project will seek to further monitor and improve quality of all RMNCAH+N services at the facility level by adding an exit interview for a random sample of patients availing any of these services.** The information gathered on the exit interviews will measure appropriateness of care based on client response to a short battery of standard specific questions. For family planning, for example, the exit interview would ask the three pertinent questions to determine quality of counseling – information on the range of methods; information on side effects; and information on what to do if experiencing a side effect. The answers on the exit interview would then be matched against the patient records for verification, and integrated into the quality payment of the RBF scheme. The exit interview reviews would also enable constructive feedback to the providers during supervision visits to improve quality.

70. **Subcomponent 2.2:** *Investing in the Early Years and nutrition (US$20 million IDA).* The project will support governmental efforts to ensure children survive and especially thrive, through the implementation of activities included in the National Strategy for Integrated Early Childhood Development (ECD) and the Nutrition Multi-Sectoral Strategic Plan.

71. **Within the integrated RMNCHA+N package, the scale-up of a set of nutrition-specific interventions to reduce stunting should generate considerable returns in economic benefits.** These interventions include: (i) as part of ANC, iron and folic acid supplementation and intermittent presumptive treatment of malaria, (ii) promotion of infant and young child feeding (IYCF) and (iii) for children 6-59 months, therapeutic zinc and ORS for diarrhea in children, and vitamin A supplementation.

72. **This component will finance the following activities in support of high-impact interventions:** Training and supervision of community and facility-based health workers to provide counseling and support on exclusive breastfeeding and complementary feeding; studies to assess feasibility and need for public provision of complementary foods to children 6-23 months in food insecure areas; micronutrient powders for children; feasibility, pilot and possible scale up of balanced energy protein supplementation for pregnant women; and technical assistance to conduct preparatory work to facilitate iron and folic acid fortification of staple foods. To mitigate the impacts of wasting, strengthening and scale up of treatment of severe acute malnutrition in children 6-59 months may be needed in target high-burden areas.

73. **Interventions will be delivered at the community level as well as through health facilities.** Counseling on and promotion of breastfeeding and complementary feeding, as well as provision of complementary food may be best done at community level in the context of a broader package of ECD orientation for parents and caregivers, and reinforced during facility visits. Facilities will continue to strengthen nutrition-specific interventions within ANC and child visits. The project will also finance the development of a Social and Behavior Change Communications strategy and the associated implementation of radio and television programs to deliver related nutrition and WASH messages. The GFF Investment Case will further sharpen the targeting and geographic specificity of nutrition and Infant and Early Years (IEY) interventions as the resource mapping will highlight coverage gaps.

74. **Subcomponent 2.2 will also support the financing of better quality measurement of nutritional status and monitoring of nutrition-related data, in addition to other knowledge generation.** The project will support: (i) co-financing (along with partners and Government) of annual SMART surveys for measurement of stunting and other nutrition indicators; (ii) determinants of malnutrition analysis to better understand variations in stunting by region; (iii) a study on lessons learned from integrated ECD interventions in Burkina Faso as well as on traditional best practices in ECD to enable advocacy for future focus and financing in this area; and (iv) other studies as deemed necessary over the life of the project to strengthen the evidence base around nutrition in Burkina Faso.

75. **Cross-linkages with other components:** The strategic purchasing approach in Component 1 will directly aid in improving the quality of nutritional services provided at the facilities through use of the quality checklist performance to provide active feedback during supervisory visits by the district health teams and to monitor progress over time. Moreover, the focus on family planning and adolescents in Component 2.1.2 will doubly serve to reduce stunting as the prevention of adolescent, or early, childbearing has been proven to improve the nutritional status of the adolescent girl and her future children. Finally, the multi-sectoral aspects of investing in the early years will greatly benefit from the investments of component 2.4 below which will serve to strengthen capacity in coordination across relevant ministries around issues like stunting.

76. **Subcomponent 2.3:** *Supporting civil registration and vital statistics (US$9 million IDA, US$2 million GFF).* This subcomponent will support elaboration of CRVS systems through various channels (e.g. community health workers, electronic registration etc.). This is a critical component for child protection, safeguarding many of their civil, political, economic, social and cultural rights. Indeed, birth registration not only enables access to basic services such as education and social security, but is also used for health services planning such as vaccinations and growth monitoring. Death registration will bring further accountability for maternal, newborn and child deaths and will be linked with death audit systems. Moreover, the CRVS will be intrinsically linked to the support of UHC as the NHIF and any CBHI will eventually benefit from more systematized registration of vital events. The subcomponent will support the scale-up and capacity of the “iCivile” platform for civil registration, and the detailed plan of activities to support CRVS will be part of the GFF Investment Case.

77. **Subcomponent 2.3 will include support to the 2018 National Burkina Faso Census which will be dedicated both to data collection and analysis for a total of US$8 million**. The population census is the backbone of the Statistical Information System (SIS) in the country. The census is the only operation designed to provide the spatial distribution of the population, its characteristics and composition at the lowest administrative level.

The 2018 population census will not only collect sociodemographic data but will also provide a granular picture of key public infrastructure in the country, including health facilities. Again, the census will be needed to establish the denominator for all coverage data, including for the NHIF, CBHI, and strategic purchasing of health services. The activities supporting the census will be implemented through a UN contract with United Nations Population Fund (UNFPA) and will include data collection, analysis and report writing.

78. **Subcomponent 2.4:** *Supporting Multisectoral coordination for RMNCAH+N (US$1 million IDA).* Subcomponent 2.4 will primarily finance operational costs and capacity building to ensure effective coordination, management and implementation of Subcomponents 2.1-2.3. A multi-sectoral approach is crucial to effectively implement sexual and reproductive health (including family planning and adolescent health), nutrition and integrated early childhood development activities. This subcomponent will strengthen the capacity of multi-sectoral steering committees supporting RMNCAH+N to carry out their functions effectively. This will be essential to ensure a functional link between the technical directorates of the ministries involved in the project implementation. As multi-sectoral approaches are challenging and as this project is supporting a longer-term national effort to build human capital in order to capture the demographic dividend, this subcomponent will also support technical assistance. Specifically, subcomponent 2.4 will finance technical assistance to establish mechanisms to facilitate processes, identify opportunities to sustainably enhance the project's effectiveness and ensure capacity building based on international best practices and experiences, in a spirit of competency transfer to national entities.

Component 3: Reinforcing health security and supporting institutional strengthening (US$15 million equivalent IDA)

79. **Component 3 will support institutional capacity needed at national, regional, and district levels to prevent, detect, be prepared, and respond to health security risks, hazards and emergencies, as well as overall project implementation and coordination support.** It addresses the key weaknesses revealed by a recent Joint External Evaluation (JEE) of Burkina Faso (December 2017).

80. **Component 3 results from a consultative process with Government to inform the detailed project design**. The MoH is receiving support from other development partners in implementing its national strategic plan for health security, but important gaps remain in terms of financial, material and human resources. A detailed resource mapping has been done with specific gaps in terms of technical and financial support. Therefore, the proposed project's support will be addressed through a collaborative and synergistic approach with other technical and financial partners involved in the area. This component will build on and complement other projects and initiatives, such as the recently closed West Africa Regional Disease Surveillance Project (P125018), the ongoing Regional Disease Surveillance Systems Enhancement Project (P154807), Global Health Security Agenda activities and other discrete activities to foster the harmonization of a functional national disease surveillance and response.

81. **The component will support strengthening surveillance and response capacities and containment activities of the human and veterinary public health systems to public health threats according the "One health approach".** The component will support the establishment of coordinating mechanisms, such as a national OneHealth platform, and the operations center for public health emergency response to facilitate coordination across the various ministries (health, agriculture, animal husbandry, environment etc.).

82. **Subcomponent 3.1:** *Strengthening of National Public Health Surveillance and information systems (US$7 million IDA).* This subcomponent will support the enhancement of national surveillance and reporting systems and their interoperability at the various levels of the health systems.

83. **Activities to be financed under subcomponent 3.1 include:** (i) investments to improve ICT capacity through the establishment of an electronic monitoring system for disease surveillance and coordinated responses; (ii) improving the linkages between national animal health and human health surveillance information systems, between national systems to regional/international disease surveillance and reporting systems. The improvement in linkages will be supported by the project through the financing of the following activities: (a) supporting coordinated community-level surveillance systems and processes across the animal and human health sectors; (b) developing capacity for interoperable surveillance and reporting systems; and (c) establishing an early warning system for infectious disease trends prediction.

84. This subcomponent will also finance activities to support (i) the operationalization of mechanisms to facilitate cross-border collaboration in surveillance (including active/event-based, passive and syndromic surveillance) for the early detection of cases; (ii) training and monitoring/reporting mechanisms for timely reporting by community- and district-level surveillance agents and veterinary facilities; and (iii) training of health professionals in disease surveillance, epidemiology, laboratory biosafety, environmental surveillance, food safety and management by the updating and operationalization of the existing human resource development plan.

85. **Subcomponent 3.2:** *Strengthening health system preparedness and emergency response capacity (US$3 million IDA).* Subcomponent 3.2 will support national efforts to enhance infectious disease outbreak preparedness and response capacity by improving local (community) and national capacities to prepare for impending epidemics in humans and animals, and to respond effectively to disease outbreak threats including the resulting mortality risks posed by infectious diseases.

86. **Activities financed by this subcomponent include:** (i) updating of cross-sectoral emergency preparedness and response plans for priority diseases and for food safety, and ensuring their integration into the broader national all-hazards disaster risk management framework; (ii) regular testing, assessment, and improvements of plans; (iii) expansion of the health system surge capacity including the allocation and utilization of existing pre-identified structures and resources for emergency response, and Infection Prevention and Control (IPC); (iv) supporting the emergency operations center; and (v) periodic outbreak simulation exercises to assess functionality of emergency notification systems at different levels of the system.

87. **Subcomponent 3.3:** *Institutional Capacity Building, Project Management, Coordination and communication (US$5 million IDA).* Subcomponent 3.3 will finance overall project coordination and management, including fiduciary aspects (financial management and procurement), monitoring and evaluation (M&E), knowledge generation and management, communication, and management (capacity building, monitoring and evaluation) of social and environmental safeguard mitigation measures. It also provides for critical cross-cutting institutional support, meeting capacity-building and training needs identified on top of specific technical capacity-building activities undertaken within the three technical components (including support to the management of operational research). It will support the routine external independent assessment of critical animal health and human health capacities of national systems using reference tools (such as OIE, PVS and JEE) to identify weaknesses and monitor progress.

Component 4: Contingency emergency response (US$0 million)

88. **The objective of this component is to improve the Government's response capacity in the event of an emergency, following the procedures governed by Bank Policy: Investment Project Financing, paragraph 13.** There is a moderate to high probability that during the life of the project one or more countries will experience an epidemic or outbreak of public health importance or other health emergency with the potential to cause a major adverse economic and/or social impact which would result in a request to the World Bank to support mitigation, response, and recovery in the region(s) affected by such an emergency. In anticipation of such an event, this contingent emergency response component (CERC) provides a mechanism for countries to request the World Bank to support mitigation, response, and recovery in the district(s) affected by such event. This program provides an important opportunity for clients to stop epidemics from spreading within and across borders through early intervention, without the need to set financing aside in a conventional contingency fund.

89. **An "Emergency Response Operational Manual" (EROM) will be prepared by the country as a condition of disbursement.** Burkina Faso will begin drafting the EROM immediately to ensure that the CERC is in place as soon as possible in the event that an emergency occurs early in the implementation of the Project. Triggers for the CERC will be clearly outlined in the EROM acceptable to the World Bank. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this activity will be in accordance with paragraph 12 of Bank Policy Investment Project Financing and will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made.

C. Project Costs and Financing

Table 4. Overview of Components and Financing by Component (US$ million)

Project Component	Project cost	International Development Association financing	Global Financing Facility financing	% financing
1. Strengthening Health System Capacity	**40.0**	**30.0**	**10.0**	100
1.1 *Establishment of the National Health Insurance Fund*	5.0	5.0	0.0	100
1.2 *Scale-up and strengthening of purchasing mechanisms*	29.0	19.0	10.0	100
1.3 *Verification and cross-cutting interventions in health financing*	6.0	6.0	0.0	100
2. Strengthening Delivery of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition	**45.0**	**35.0**	**10.0**	**100**
2.1 *Strengthening maternal, newborn, child and adolescent health service delivery*	13.0	5.0	8.0	100

2.2 *Investing in the Early Years and nutrition*	20.0	20.0	0.0	100
2.3 Supporting civil registration and vital statistics	11.0	9.0	2.0	100
2.4 Supporting multisectoral coordination for RMNCAH+N	1.0	1.0	0.0	100
3. Reinforcing health security and supporting institutional strengthening	**15.0**	**15.0**	**0.0**	**100**
3.1 *Strengthening of National Public Health Surveillance and information systems*	7.0	7.0	0.0	100
3.2 *Strengthening the capacity of MOH in health financing and development of long term reform strategies*	3.0	3.0	0.0	100
3.3 *Institutional Capacity Building, Project Management, Coordination and communication*	5.0	5.0	0.0	100
4. Contingency emergency response	**0.0**	**0.0**	**0.0**	**0.0**
Total project costs	**100.0**	**80.0**	**20.00**	**100**

D. Project Beneficiaries

90. **The main beneficiaries of the program will be prioritized populations of Burkina Faso, with targeting based on health needs, poverty and overall vulnerability.** Specific direct beneficiaries of the project include economically poor populations, adolescents, women and children under five. As the project will contribute to strengthen key functions of the overall health system, certain interventions will also benefit the national population.

91. **From an institutional perspective, health personnel, notably midwives, nurses, and community health agents, will benefit from training in family planning, reproductive health and disease surveillance and epidemic response.** Thanks to the multidisciplinary approach of health security, the strengthening of the health security system will benefit other sectors including the environment and animal health sectors.

E. Results Chain

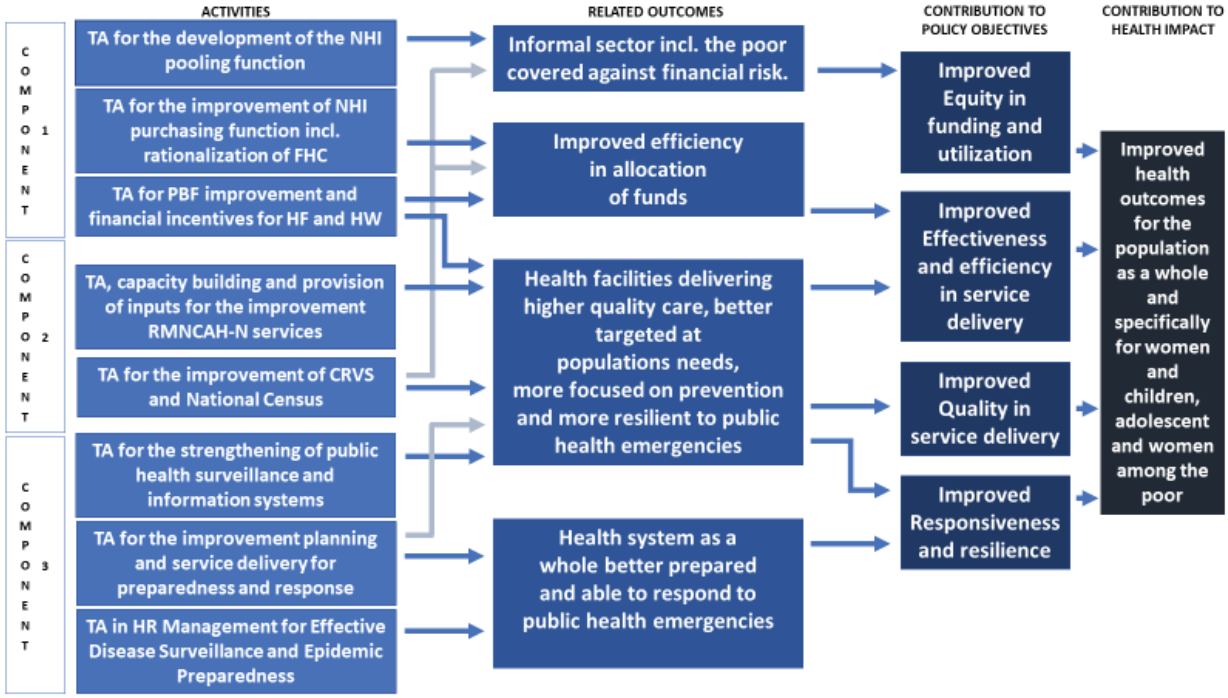
92. **The project's four components are designed to synergize.** Through its support to the NHIF, the project aims on the one hand to assist in the development of a system of financial risk protection for members of the informal sector, including the poor, which would incentivize greater utilization from these groups. As a complement, by supporting the rationalization of the free healthcare scheme, the project will contribute to ensuring that essential services are effectively delivered free of charge. Finally, through the improvement and scale-up of PBF, the project incentivizes providers to deliver services with greater quality.

93. **Health financing policy can only provide incentives for higher quality, more efficient service delivery.** Therefore, as part of component 2, through technical assistance, capacity building and direct provision of inputs, the proposed project will have a direct action on these policy objectives. Support to CRVS and the conduct of the national census will have a positive impact on the project, especially by allowing a better targeting of health financing and service delivery interventions.

94. **Finally, Component 3 will ensure that the system will be able to prevent, detect and respond to public health emergencies.** In doing so, it will also contribute to the quality of services delivered, to the responsiveness and resilience of the whole system.

95. **All components will ultimately contribute to improved health outcomes for the population of Burkina Faso as a whole and specifically for women, children and adolescents among the poor**.

Figure 5: Results Chain for the Health Services Reinforcement Project



F. Rationale for Bank Involvement and Role of Partners

96. **The rationale for the World Bank support to Burkina Faso on health services performance is multidimensional.** First, its technical input is based on international experience on health systems strengthening and specifically on performance-based financing and the capacity to mobilize a wide-range of technical expertise to support key strategies and reforms (e.g., RMNCAH investment case, health financing strategy). The World Bank will hence be able to mobilize its own technical resources as well as organizing south-south expertise exchange in support of the improvement of such financing mechanisms as the NHIF (pooling of funds) and PBF (strategic purchasing). The ongoing Burkina Faso Reproductive Health Project (P119917) has been successfully supporting the Government to implement key reforms such as the piloting of Performance-Based Financing and CBHI.

97. **Second, the World Bank can play an important convening role to support mobilization and channel additional resources to scale-up delivery of effective and efficient RMNCAH services, as Burkina Faso is now part of the Global Financing Facility in support of Every Woman Every Child.** The World Bank is playing a key

role to promote innovative approaches in the health sector (for example, Community PBF) and overall human development sector promoting a multisector approach (Component 2 will support innovative interventions through a comprehensive program to address education, health and fertility challenges). Finally, the World Bank has led the design and implementation of several regional projects aimed at strengthening disease surveillance and health security upon which this project is building.

98. **Moreover, the World Bank's mandate allows it to act as a convening power for all governmental actors involved in health financing reforms**, namely, in the case of the Burkina Faso NIH, the Ministry of Civil Servants and Social Protection, the Ministry of Health, the Ministry of Finance and the Ministry of Women, National Solidarity and Family.

99. **The project, through support of the GFF, will provide new opportunities to improve alignment and synergies across development partners engaged in the health sector.** The national RMNACH Investment Case will outline key priorities for the health sector with a focus on women and children. The national platform to coordinate GFF-related activities will lead efforts for improved coordination.

G. Lessons Learned and Reflected in the Project Design

100. **The observed positive influence of PBF on quality of care can be strengthened by enhancing its synergy with the free healthcare schemes and its integration within a broader health financing strategy, especially considering pooling of funds to enhance the coverage of the informal sector.** During the last years of implementation of the PBF, as part of the previous Reproductive Health Project (P119917), it coexisted with the national scale-launch of the free healthcare scheme specifically targeted at health services for mothers and children under five. The proposed project offers the opportunity to seek synergies between the two mechanisms, by supporting both the scale-up and improvement of the PBF to cover a greater share of the population in greatest need with higher quality services and providing technical support for the improvement of the free healthcare scheme to ensure that it efficiently allocates resources to buy sufficient quantity of care. This is even more relevant with the planned progressive transfer of both mechanism under the CNAMU.

101. **Community health workers are a key asset of both the PHC delivery model and of social mobilization efforts for PBF and CBHI (as part of the establishment of the MHI fund), and should as such be included in the PBF incentive scheme.** As part of the Reproductive Health Project, community health workers were only partially integrated in the PBF incentive scheme, while they already represented the first point of contact with PHC of most of the population. Since then, their role in service delivery has been re-emphasized in national strategic documents, both in terms of their potential for community mobilization as well as enrollment efforts for CBHI and the broader national MHI scheme. The new project hence offers an opportunity to include them in the broad effort to enhance the performance of the health system in Burkina Faso.

102. **Lessons learned from the implementation of early years activities as well as GFF processes in pioneer countries are considered in this project**. Additionally, the project design was inspired from the experiences of other countries implementing similar projects, focusing on improving Sexual and Reproductive Health (SRH), Early Years and nutrition.

103. **A multi-sectoral approach is crucial to achieve strong and sustainable results in the field of SRH as well as in early childhood development including nutrition.** Such an approach helped promote a systemic approach

which is essential to reach the project's goals as it considers the many determinants that affect results.

104. **As part of the GFF process, effective leveraging of funds and investments from other development partners can increase the scope of interventions and enhance achievements.** As part of the development of the investment case, the project was developed in close coordination and collaboration with many stakeholders including senior officials from several ministries, private sector, civil society, and development partners interested in moving forward the Universal Health Coverage agenda and more globally in human development. The interventions were chosen to complement current and expected investments by other development partners.

105. **Component 3 benefits from a rich set of lessons drawn from a variety of sources** including: (i) the achievements and challenges faced by World Bank health systems strengthening and disease control operations that are contributing to disease surveillance capacity for human and animal health; (ii) a comprehensive literature review of existing regional disease surveillance and response networking arrangements, the Regional Disease Surveillance Systems Enhancement Project (REDISSE, P159040), the West African Regional Disease Surveillance (WARDS, P125018) Project and Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI, P100273) Project; (iii) best practices and lessons learned from international initiatives and development partner projects with similar objectives; and (iv) lessons learned from major infectious disease outbreaks, especially outbreaks that occurred in Burkina Faso in recent years.

106. **Some of the most salient experiences and lessons learned incorporated in the REDISSE II and WARDS Implementation and Completion Results include improving cooperation across sectors, among countries and between countries at critical cross-border junctures, as well as with development partners.** The design of Component 3 promotes cooperation across sectors through adoption of a One Health approach, linkages between disease surveillance and epidemic preparedness systems, and all hazard disaster management systems at country and regional levels. Collaboration among countries and with development partners will be facilitated through the establishment of national and regional platforms for joint planning and resource coordination.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

107. **By complying with West African Economic and Monetary Union (WAEMU) guidelines, Burkina Faso has presented the 2017 budget law in the form of a program-budget**. This program-budget allocated three programs to the Ministry of Health resulting in 21 actions with a three-year budget and impact indicators. The head of each program are program coordinators, all civil servants, nominated by governmental decision and accountable to the National Assembly for the financial and physical results. These three program-budgets are: (055) access to health services, (056) health services provision and (057) piloting and support to the services of the Ministry of Health.

108. **In 2017, the Government of Burkina Faso adopted a new regulation of projects and programs which applies also to donor-financed projects.** The regulation intends to strengthen the capacity of line ministries to which projects and programs are mapped. To this end, it integrates Project Implementation Units (PIUs) into the

adopted program-budget framework as a response to the important number and high operating costs of PIUs. Thus, all projects and programs belong to a budget- program to be managed by a program coordinator. This new regulation comes within the context of results-based management. Both the program-budget guidelines and the new national regulation of projects have an impact on the implementation arrangements of the present project.

109. **Under the Program Based Budgeting model that recently began in Burkina Faso, the proposed project is classified as a Category 1 project linked to the Program-budget titled "National Health Public Program" and coordinated by the General Directorate of Public Health (GDPH) at the central level of the Ministry of Health.** Embedded within the GDPH and under the direct supervision of the General Director of Public Health, a Project Coordinator will be contracted to oversee and support the project and then will be directly responsible for the achievement of the project's objectives.

110. **Under the previous health operations in Burkina Faso, a dedicated PIU was used for day-to-day fiduciary management of the project** (*Programme d'Appui au Développement Sanitaire, PADS*)**.** To institutionalize leadership and coordination of the activities supported by the operation, the project will use existing structures within the new MOH structure, both for fiduciary and technical aspects. The Directorate of Administration and Finance (DAF) will oversee the financial management aspects of Bank financing, while the Directorate of Public Procurement (*Direction des Marchés Publiques*, DMP) will oversee procurement aspects. Key technical actors will lead implementation of project activities based on their scope of oversight. For example, the Technical Secretariat for Universal Health Coverage and DGESS will lead activities primarily within Component 1 (strategic purchasing, CBHI, etc.) and coordinate across units and ministries (such as the Ministry of Civil Service and Welfare and the CNAMU). The Technical Secretariat for Demographic Dividend will work with the Directorates of Family Health, Nutrition and other relevant units for interventions related to maternal and child health (primarily covered in Component 2 of the project). The Directorate for Health Promotion (DLM) will work with key stakeholders within the MOH and across line ministries (Agriculture, etc.) for activities related to disease surveillance and health security under Component 3.

111. **The Review Committee is chaired by the General Secretary of the Ministry of Health, and comprises statutory members limited to 20 people from the structures involved in the program-budget of the project.** The observer members include technical and financial partners and any person whose participation in the sessions of the committee is deemed necessary. However, the number of observers cannot exceed three per session.

112. **Attributions of the review committee are detailed in decree n°2018 – 0092/PRES /PM/MINEFID dated 15 February 2018.** This decree pertains to general rules of development projects and programs implemented in Burkina Faso.

113. **The financial management (FM) arrangements for the project have been designed taking into account:** (i) Burkina Faso's recent political situation; (ii) the country's overall Public Finance Management (PFM) performance; and (iii) the World Bank's minimum requirements under the World Bank Policy and Directive on Investment Project Financing, which describes the World Bank's policies and procedures for FM.

114. **The legislative and institutional framework for public financial management is in place in Burkina Faso.** This framework is in line with, or approximates international standards. In addition, Burkina Faso has transposed

the WAEMU directives, regulations, and rules on public finances into national law. However, the challenges faced in operationalizing the various financial management components including cash constraints as well as compliance with this legislative framework, rules and regulations, do not allow at present to rely fully on the public expenditure framework for the proposed Project.

115. **Therefore, the Government of Burkina Faso has requested to use a ring-fenced financing mechanism for the fiduciary aspects of the project.** Specifically, the government has requested to set up a dedicated FM Unit within the Directorate of Administration and Finances (DAF) of the Ministry of Health, to manage the fiduciary aspects of the Project. More details are provided in the Appraisal Summary and Annex 1.

116. **Private sector engagement:** Learning from the recent outbreaks of Dengue fever that demonstrate the need for a more harmonized approach to disease surveillance and response within countries and between the public and private health sector, this project will aim: to (i) reduce barriers to private sector participation in health system surveillance and response to infectious disease outbreak; (ii) improve sustainable investment in this sector so that it can fully contribute to strengthen the whole health system; and (iii) strengthen the collaboration between the private and public sector to provide better quality of care and health services.

117. **Specifically, the project will strengthen the public private-partnership so that each sector can benefit from the comparative advantage of the other.** Trainings and behavior change communication will concern both the private sector and the public sectors; the inclusion of private sector data in the national system of information will be improved by establishing an interoperability between the National Health Data Warehouse (ENDOS) and private sector data and in the system of transport and transfer of samples as well; this sector will be involved in the multi-sectoral coordination platform according to the Onehealth approach. The terms and conditions of an effective supervision and controls of private facilities will be established by mutual agreement. Then, incentive mechanisms will be developed to improve the participation of the private sector in disease surveillance and data reporting.

118. **Systems Development (ICT, Logistics and Supply Chain Management System**): To enhance data quality reporting and real-time monitoring of health surveillance data, the project will develop and operationalize an electronic surveillance system using mobile technology and geographic information system (GIS) from the peripherical to the central level. In addition, the supply chain management will be improved both in the public and private sector. The distribution of specific screening inputs to health facilities during an emergency response, such as dengue fever outbreak, will no longer be exclusive to the public sector.

B. Results Monitoring and Evaluation Arrangements

119. **The Results Framework focuses on accountability for results in the delivery of RMNACH, nutrition and health security services.** The project approach to results monitoring aims at extending beyond tracking of inputs and outputs by placing a strong emphasis on intermediate outcomes. When possible, the proposed results framework will use existing indicators and data to measure the progress of both the project and its contribution to the overall national program; this will benefit the program by strengthening and increasing the efficiency of existing data collection mechanisms.

120. **Routine monthly and quarterly data collected via the web-based PBF system will be aggregated for the project's quarterly and annual indicators and be linked to the national DHIS-2 system.** The project

monitoring system will include (i) identification and consolidation of M&E indicators; (ii) training and capacity building initiatives at the national, regional, and local levels; (iii) standardized methods and tools to facilitate systematic collection and sharing of information; (iv) an independent review by external technical consultants (External Evaluation Agency); and (v) annual program evaluations and strategic planning exercises for each component.

121. **The GFF Investment Case will include both a Results Framework with key indicators to track progress in achieving objectives as well as a clearly defined learning agenda.** The content of the learning agenda, which may include impact evaluations, qualitative research, specific surveys, and process evaluations, will be defined later in 2018 during the process of developing the Investment Case.

122. **The project will also include a prospective evaluation for the multisectoral nutrition activities in addition to supporting through co-financing key surveys such as DHS, MICS, health facility surveys (for instance Service Delivery Indicators or Service Availability and Readiness Assessment surveys), and national health accounts.**

C. Sustainability

123. **Technical sustainability will be ensured by knowledge transfer activities throughout the Project**. While capacity already exists for implementing Component 1 through previous experience with PBF and an extensive training program which continues to build in-country capacity, some national technical entities such as the National Strategic Technical Unit, the National Health Insurance Fund unit, and the "*Résultologie*" Unit will benefit from capacity building activities during project implementation through trainings and on-the-job coaching. A training of trainers' program for strategic purchasing (SP)will be developed and will create a pool of knowledgeable strategic purchasing trainers who will then train additional trainers using cascade training to ensure capacity at all levels of the health system.

124. **Sustainability in terms of capacity to manage the Strategic Purchasing (SP) tool will be ensured in two ways:** (i) the inclusion of capacity transfer in the contract of the international institution to be contracted; and (ii) learning by doing. The TORs of the international firm will include specific capacity transfer requirements whereby the firm will be required to: (i) assist in the design, development and implementation of Strategic Purchasing tools (Testing of the tools); assist DGSP and NHIF in the preparation, organization, evaluation and follow up of the SP training at all levels; (ii) assist in the verification of quantity and quality at facility level and help strengthen the M&E system (through national DHIS-2); (iii) oversee the assessment made by local health verification teams who will verify the extent to which each health facility achieves its quantitative and qualitative performance indicators; (iv) support the process of household surveys by sub-contracting local organizations (CSOs) (procurement, training and monitoring); and (v) review the performance of CSOs contracted to carry out consistency checks between facilities records and exit surveys of patients.

125. **In parallel, the MOH will benefit from learning by doing.** The Technical Secretariat for Universal Health Coverage (TS-UHC) team in charge of SP implementation will directly learn from the day-to-day implementation of SP.

126. **Financial sustainability of SP can be reasonably achieved, given the limited cost of this mechanism and the co-financing by the government via the free care fund and the growing interest of other donors for it**. By spending US$4-5 per capita per year (including overhead costs) and less than US$100 million per year for

national coverage, given current expenditure patterns, the cost is likely to be affordable and sustainable in the long term. Additionally, by integrating an ongoing policy dialogue on reforming the financing structure of the MoH, including the replacement of the budget for health facility operational costs that is managed by a centralized decision-making approach with budget lines for SP subsidies which health facilities can plan and use in an autonomous manner and by making sure SP is embedded in the broader health sector national financing strategy, the project is expected to institutionalize these SP reforms. However, as in most Sub-Saharan countries, the relatively low levels of GDP per capita will require donor support to Burkina Faso for many years to come. Because of its direct focus on results, the support for the SP methodology has been popular with a wide array of donors and is likely to remain so in the medium term. The financial impact will be reflected in the national budget through the MOH's medium term expenditure framework (MTEF) and the intra-sectoral budget at year 3.

127. **Political commitment is strong as all project components are fully aligned with national priorities.** Burkina Faso has distinguished itself by acquiring political consensus on strategic purchasing and this was evident by the participatory and inclusive drafting of the Strategic Purchasing Orientation Document lead by the General Directorate of Studies and Sectoral Statistics in the Ministry of Health.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

128. **The UNDP 2016 Human development index ranked Burkina Faso 185th among 188 countries having provided comparable data.** The UNDP World Development report 2017 indicated that 43.7 percent of the population currently lives under the income poverty line of PPP US$1.90 a day. Three quarters of the population lives in rural areas. This reflects a need for development assistance to focus on high-impact interventions targeted at the poorest.

129. **According to the Burkina Faso SARA 2016 prepared by the MoH with the support of the World Health Organization (WHO), although mother and child health (MCH) services show a higher level of availability as compared to other services there are important disparities in terms of availability of key inputs**. The most vulnerable part of the population moreover lives in under-served areas.

130. **The proposed interventions are focused on the vulnerable and are specifically designed to scale-up interventions rendering needed essential health services available to them**, with a higher level of quality, while ensuring that they will not endure financial hardship to receive them, in line with the general definition of UHC.

131. **As reflected in national strategic documents, Burkina Faso is moving toward covering the whole population through a universal insurance mechanism, under the common NHIF pool.** To cover the informal sector, the country opted to depart from the traditional model of CBHI, with mandatory enrolment and budget subsidies to cover the poorest. This is the path followed by countries which managed the fastest take-off of their insurance schemes, for instance Rwanda, Ghana and more recently Senegal.

132. **The country also opted for a clear purchaser-provider split.** It is expected that the management of the free healthcare scheme by the NHIF will bring more efficiency in the use of resources. Later, with the support of

the proposed operation, the management of the PBF will be transferred to the NHIF, so that the fund can also purchase quality. Altogether, through this project, the World Bank is supporting the emergence of a strategic purchaser in Burkina Faso, in accordance with international best practice.

133. **It is obvious however that health financing alone cannot achieve the shift to higher quality/efficiency, patient-centered care.** It merely provides incentives to move in the right direction. Hence, the proposed project promotes, in components 2 and 3, essential medical services and health systems functions which have proven to have the highest impact on health outcomes, especially of the most vulnerable.

134. **A comprehensive economic assessment for the proposed Project could not be conducted due to the limited up-to-date data and information available to develop a formal cost-benefit analysis.** However, the operation is expected to improve the living conditions of the population through the reduction of financial risk, improved access to quality health care, in particular for the poor and vulnerable populations who did not have access to services, and health security.

135. **Expected impact on financial risk protection:** There are hints of an increase in financial risk protection. Over the past years, it was possible to observe a decrease of out-of-pocket payments (36.5 percent in 2015 down to 31.6 percent in 2016 according to NHA) while utilization increased from 1.74 to 2.49 contacts per inhabitant per year for the population below five years, and from 0.87 to 1.42 contacts per inhabitant per year for the general population for the same period. This seems to be a direct consequence of the introduction of the free healthcare scheme and hints at an actual increase in the protection against financial risk. However, other indicators highlight persisting issues. For instance, pharmaceuticals and medical devices represented more than 50 percent of out of pocket payments in 2016, which could underline a recourse to private pharmacies in case of stock-outs in the public sector.

136. **Through its interventions, the present project is expected to have a positive impact on financial risk protection through three channels**:

a. Through support to the scale up of the insurance component of the NHIF (for the population in both the informal and formal sectors), it is expected to contribute to increasing the coverage and consecutive prepayments for health significantly. By the end of the proposed project (end 2023), the NHIF plans to cover 100 percent of the formal sector and of those working in the “organized” informal sector, 25 percent of those working in the “non-organized” informal sector, and subsidize the enrollment of 50 percent of the most vulnerable (indigents);
b. Through its support to optimizing the free healthcare scheme, it will contribute to an improved management of the resources dedicated to this scheme and hence limit stock-outs; and
c. Through direct support, as part of Components 1 and 2, to improve the effectiveness and quality of care related to RMNCHA-N, the proposed project is likely to contribute to a further decline of out-of-pocket payments and increase the protection of the population of Burkina Faso against financial risk.

137. **Buying cost-efficient RMNCAH+N interventions:** Overall, the set of interventions on RMNCAH-N and nutrition that will be strategically purchased have proven to be cost effective in a variety of studies and across many countries and evidence suggests that providing this package to mothers and children is highly cost-effective (US$82-142 per disability-adjusted life year (DALY) averted). With its strategic purchasing component, the project will contribute to improved allocative and technical efficiency in the health sector, which remain an issue in Burkina Faso. Total health expenditures have nearly doubled since 2000, but many health outcomes

remain poor. Intelligent and prioritized investments in health are still needed to improve health outcomes, which this project would support. As part of the development of the GFF Investment Case in the course of 2018, a number of studies are scheduled to conduct an equity and cost-efficiency assessment which will allow for in-depth analysis of the expected impact of the planned interventions. PBF will be scaled-up to priority regions to provide a financial incentive for the qualitative delivery of this package of care focused on RMNCAH-N, which in turn will create a strong incentive for increased utilization.

138. **Factoring in health security:** The health security component of the project will reinforce protection and especially prevention measures against infectious diseases in Burkina Faso. These infectious diseases remain the leading cause of mortality in Burkina (especially for children under-five) and, more particularly, those with epidemic potential remain a huge threat to the destabilization of the entire health system (as recently demonstrated by the Ebola virus disease in Guinea, Liberia or Sierra Leone). Fear, widespread panic and the quarantine of infected patients during epidemic outbreaks have also had a huge economic impact on trade in and between countries by reducing mobility and thus the consumption habits. Component 3 would thus help Burkina Faso's health system be more resilient and will strengthen it in terms of early detection and rapid containment of epidemic-prone diseases, hence preserving health and well-being particularly among mothers and children.

139. **It is worth noting that the two first components are indirectly contributing to some of the achievements of the third component**. By boosting financial risk protection and guaranteeing the availability and quality of care provided, they indeed create strong incentives for increased utilization and overall improvement of the population's trust in health providers. And it has been well documented that frequent and early contact with providers is a condition for prevention and early diagnosis.

B. Fiduciary

(i) Financial Management

140. **The assessment of the DAF and the FM Unit was carried out in February 2018**. The objective of the assessment was to determine whether the DAF and the FM Unit have adequate FM arrangements in place to ensure that the Project funds will be used only for the purposes for which the financing was provided, with due attention to considerations of economy and efficiency. The FM assessment considers, based on the existing FM arrangements, the degree to which (a) the budgeted expenditures are realistic, prepared with due regard to relevant policies, and executed in an orderly and predictable manner, (b) reasonable records are maintained, (c) financial reports are produced and disseminated for decision-making, management, and reporting, (d) adequate funds are available to finance the Project, (e) there are reasonable controls over Project funds, and (f) independent and competent audit arrangements are in place. The assessment complied with the Financial Management Manual for World Bank investment project financing operations, effective December 11, 2014.

141. **The main finding of this assessment was that the DAF is not familiar with Bank-financed projects including FM procedures**. None of the 40 actual employees of the DAF are familiar with Bank-financed project procedures and requirements. The assessment also revealed that the budget and accounting software used by the DAF (CID for the budget execution and CIE for accounting and reporting) were not fully effective and that the accounting of projects funded by other donors (West African Health Organization - WAHO, UNICEF…)

was made through Excel. However, the execution of the budget allocated to the Ministry of Health follows the country public expenditure chain and relies on the national institutions in charge of internal and external controls (the Technical Inspection Services (ITS) within the Ministry of Health, the General Finance Inspectorate (Inspection Générale des Finances, IGF) within the Ministry of Economy, Finance and Development (MINEFID); the Court of Accounts (*Cour des Comptes*) and the Control and Anti-Corruption State Authority (*Autorité Supérieure de Contrôle d'Etat et de Lutte contre la Corruption, ASCE-LC*) those performances are globally deemed acceptable despite the financial and human resources capacity challenges. Finally, the assessment revealed that the dedicated FM Unit is not established yet within the DAF of the Ministry of Health.

142. **The overall FM risk for the project is rated Substantial.** This is due to (i) the lack of experiences and familiarity of the DAF and Dedicated FM Unit of the Ministry of Health with Bank-FM procedures; (ii) the lack of an effective and operational accounting software and (iii) the design of the project which involves several actors with beneficiaries based in remote and geographically dispersed locations within the country. The project will be supervised on a risk-based approach.

143. **From the assessment of areas critical for the operationalization of the FM Unit to be established with the DAF of the Ministry of Heath, and of related identified risk factors, it was concluded that Ministry of Health could be in a position to manage World Bank funds once the following measures are implemented prior to and after project effectiveness:** (i) appoint, on a competitive basis, the key FM staff including the Project Financial Management Officer (*Résponsable Administratif et Financier – RAF*) and one accountant; (ii) draft the FM procedures manual and the Project Implementation Manual; and (iii) acquire and install an accounting software acceptable to the Bank and train the users of the software. The Project staffing arrangements will be finalized once the project implementation design is completed. The national institutions in charge of internal and administrative controls listed above will continue to fulfill their legal mandate.

144. **Furthermore, as part of the implementation of the Decree related to the modalities of World Bank-financed operations in Burkina Faso, the Ministry of Finance will assign an internal controller to the Project.** The internal control policies, rules and procedures will be detailed in the Project Administrative, Financial and Accounting Procedures Manual due by project effectiveness. The internal auditor's work program and reports will be submitted to the World Bank bi-annually, no later than 45 days after the end of each semester.

145. **Finally, the DAF will be required to prepare and submit to the Bank,** (a) approved annual work plan and budget (AWPB) not later than November 30 of the year preceding the year the AWPB should be implemented; (b) interim un-audited financial reports (IFR) on a quarterly basis; and (c) audited annual financial statements (e.g. audit reports prepared by independent external auditors). The project will comply with the World Bank disclosure policy of audit reports. The annual work plan and budget, the quarterly IFR and the annual financial statements will reflect the activities implemented directly by UNFPA and other implementing agencies.

146. **The grant will finance 100 percent of eligible expenditures of the project inclusive of tax**. An initial deposit equivalent to an initial expenditures forecast will be released by IDA at the request of the project upon effectiveness. A designated account (DA) in XOF will be opened at the central bank (BCEAO). A Project Account (PA), managed by the FM Unit with signatories of the Project Manager and the DAF, will be opened in a commercial bank under terms and conditions acceptable to the Bank. This PA will be used to pay for all the expenditures related to the project. Terms and conditions for justification of IDA funds transferred to other

agencies involved in the implementation of the project activities for them to make payments of expenditures, will be detailed in the subsidiary grant agreements or the Memorandum of Understanding between the Project and the agency, as well as in the implementation manual. Interest incomes on the PA will be deposited into a sub-account opened in a commercial bank and used according to the FM manual.

147. **Funds flow:** Upon credit effectiveness, transaction-based disbursements will be used. The project will finance 100 percent of eligible expenditures inclusive of taxes.

148. **Disbursements under this project will be carried out in accordance with the provisions of the Disbursement Guidelines ("World Bank Disbursement Guidelines for Projects, dated February 1, 2017"), the Disbursement Letters and the Financing Agreements.** An initial advance up to the ceiling of the DA will be made into the DA, and subsequent disbursements will be made against submission of Statements of Expenditures (SOE) reporting on the use of the initial/previous advance. The E-signature of Withdrawal Application (WA) will be used by the project and WA will be prepared on a monthly basis. The other methods of disbursing the funds (reimbursement, direct payment) will also be available to the project. The ceiling of the DA will be stated in the Disbursement and Financial Information Letter (DFIL). Withdrawal applications will be accompanied by all records required by the Bank in the Disbursement Letter. All supporting documentation will be retained at MoH and must be made available for periodic review by Bank' missions and external auditors.

149. **Disbursement of funds to UNFPA:** Upon signing of the agreement between the government and UNFPA, application for withdrawal of proceeds will be prepared by the Project and submitted to IDA. The special World Bank disbursement procedures will be used to establish a "Blanket Commitment" to allow the amount to be advanced. Funds withdrawn from the IDA grant account will be deposited directly into the UN bank account provided by UNFPA for the project activities to be implemented by the UN agency. The amount advanced will be documented through the quarterly unaudited Interim Financial Reports as actual expenditures are incurred by the UNFPA.

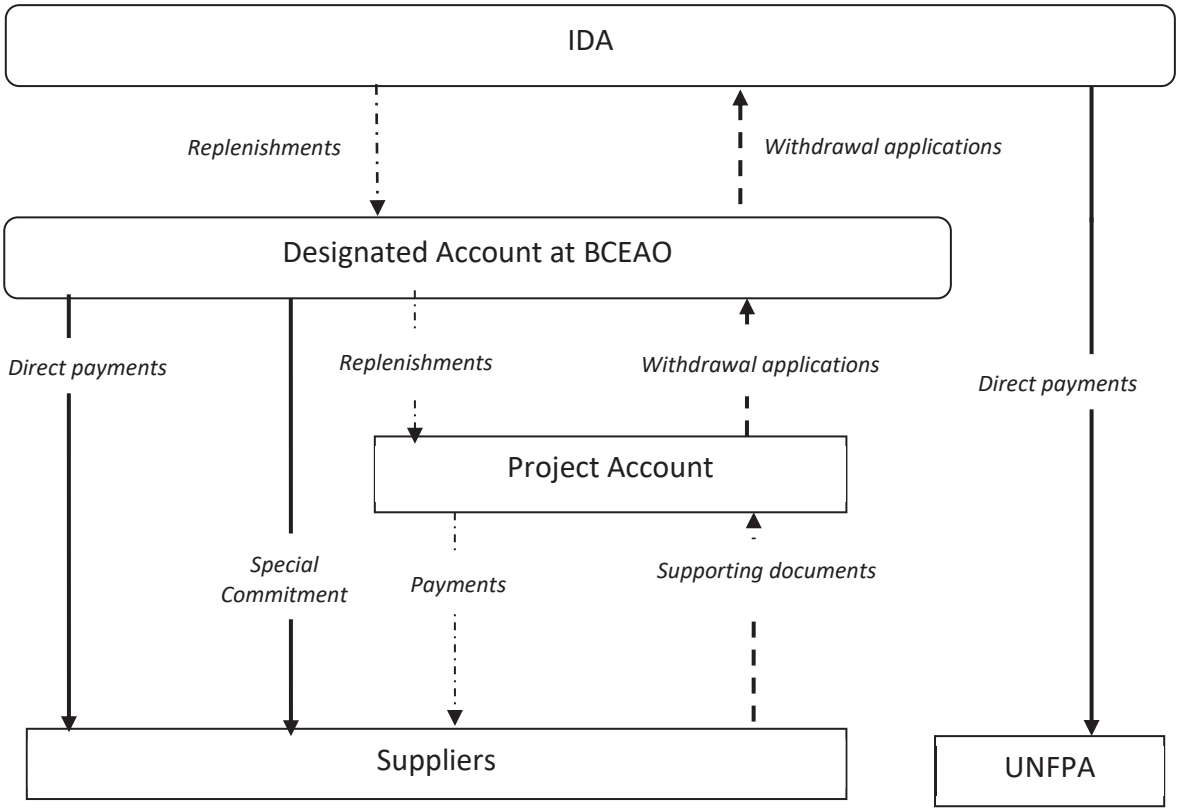
150. **Payments to other implementation Agencies and services providers:** the DAF will make payments to other implementing Agencies in regard to the specified activities in the components of the project. Payments will be made in accordance with the payment modalities, as specified in the respective contracts/conventions. In addition to these supporting documents, the DAF will consider the findings of the internal and external auditors while approving the payments. The DAF will reserve the right to verify the expenditures ex-post, and refunds might be requested for non-respect of contractual/convention clauses.

Table 5: FM action plan

#	Items	Timeline	Activities
	Staffing		
1	FM Officer (RAF) and Accountant	Prior to Project Effectiveness	Hire on a competitive basis or appoint a FM Officer and an accountant with experience and qualifications acceptable to the Association.
	Accounting		
2	Accounting software	Two months following Project Effectiveness	Acquire and set up no later than two months after effectiveness an accounting software acceptable to the Association

3	Project Administrative, Accounting and Financial Procedures Manual	Prior to Project Effectiveness	Adopt the Project Administrative, Accounting and Financial Procedures Manual
	Internal control		
5	Internal auditor	Two months following Project Effectiveness.	An internal auditor will be assigned to the project by the Ministry of Finance
	Auditing		
6	External auditor	By six months after Project Effectiveness	Recruit an external auditor to conduct an audit of the Project annual financial statements

Figure 6: Funds Flow Chart



(ii) Procurement

151. **Applicable policies and procedures:** Procurement for works, goods, non-consulting, and consulting services for the **Project** will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers (Procurement Regulations), July 2016--revised November 2017, and the "World Bank's Anti-Corruption Guidelines: Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants" (revised as of July 1, 2016), and the provisions stipulated in the Financing Agreement.

152. All goods, works and non-consulting services will be procured in accordance with the requirements set forth or referred to in the Section VI. Approved Selection Methods: Goods, Works and Non-Consulting Services of the "Procurement Regulations," the consulting services will be procured in accordance with the requirements set forth or referred to in the Section VII. Approved Selection Methods: Consulting Services of the "Procurement Regulations," the Project Procurement Strategy for Development (PPSD), and Procurement Plan approved by the World Bank.

153. **When approaching the national market, as agreed in the Procurement Plan, the country's own procurement procedures may be used with the requirements set forth or referred to in paragraphs 5.3 to 5.6 related to the National Procurement Procedures.** Burkina Faso's standard bidding documents are acceptable to be used for National Competitive Bidding, provided a clause is included to reject bid calculation error which is plus/minus 15 percent of the initial bid's amount (before correction).

154. **Procurement risk assessment and mitigating measures**: Following the recently adopted regulation of projects and programs, it is intended to integrate the Project PIU into the program-budget managed by a program coordinator. The proposed project is classified as a Category 1 (i.e. directly implemented by the public administration) project linked to the program-budget titled "National Health Public Program (NHPP)" and coordinated by the General Directorate of Public Health (GDPH) at the central level of the Ministry of Health. The NHPP will be responsible for implementing this project. However, it has no experience implementing World Bank-financed projects. The procurement risk is rated **Substantial** due to: (i) Lack of experience of the NHPP to implement projects financed by the World Bank; (ii) MoH's DAF, DMP and DCMEF have no experience on the World Bank's new procurement framework; and (iii) Delays in the procurement process which are mainly due to delays in the review of files and in the publication of procurement notices by DCMEF who is in charge of prior control; difficulties in mobilizing the technical sub-commissions; and the numerous unforeseen interactions between the contracting authorities and the control structures due largely to the absence of a manual of procedures.

Table 5: Procurement Mitigation Measures

Implementing Agency	Procurement mitigation measures	By when	Responsible
MoH	Train the DAF, DMP, DCMEF and the Tender Committee on the World Bank's New Procurement Framework	3 months after effectiveness	NHPP and World Bank
NHPP	Elaborate and submit for IDA approval the Project Implementation Manual including the section on Procurement	3 months after effectiveness	NHPP
NHPP	Nominate or hire a procurement specialist with TORs, experience and knowledge acceptable by IDA	3 months after effectiveness	NHPP
NHPP	Deploy and use the procurement tracking system developed for the MoH and Economic Governance Project	3 months after effectiveness	NHPP

155. **Procurement plan and PPSD**. The client has developed a Project Procurement Strategy for Development (PPSD), that describes how procurement support the development objectives of the project and deliver the best Value for Money and a procurement plan covering at least the 18 first months of the project implementation. The Bank reviewed the PPSD and draft Procurement Plan prior to loan negotiations, providing non-objection on May 24th, 2018. The Procurement Plan, including its updates, shall include for each contract (a) a brief description of the activities/contracts, (b) the selection methods to be applied, (c) the cost estimates, (d) time schedules, (e) the Bank's review requirements; and (f) any other relevant procurement information. Any updates of the Procurement plan shall be submitted to the World Bank for approval. The Recipient shall use the World Bank's online procurement planning and tracking tools (STEP) to prepare, clear and update its Procurement Plans and conduct all procurement transactions.

156. **Oversight and monitoring arrangements for procurement.** A Project Implementation Manual (PIM) will be developed prior to effectiveness and will be submitted to Bank for review and approval. The PIM will define the project's internal organization, role and responsibilities for each shareholder (NHPP, PIU, DAF, DMP, DCMF, ARCOP, Etc.) and its implementation procedures, and will include, among other things, all the relevant procedures for calling for bids, selecting consultants, and awarding contracts. The project monitoring arrangements for procurement will be analyzed and developed.

C. Safeguards

(i) Environmental Safeguards

157. **The proposed operation aims to stimulate utilization of services, which will have an impact on the total amount of medical wastes produced by health facilities.**

158. **With respect to the project's development objectives, components, sub-components and activities to be implemented, the project is rated as a Category B (Partial Assessment) with a Moderate risk and one policy triggered: OP/BP 4.01, Environmental Assessment.** A Medical Wastes Management Plan (MWMP) has been prepared, reviewed, approved and published at the country level and on the World Bank's web site on May 22, 2018. This plan was prepared in 2005, updated in 2011 and 2017 for the period of 2018 – 2020; it will be implemented by the Ministry of Health, and regularly monitored and evaluated by the national agency in charge of environmental assessments (BUNEE).

159. **Potential risks and negative impacts at the implementation stage will consist of household and medical waste production increasing (see the Project Development Objective Indicators and Health facilities providing youth friendly services), site specific and easily manageable by the system put in place.** Potential positive impacts will consist of landscaping of health facilities in view of climate change effects. This MWMP is organized around the following aspects: (i) a situational analysis of wastes management; (ii) a three-year priority actions for waste management; (iii) a performance framework; (iv) an operational plan of activities; (v) a monitoring and evaluation mechanism; (vi) recommended capacity building measures for environmental planning and monitoring of project activities; and (vii) a financing plan. The proposed project will comply with the requirements of the World Bank's new Environmental and Social Management Framework. A roadmap outlines the steps, budgets, responsibilities and timelines for consideration of environmental safeguards, including updating, reviewing, approving and publishing the instrument, recruitment and training of the Environmental Specialist of the Project Implementation Unit and the other stakeholders.

160. **Responsibility and oversight of the project's overall compliance with national and World Bank triggered safeguard policy will be devolved to the environmental specialist within the Project Implementation Unit (PIU).** He will serve as the main person in charge of project implementation and monitoring of safeguard aspects. In close collaboration with the national environmental agency, he will periodically monitor the program's compliance with proposed mitigation measures.

161. **The potential beneficiaries (public and private), the modalities of interventions, the chain of management of the MWMP, the sites of discharges, the transport logistics, the follow-up and the evaluation system will be an integral part to align the plan with the national health vision, including capacity building for stakeholders, climate change, risks management, biodiversity and labor influx.**

(ii) Social Safeguards

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

163. **Moreover, the proposed operation will have a positive impact on gender in Burkina Faso.** Given that the Project's objectives are to improve maternal and child health in target areas, improving women's health is an essential component of the intervention. Particular attention will also be given to ensuring the active participation of women in project areas through the use of community-based organizations (local NGOs, women's groups, agricultural groups, etc.). The Project is expected to have a positive impact not only on pregnant women but on all women, as PBF credits will improve the quality of care for the identified package of health services essential for the general population. **No specific social safeguards policies will be triggered by the project.**

164. **Involuntary Resettlement:** The expected activities of the project aim to reinforce and stimulate the frequency of the country health services. No activities will involve the acquisition of land that would lead to loss of property, loss or disruption to sources of income or livelihood, etc. No physical investment that could trigger World Bank OP / BP 4.12 is expected under the project implementation.

(iii) Other Safeguards

165. **No other safeguards policies will be triggered.**

(iv) Grievance Redress Mechanisms

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

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

V. KEY RISKS

167. **The overall risk associated with the project is rated "Substantial".** While the government has shown strong commitment to its various health financing and UHC reforms and to the project, the regulatory and stewardship functions at the central level have to be strengthened, and may hinder implementation. The complexity and ambition of the project are significant and increase levels of implementation risk. As such Political and Governance, Sectoral Strategies and Policies, Technical design of the Project, Institutional Capacity for Implementation and Sustainability, and Fiduciary are all rated Substantial.

168. **Various mitigation measures have been put in place to address these risks.** The risks related to politics and governance, as well as health sector strategies and policies, will be mitigated by supporting and aligning with the government's commitment for reform in Burkina Faso's health sector. Alignment with the key partners in the health sector should also reduce program incoherence and donor misalignment risks. As part of the GFF process, the government will lead a participatory process to identify priorities around RMNCAH+N to develop an investment case. This process will be undertaken using a country platform comprised of relevant ministries, financial and technical development partners, civil society and private sector, creating broad ownership and buy-in. Not only will the Investment Case, thus, be a jointly consulted and agreed document, the country platform will be charged with monitoring the progress of implementation of the Investment Case over the ensuing years. This monitoring function will benefit not only GFF investments but also other partner investments including IDA by ensuring that a vested group of stakeholders are overseeing the use of funds for a shared purpose.

169. **The risks related to the technical design of the project are mitigated as the project builds on lessons learned from several years of engagement by the World Bank in Burkina Faso's health sector.** Knowledge is also being drawn from considerable investments in education and social protection, thus bringing a set of comprehensive experiences in human development in the country.

170. **The risks related to institutional capacity for implementation and sustainability, as well as fiduciary risks, will be mitigated through measures identified in the financial management and procurement action plans.** These include significant technical assistance and support to the Ministry of Health to ensure sufficient fiduciary capacity is in place for effective project implementation. While the MOH already manages significant resources from development partners, expertise from the PIU of the current World Bank project (PADS), as well as additional consultants, will be mobilized in a timely manner to give on-site support and training.

171. **In addition, given the unstable security situation in the regions bordering Mali and Niger (the North and the Southwest), additional implementation challenges in scaling-up will exist.** For example, implementation support for the Reproductive Health Project (P119917) has been hampered due to the security concerns. To

address this issue, the project will potentially contract local non-governmental organizations, whose capacity will be built to provide technical assistance and implementation support in the rollout of the programs in the insecure regions.

172. **The risk of the ability of the government to mobilize counterpart financing in a timely manner remains significant although it has been reduced, given the recent actions taken by the Ministry of Finance through the Program-Based Budgeting reform (where each ministry will plan and integrate counterpart contributions in its own budget).** The National Strategic Purchasing Technical Unit, while operational, remains in its infancy stage and needs substantial coaching and hands-on training and support to be effective in its role as a national coordination body.

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework

Project Development Objectives(s)

The Project Development Objective (PDO) is to increase the quality and utilization of health services with a particular focus on maternal, child and adolescent health, nutrition and disease surveillance

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	End Target
Increase the quality and utilization of health services					
People who have received essential health, nutrition, and population (HNP) services		Yes	Number	0.00	5,000,000.00
Number of women and children who have received basic nutrition services		Yes	Number	0.00	3,000,000.00
Average score of the quality of care checklist			Number	0.00	70.00
Improved disease surveillance					
Multi-hazard national public health emergency preparedness and response plan is implemented			Number	1.00	4.00

Intermediate Results Indicators by Components	DLI	CRI	Unit of Measure	Baseline	End Target
Strengthening Health System Capacity					
Facilities receiving strategic purchasing quality payments on time			Percentage	0.00	75.00
Number of districts applying ths strategic purchasing approach as a purchasing mechanism for PHC			Number	19.00	50.00
National Health Insurance Fund operationalization index			Number	0.00	3.00
Strengthening Delivery of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition					
Number of community health workers receiving training on community-level IYCF and IMPC			Number	0.00	5,000.00
Number of women using modern contraceptives			Number	0.00	1,650,000.00
Percent of newborns receiving birth certificates			Percentage	81.00	90.00
Number of children immunized			Number	0.00	750,000.00
Proportion of women delivering in facilities in the strategic purchasing program receiving post-partum family planning			Percentage	0.00	50.00
Proportion of adolescent girls delivering in facilities in the strategic purchasing program receiving post-partum family planning			Percentage	0.00	50.00
Average exit interviews scores of RMNCAH+N services in facilities in the strategic purchasing program			Number	0.00	70.00
Reinforcing Health Security and Supporting Institutional Strengthening					
Interoperable, interconnected, electronic real-time reporting			Number	2.00	4.00

system (national capacity score)					
Mechanism is established for the coordination of relevant sectors for implementation of IHR			Number	2.00	4.00

Monitoring & Evaluation Plan: PDO Indicators	
Indicator Name	People who have received essential health, nutrition, and population (HNP) services
Definition/Description	
Frequency	Quarterly
Data Source	MOH HMIS
Methodology for Data Collection	HMIS data
Responsibility for Data Collection	MOH
Indicator Name	Number of women and children who have received basic nutrition services
Definition/Description	
Frequency	Quarterly
Data Source	MOH HMIS
Methodology for Data Collection	HMIS data

Responsibility for Data Collection	MOH
Indicator Name	Average score of the quality of care checklist
Definition/Description	Average score of the quality of care checklist as per the defined methodology in the strategic purchasing strategy
Frequency	Every semester
Data Source	Strategic purchasing operational data
Methodology for Data Collection	Routine quality of care evaluation scores documented
Responsibility for Data Collection	MOH
Indicator Name	Multi-hazard national public health emergency preparedness and response plan is implemented
Definition/Description	Description: JEE Score: Capacity graded on a score of 1-5 where: 1 = no capacity (national public health emergency preparedness and response plan is not available to meet the IHR core capacity requirements); 2 = limited capacity (a multi-hazard national public health emergency preparedness and response plan to meet IHR core capacity requirements has been developed); 3 = developed capacity (national public health emergency response plan(s) incorporates IHR related hazards and Points of Entry AND Surge capacity to respond to public health emergencies of national and international concern is available); 4 = demonstrated capacity (procedures, plans or strategy in place to reallocate or mobilize resources from national and intermediate levels to support action at local response level (including capacity to scaling up the level of response); 5 = sustainable capacity (the national public health emergency response plan(s) is implemented/tested in actual emergency or simulation exercises and updated as needed).

Frequency	Annually
Data Source	JEE and OIE PVS Experts report
Methodology for Data Collection	JEE and OIE PVS Experts report
Responsibility for Data Collection	

Monitoring & Evaluation Plan: Intermediate Results Indicators	
Indicator Name	Facilities receiving strategic purchasing quality payments on time
Definition/Description	Numerator: Total number of districts enrolled in the strategic purchasing program who receive their quality subsidies within three months of verification. Denominator: Total number of districts enrolled in the strategic purchasing program
Frequency	Every semester
Data Source	ST-CSU reports
Methodology for Data Collection	Reporting mechanisms as defined by the strategic purchasing strategy
Responsibility for Data Collection	ST-CSU

Indicator Name	Number of districts applying ths strategic purchasing approach as a purchasing mechanism for PHC
Definition/Description	Number of districts applying strategic purchasing (as defined in the National Strategic Purchasing Strategy, i.e. purchasing of both quantity and quality and including robust verification mechanisms) as purchasing mechanism for PHC
Frequency	Annual
Data Source	ST-CSU reports
Methodology for Data Collection	Counting number of districts applying PBF
Responsibility for Data Collection	ST-CSU
Indicator Name	National Health Insurance Fund operationalization index
Definition/Description	This indicator is an index which reflects the effectiveness of NHI funds schemes dedicated to the target population of the project (namely: free healthcare scheme, CBHI-based scheme for the informal sector, and subsidization of the indigents' enrolment in the CBHI-based scheme). Effectiveness of each scheme will be assessed against enrolment, payments to facilities, reception of budget subsidies by the NHIS, and recording of the preceding in the NHI fund information system)
Frequency	Annual
Data Source	National Health Insurance Fund
Methodology for Data Collection	Annual evaluation routine enrolment / subsidies / payment records
Responsibility for Data Collection	NHI Fund

Indicator Name	Number of community health workers receiving training on community-level IYCF and IMPC
Definition/Description	Number of community health workers receiving training on community-level Infant and Young Child Feedbing (IYCF) and Integrated Management of Childhood Illness (IMCI)
Frequency	Semesterly
Data Source	MOH reports (Specific directorate to be identified)
Methodology for Data Collection	Counting number of CHWs newly trained on IMCI
Responsibility for Data Collection	MOH
Indicator Name	Number of women using modern contraceptives
Definition/Description	Number of women using modern contraceptive methods
Frequency	Quarterly
Data Source	HMIS reports
Methodology for Data Collection	Facilities report to HMIS using monthly activity report
Responsibility for Data Collection	MOH
Indicator Name	Percent of newborns receiving birth certificates
Definition/Description	Percent of newborns receiving birth certificates
Frequency	Annual

Data Source	TBD
Methodology for Data Collection	Annual reports
Responsibility for Data Collection	MOH
Indicator Name	Number of children immunized
Definition/Description	Number of children immunized
Frequency	Quarterly
Data Source	HMIS reports
Methodology for Data Collection	Data from HMIS monthly reports
Responsibility for Data Collection	MOH
Indicator Name	Proportion of women delivering in facilities in the strategic purchasing program receiving post-partum family planning
Definition/Description	Proportion of women delivering in facilities in the strategic purchasing program receiving post-partum family planning
Frequency	Quarterly
Data Source	RBF reporting system

Methodology for Data Collection	Routine quality of care evaluation scores
Responsibility for Data Collection	MOH
Indicator Name	Proportion of adolescent girls delivering in facilities in the strategic purchasing program receiving post-partum family planning
Definition/Description	Proportion of adolescent girls (as per national definition) delivering in PBF facilities receiving post-partum family planning
Frequency	Quarterly
Data Source	Quarterly
Methodology for Data Collection	RBF reporting system
Responsibility for Data Collection	MOH
Indicator Name	Average exit interviews scores of RMNCAH+N services in facilities in the strategic purchasing program
Definition/Description	Average score (0 to 100) of exit interviews (to be developed) of patients receiving RMNCAH+N services in strategic purchasing facilities
Frequency	Quarterly
Data Source	Exit interview data (RBF monitoring data)
Methodology for Data Collection	Exit interviews

Responsibility for Data Collection	MOH
Indicator Name	Interoperable, interconnected, electronic real-time reporting system (national capacity score)
Definition/Description	Capacity graded on a score of 1-5 where: 1 = no capacity (national public health emergency preparedness and response plan is not available to meet the IHR core capacity requirements); 2 = limited capacity (a multi-hazard national public health emergency preparedness and response plan to meet IHR core capacity requirements has been developed); 3 = developed capacity (national public health emergency response plan(s) incorporates IHR related hazards and Points of Entry AND Surge capacity to respond to public health emergencies of national and international concern is available); 4 = demonstrated capacity (procedures, plans or strategy in place to reallocate or mobilize resources from national and intermediate levels to support action at local response level (including capacity to scaling up the level of response); 5 = sustainable capacity (the national public health emergency response plan(s) is implemented/tested in actual emergency or simulation exercises and updated as needed)
Frequency	Annually
Data Source	JEE and OIE PVS Experts report
Methodology for Data Collection	JEE and OIE PVS Experts report
Responsibility for Data Collection	

Indicator Name	Mechanism is established for the coordination of relevant sectors for implementation of IHR
Definition/Description	Capacity graded on a score of 1-5 where: 1 = no capacity (Coordination mechanism between relevant ministries is not in place); 2 = limited capacity (Coordination mechanism between relevant ministries is in place); (National Standard Operating Procedures (SOPs) or equivalent exists for the coordination between IHR NFP and relevant sectors); 3 = developed capacity (A multisectoral, multidisciplinary body, committee or taskforce addressing IHR requirements on surveillance and response for public health emergencies of national and international concern is in place and participated in latest event); 4 = demonstrated capacity (Multisectoral and multidisciplinary coordination and communication mechanisms are tested and updated regularly through exercises or through the occurrence of an actual event; Action plan developed to incorporate lessons learnt of multisectoral and multidisciplinary coordination and communication mechanisms); 5 = sustainable capacity Annual updates on the status of IHR implementation to stakeholders across all relevant sectors conducted
Frequency	Annual
Data Source	JEE (IHR and GHSA) and OIE PVS evaluation at year-3 and end of project
Methodology for Data Collection	JEE and OIE PVS Experts report
Responsibility for Data Collection	JEE and OIE PVS Experts report

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Burkina Faso
Health Services Reinforcement Project

Project institutional and implementation arrangements

- ✓ **Under the Program Based Budgeting model that recently began in Burkina Faso, the proposed project is classified as a Category 1 project linked to the Program-budget titled "National Health Public Program" and coordinated by the General Directorate of Public Health (GDPH) at the central level of the Ministry of Health.** Embedded within the GDPH and under the direct supervision of General Director of Public Health, a Project Coordinator will be contracted to oversee and support the project and then will be directly responsible of the achievement of the project's objectives.

- ✓ **The review committee is chaired by the Secretary General or any other executive designated by the Ministry of health and comprises statutory members limited to twenty (20) people from the structures involved in the program-budget of the project.** The observer members are composed of the technical and financial partners and any person whose participation in the sessions of the committee is deemed necessary. However, their number cannot exceed three (03) persons per session.

- ✓ **The attributions of the review committee are defined by the national decree on general rules pertaining to development programs and projects.**

- ✓ **Also, as part of the GFF process, the national GFF coordination platform will oversee achievement of interventions related to the GFF Investment Case and Health Financing Strategy.** The role and composition of the GFF platform (integrated into existing in-country coordination mechanisms) was validated during the GFF initiation mission in February 2018. As per the PNDES, each sector (14) has established a Sectoral Dialogue Framework (*Cadre Sectoriel de Développement (CSD*)), including the health sector. The CSD for health includes a wide array of stakeholders, including government (MOH as well as other relevant ministries), civil society and development partners. As such, it was deemed appropriate to use the health CSD as the coordination platform for GFF activities in Burkina Faso.

- ✓ **Under the previous health operations in Burkina Faso, a dedicated PIU was used for day-to-day fiduciary management of the project** (*Programme d'Appui au Développement Sanitaire, PADS*)**.** To institutionalize leadership and coordination of the activities supported by the operation, the project will use existing structures within the new MOH structure, both for fiduciary and technical aspects. The DAF will oversee financial management aspects of Bank financing, while the Directorate of Public Procurement (*Direction des Marchés Publiques, DMP*) will oversee procurement aspects. Key technical actors will lead implementation of project activities based on their scope of oversight. For example, the Technical Secretariat for Universal Health Coverage and DGESS will lead activities primarily within Component 1 (strategic purchasing, CBHI, etc.) and coordinate across units and ministries (such as the Minister of Civil Service and Welfare and the CNAMU). The Technical Secretariat for Demographic Dividend will work with the Directorate of Family Health, Nutrition and other relevant units for interventions related to maternal and child health (primarily covered in Component 2 of the project). The Directorate for Illness Prevention (DLM) will work with key stakeholders within the MOH

and across line ministries (Agriculture, etc.) for activities related to disease surveillance and health security under Component 3.

Project administration mechanisms

- ✓ **Under the proposed operation no dedicated PIU external to the ministry will be created, as was the case for the RHP.** As the experience with the PADS staff was highly satisfactory and they hold invaluable experience and knowledge in implementation of the PBF program, certain staff from PADS will either be transferred to the DAF and DMP or provide punctual technical assistance. These include the Financial Management Specialist, the Procurement Specialist, the Accountant and Assistant Accountant, and Internal Auditor.

- ✓ **The project will also support the recruitment of additional technical staff to support the programs and departments involved in GFF-related processe**s. These include a Reproductive Health Specialist and Monitoring and Evaluation Specialist (with international experience) for the National Program for the reduction of Maternal and Child Mortality and a Health Economist and Health Financing Expert for the Department of Financial Resources and Planning within the Ministry of Public Health. Other experts, such as a PBF Expert, a Public Health expert, a Health System Reform Expert, a Health Economist, a Pharmaceutical Specialist, a Communications Expert, and a Monitoring and Evaluation Specialist will potentially be recruited in accordance with IDA guidelines for the selection of consultants to provide support to units and directorates involved in project implementation. Other experts may be recruited on a need basis.

- ✓ **The project policies and procedures will be incorporated in a project implementation manual.** It will be completed by a national strategic purchasing manual prepared by the ST-CSU. The World Bank will ensure that technical manuals are consistent with the project's overall implementation manual and safeguard instruments.

- ✓ **Counter-verification of the strategic purchasing program's results will be conducted by an independent third party.** Certain counter-verification mechanisms exist in the ongoing free healthcare program but they have been deemed insufficiently rigorous and will be strengthened through the program. The independent third party will be contracted by the Ministry of Health within nine months of effectiveness and replace the NGOs currently conductive verification activities under the free healthcare program. The EEA's roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted for which SP payments have been made.

- ✓ **The financing will comply with the existing manual of procedures and funds received and expenses will be included in quarterly financial reports according to the same format.**

- ✓ **All project funds will be subject to a financial audit following existing audit arrangements.** The terms of reference of the existing independent external auditor will be amended to take into account this financing.

Financial management

12. **The financial management (FM) arrangements for the project have been designed with consideration for**: (i) Burkina Faso's recent political situation; (ii) the country's overall PFM performance; and (iii) also considering

the Bank's minimum requirements under Bank Policy and Directive–IPF, which describes the overall Bank policies and procedures for FM.

13. **The legislative and institutional framework for public financial management is in place in Burkina Faso. This framework is in line with, or approximates international standar**ds. In addition, Burkina Faso has transposed the WAEMU directives, regulations, and rules on public finances into national law. However, the challenges faced in operationalizing the various financial management components including cash constraints as well as compliance with this legislative framework, rules and regulations, do not allow at present to rely fully on the public expenditure framework for the proposed Project.

14. **Therefore, the Government of Burkina Faso has requested to use a ring-fenced financing mechanism for the fiduciary aspects of the Health Services Reinforcement Project (HSRP).** Specifically, the government has requested to set up a dedicated FM Unit within the Directorate of Administration and Finances (DAF) of the Ministry of Health, to manage the fiduciary aspects of the Project. This FM Unit under the responsibility of the Director of the DAF of the Ministry would manage the overall FM aspects of the Project.

15. **The assessment of DAF and the FM Unit was carried out in February 2018**. The objective of the assessment was to determine whether the DAF and the FM Unit have adequate FM arrangements in place to ensure that the Project funds will be used only for the purposes for which the financing was provided, with due attention to considerations of economy and efficiency. The FM assessment considers, based on the existing FM arrangements, the degree to which (a) the budgeted expenditures are realistic, prepared with due regard to relevant policies, and executed in an orderly and predictable manner, (b) reasonable records are maintained, (c) financial reports are produced and disseminated for decision-making, management, and reporting, (d) adequate funds are available to finance the Project, (e) there are reasonable controls over Project funds, and (f) independent and competent audit arrangements are in place. The assessment complied with the Financial Management Manual for World Bank investment project financing operations, effective December 11, 2014.

Description of the FM institutional arrangements for the project

16. **The Ministry of Health (MoH) would be the Implementing Agency (IA) for the proposed Project with oversight and coordination responsibilities.** Under coordination from the Minister and Secretary General, technical activities will be undertaken by the relevant directorates and units in the ministry.

17. **The DAF of the Ministry of Health will oversee the entire project financial management including management of the funds and the designated account and will primarily be responsible for:** (i) planning and budgeting; (ii) disbursement and financial reporting; (iii) procurement; and (iii) internal controls and auditing. The current Finance Director of Ministry of Health will have the overall oversight of the project financial management system. For the purpose of this project, the ministry of Health will hire on a competitive basis or designate the key FM staff including the Project Financial Management Officer (*Responsable Administratif et Financier* – RAF) and one accountant to support the current FM team of the DAF composed of civil servants.

18. **UNFPA will implement some activities estimated at US$8 million**. The government will enter service with UNFPA through technical and supplies agreements. UNFPA will report on the utilization of the funds managed. The supplies and technical agreements will provide detailed on payments methods, reporting, auditing and

transparency arrangements. UNFPA will handle financial management aspects of the activities under its responsibility using its own procedures set out in their Financial Regulations and Rules.

Risk assessment and mitigation

19. **The Bank's principal concern is to ensure that project funds are used economically and efficiently for the intended purpose**. Assessment of the risks that the project funds will not be so used is an important part of the financial management assessment work. The risk features are determined over two elements: (i) the risk associated to the project as a whole (inherent risk), and (ii) the risk linked to a weak control environment of the project implementation (control risk). The content of these risks is described below.

20. **The overall FM risk before mitigation measures is rated High**. This is due to (i) the lack of experiences and familiarity of the DAF and Dedicated FM Unit of the Ministry of Health with Bank-FM procedures; (ii) the lack of an effective and operational accounting software and (iii) the design of the project which involves several actors with beneficiaries based in remote and geographically dispersed locations within the country.

21. **Consequently, additional measures will be incorporated into the design of the project FM arrangements to mitigate the overall FM risk** (i) by strengthening the FM capacity and the internal control environment of the MoH (ii) and by maintaining a continuous timeliness and reliability of information produced by the MoH.

22. **The residual risk after mitigation measures is rated Substantial.**

23. **The table below summarizes the risks and mitigation measures for the MoH (Table 1.1)**

Table 1.1: MOH - Financial management risk assessment and mitigation measures

Risks	Risk Rating	Risk Mitigating Measures	Residual Risk Rating
Inherent Risk			
Country Level	**M**		**M**
Entity Level The DAF is not familiar with the Bank-financed projects including FM procedures The dedicated FM Unit is not established yet within the DAF of the Ministry of Health	**H**	✓ Hire on a competitive basis or appoint a FMS and an accountant with experience and qualifications acceptable to the Bank. ✓ Adopt the Project Implementation Manual ✓ Adopt the Project Administrative, Accounting and Financial Procedures Manual	**S**
Project level Project activities could be prone to irregularities (workshops, conferences, trainings). The design of the project is complex with the involvement of several actors and with beneficiaries based in remote and geographically dispersed locations	S	✓ All budgets related to some Project activities (workshops, conferences, training, treasury advances to rural and regional implementation agencies …) will be subject to Bank prior review ✓ Supervision mission will include detailed reviews of expenditures ✓ In case of subsidiary grants, an FM assessment of the main beneficiaries will be conducted by the Bank, and additional risk mitigation measures will be proposed, if needed. ✓ Terms and conditions for justification of IDA funds transferred to other agencies involved in the implementation of the project activities for them to make payments of expenditures, will be detailed in the subsidiary grant agreements or the Memorandum of Understanding between the Project and the agency, as well as in the implementation manual.	S
Overall Inherent Risk	S		S
Control Risk			
Budgeting The DAF use of country systems and procedures for budget planning, execution and monitoring	**M**	✓ A detailed annual work plan and budget required each year and proclaimed. ✓ AWP reviewed and approved by the steering committee. ✓ The project Financial Procedures Manual will define the arrangements for budgeting, budgetary control and the requirements for budgeting revisions. ✓ IFR will provide information on budgetary execution and analysis of variances between actual and budget expenses.	**M**
Accounting Lack of experiences and familiarity of the DAF and Dedicated FM Unit of the Ministry of Health with	**H**	Mitigation measures to implement prior to Project effectiveness:	**S**

Bank-FM procedures. Lack of an effective and operational accounting software.		✓ Hire or appoint an FMS and an accountant with experience and qualifications acceptable to the Bank, ✓ Acquire and set up before effectiveness an accounting software acceptable to the Bank ✓ Adopt the Project Implementation Manual ✓ Adopt the Project Administrative, Accounting and Financial Procedures Manual ✓ The Project will follow the SYSCOHADA accounting principles.	
Internal Control: The Project will rely on national institutions in charge of internal controls whose performances are globally deemed acceptable despite the financial and human resources capacity challenges	**S**	✓ The internal control procedures will be detailed in the Project manuals. ✓ Prior to the effectiveness of the Project, an internal auditor will be assigned to the project by the Ministry of Economy and Finance. The internal auditor work program and reports will be submitted to the bank bi-annually, no later than 45 days after the end of each semester. ✓ National internal control institutions such as the Technical Inspection Services (ITS) within the Ministry of Health, the General Finance Inspectorate (Inspection Générale des Finances, IGF) within the Ministry of Economy, Finance and Development (MINEFID); and the Control and Anti-Corruption State Authority (*Autorité Supérieure de Contrôle d'Etat et de Lutte contre la Corruption, ASCE-LC*) may review project activities periodically.	**S**
Funds Flow: Lack of justification of funds transferred to implementing agencies Transfer of funds to UNFPA	**S**	✓ A designated account (DA) in XOF will be opened at the central bank (BCEAO). ✓ A Project Account (PA), will be opened in a commercial bank under terms and conditions acceptable to the Bank. This PA will be used to pay for all the expenditures related to the project. ✓ Terms and conditions for justification of IDA funds transferred to other agencies involved in the implementation of the project activities for them to make payments of expenditures, will be detailed in the subsidiary grant agreements or the Memorandum of Understanding between the Project and	S

		the agency, as well as in the implementation manual. Interest incomes on the PA will be deposited into a sub-account opened in a commercial bank and used according to the FM manual. ✓ For UNFPA payments, the special World Bank disbursement procedures will be used to establish a "Blanket Commitment". The "Blanket Commitment" will be set up for UNFPA for the full amount to be transferred to the UN agency as an Advance.	
Financial Reporting Delays in financial reporting due to lack of experience and familiarity of the DAF and Dedicated FM Unit of the Ministry of Health with Bank-FM procedures Lack of an effective and operational accounting software	**H**	Mitigations measures: ✓ A computerized accounting system will be used; ✓ (ii) IFR and financial statements formats will be agreed at project negotiations. ✓ (iii) FM team of the PIU recruited on competitive basis and capacity building planed before project effectiveness (hands on support and training with PSAC team during the PPA period) ✓ Submit Interim Financial Reports on a quarterly basis to the Bank, no later than 45 days after the end of each quarter ✓ Submit annual financial statements annually, no later than six months after the end of the year.	**S**
Auditing Delays in submission of audit report The scope of the mission may not cover expenditures incurred by implementing entities	**S**	✓ A private external auditor will be appointed to conduct the audit of the financial statements of the Project. ✓ The ToRs of the external auditor (to be reviewed by IDA) will include field visits and specific report on findings of physical controls of goods, services and works acquired by the Project The scope of the audit will cover the activities implemented by the Project and any partner implementing agencies. However, the activities managed directly by UNFPA will be excluded from the scope of the external auditor. Request for elimination of audit for the activities implemented by UNFPA will be sought during Project Preparation.	**S**
Fraud and Corruption Possibility of circumventing the internal control system with colluding practices as bribes, abuse of administrative positions, misprocurement	**M**	✓ The ToR of the external auditor will comprise a specific chapter on corruption auditing ✓ (The ASCE-LC will review Project activities. Copy of ASCE-LC reports will be submitted to the Bank; ✓ Measures to improve transparency such as providing information on	**M**

		the project status to the public and public disclosure of audit reports on Project annual financial statements are built into the project design	
Overall Control Risk	***H***		***S***
Overall FM Risk	**H**		**S**

Strengths and Weaknesses

24. **The strengths arising from the Financial Management assessment of the DAF are its previous experience on implementation of projects financed by international donors (UNICEF, WHO, OOAS).** Funds included in the Finance Law are managed using the national rules and procedures, while funds not included in the budget law are managed using a ring-fenced "parallel" mechanisms mainly the procedures of each donor (UNICEF, WAHO; WB…). In addition, the DAF use of country systems and procedures for budget planning, execution and monitoring. Finally, the DAF already has: (i) a detailed manual of procedures (ii) an archiving system which allows the audit of funds of each donor (iii) acceptable budgeting arrangements.

25. **The main finding arising from this assessment conducted in February 2018 was that the DAF is not familiar with the Bank-financed projects including FM procedures**. None of the 40 actual employees of the DAF are familiar with Bank-financed project procedures and requirements. The assessment also revealed that the budget and accounting software used by the DAF (CID for the budget execution and CIE for accounting and reporting) were not fully effective and that the accounting of projects funded by other donors (WAHO, UNICEF…) was made through Excel. However, the execution of the budget allocated to the Ministry of Health follows the country public expenditure chain and relies on the national institutions in charge of internal and external controls (the Technical Inspection Services (ITS) within the Ministry of Health, the General Finance Inspectorate (*Inspection Générale des Finances*, IGF) within the Ministry of Economy, Finance and Development (MINEFID); the Court of Accounts (*Cour des Comptes*) and the Control and Anti-Corruption State Authority (*Autorité Supérieure de Contrôle d'Etat et de Lutte contre la Corruption*, ASCE-LC) those performances are globally deemed acceptable despite the financial and human resources capacity challenges. Finally, the assessment revealed that the dedicated FM Unit is not established yet within the DAF of the Ministry of Health.

Financial Management Action Plan

26. **The Financial Management Action Plan described below has been developed to mitigate the overall financial management risks.**

Table 1.2: Financial management action plan

#	Item	Timelines	Activities
	Staffing		
1	FM Officer (RAF) and Accountant	Prior to Project Effectiveness	Hire on a competitive basis or appoint a FM Officer (RAF) and an accountant with experience and qualifications acceptable to the Bank.
	Accounting		
2	Accounting software	Two months following Project Effectiveness	Acquire and set up no later than two months after effectiveness an accounting software acceptable to the Bank
3	Project Administrative, Accounting and Financial Procedures Manual	Prior to Project Effectiveness	Adopt the Project Administrative, Accounting and Financial Procedures Manual

	Internal control		
5	Internal auditor	Two months following Project Effectiveness	An internal auditor will be assigned to the project by the Ministry of Finance
	Auditing		
6	External auditor	By six months after Project Effectiveness	Recruit an external auditor to conduct an audit of the Project annual financial statements. The scope of the audit will cover the activities implemented by the Project and any partner implementing agencies However the activities managed directly by UNFPA will be excluded from the scope of the external auditor. Request for elimination of audit for the activities implemented by UNFPA will be sought during Project Preparation. Funds transferred to UNFPA will be managed and audited in compliance with UNFPA Financial Regulation and the technical assistance agreement.

27. **Internal control system and internal audit**: Internal control system is aimed to ensure (i) the effectiveness and efficiency of operations, (ii) the reliability of financial reporting, and (iii) the compliance with applicable laws and regulations. The Project will rely on the existing internal control system comprising periodic reviews from (a) The Public Treasury Inspectorate (*Inspection Générale de l'Etat*) (b) the General Inspectorate of Finance (Inspection Générale des Finances), and (c) ASCE-LC. The reports of the periodic reviews will be sent to the Bank. The internal control policies, rules and procedures of the Project will be detailed in the Project implementation manual and in the Project administrative, financial and accounting procedures manual. Those procedures will include provisions pertaining to segregation of duties, delegation of authority, fixed asset management, accounts reconciliation, and other specific internal control if needed. Within two months of effectiveness of the Project, an internal auditor will be assigned to the project by the Ministry of Economy and Finance. The internal auditor work program and reports will be submitted to the bank bi-annually, no later than 45 days after the end of each semester.

28. **Planning and budgeting**: The DAF will prepare a detailed annual work plan and budget (AWP&B) which should be approved by the Review Committee. The Project will submit its AWP&B to IDA for comments, prior to each new year (no later than November 30 of the previous year). The work plan and budgets will identify the activities to be undertaken and the role of respective parties in implementation including UNFPA.

29. **Accounting policies:** The prevailing accounting policies and procedures in line with the West African Francophone countries accounting standards—SYSCOHADA—in use in Burkina Faso for ongoing World Bank-financed operations will apply. The accounting systems and policies and financial procedures used by the Project will be documented in the project's administrative, accounting, and financial manual. The Project will acquire and set up within two months of effectiveness an accounting software which will facilitate (i) the processing of financial information of the Project (ii) the preparation of interim quarterly financial statements and annual financial statements under format acceptable to the Bank. This software should be capable of recording transactions and reporting project operations in a timely manner including preparation of

withdrawal application and periodic financial reports (IFR and annual financial statements). In a nutshell, the system should integrate budgeting, operating and cost accounting systems to facilitate monitoring, evaluation and reporting.

30. **Interim financial reporting:** The DAF will submit the Interim Financial Report (IFR) to the Bank within 45 days after the end of the calendar semester. The IFRs should provide sufficient pertinent information for a reader to establish whether (i) funds disbursed to projects are being used for the purpose intended, (ii) project implementation is on track, and (iii) budgeted costs will not be exceeded. The quarterly IFR for the project will include the following (i) an introductory narrative discussion of project developments and progress during the period, to provide context to (or other explanations of) financial information reported; (ii) a Sources and Uses of funds Statement, both cumulatively and for the period covered by the report, showing separately funds provided under the Credit; (iii) a Use of funds by components Statement, cumulatively and for the period covered by the report; (iv) the designated account reconciliation, including bank statements and general ledger of the bank account; (v) the disbursement forecasts of the upcoming six months; (vi) explanation of variances between the actual and planned. The quarterly IFR will reflect the activities implemented directly by UNFPA.

31. **UNFPA Interim financial reporting:** The arrangements for UNFPA financial reporting will be detailed in the technical assistance and supplies agreements between the Project and UNFPA.

32. **Annual financial reporting:** In compliance with International Accounting Standards and IDA requirements, the DAF will produce annual financial statements. These include (a) a Balance Sheet that shows assets and liabilities; (bi) a Statement of Sources and Uses of Funds showing all the sources of project funds and expenditures analyzed by project component and/or category; (c) a Statement of Commitments; (d) notes related to significant accounting policies and accounting standards adopted by management and underlying the preparation of financial statements and (e) a Management Assertion that project funds have been expended for the intended purposes as specified in the relevant financing agreements.

33. **External Auditing:** The DAF will submit audited Project Financial Statements (PFS) satisfactory to the World Bank (IDA) every year. A single opinion on the Audited Project Financial Statements in compliance with International Federation of Accountant (IFAC) will be required. In addition, a Management Letter will be required. The Management Letter will contain auditor observations and comments, and recommendations for improvements in accounting records, systems, controls and compliance with financial covenants in the Financial Agreement. The audited financial statements must be submitted to the Bank within six (6) months after closure of the fiscal year. The Project will recruit an external private auditor to audit the annual financial statements of the Project by 6 months after effectiveness. However, the activities managed directly by UNFPA will be excluded from the scope of the external auditor appointed by the government.

34. **Audit of the funds managed by UNFPA:** A total amount of US$ 8 million of the project will be awarded to UNFPA via direct payments. The funds will be managed by UNFPA following UN Financial Regulations and Rules. As a result, reliance will be placed on the UN agency's external auditor's reports as necessary. Request for elimination of audit requirements will be prepared and should be granted during the project preparation. To mitigate any risks of inappropriate use of the project funds, some alternative mechanisms should be put in place including the followings: (i) at least two field based-visits, will be conducted during the first 12 months of the project implementation period. The supervision intensity will be adjusted over time taking into account

the project FM performance and FM risk level; (ii) the government will have the entire responsibility to ensuring that works, goods and service are delivered effectively to the intended beneficiaries during the project implementation; however where deemed appropriate (e.g. UNFPA systems and IFRs have showed some weaknesses or deficiencies) , the Bank team may request the government to put in place adequate arrangements to conduct some physical inspections of goods and services delivered by the UN agency ; and (iii) the Bank FM team will have adequate access to the financial information, documents, and records for activities implemented by the UNFPA on behalf of the government.

Table 1.3: Audit report requirements

Report	Deadline	Responsible
Audited financial statements including audit report and management letter	6 months after the end of the year	DAF of the Ministry of Health

35. **Governance and anti-corruption:** The risk of irregularities and corruption within the project activities is Moderate given the nature and implementation arrangements of the project activities. The following measures are envisaged to mitigate the risk of misuses, irregularities and corruption (i)The ToR of the external auditor will comprise a specific chapter on corruption auditing; (ii) the ASCE-LC will review Project activities. Copy of ASCE-LC reports will be submitted to the Bank; (iii) measures to improve transparency such as providing information on the project status to the public and public disclosure of audit reports on Project annual financial statements are built into the project design.

36. **Funds flow:** Upon credit effectiveness, transaction-based disbursements will be used. The project will finance 100 percent of eligible expenditures inclusive of taxes.

37. **A designated account (DA) in XOF will be opened at the central bank (BCEAO).** A Project Account (PA), managed by the FM Unit with signatories of the Project Manager and the DAF, will be opened in a commercial bank under terms and conditions acceptable to the Bank. This PA will be used to pay for all the expenditures related to the project. Terms and conditions for justification of IDA funds transferred to other agencies involved in the implementation of the project activities for them to make payments of expenditures, will be detailed in the subsidiary grant agreements or the Memorandum of Understanding between the Project and the agency, as well as in the implementation manual. Interest incomes on the PA will be deposited into a sub-account opened.

38. **Support to the implementation plan**: FM supervisions will be conducted over the project's lifetime. The project will be supervised on a risk-based approach. The objective of the implementation support plan is to ensure the project maintains a satisfactory FM system throughout its life. Based on the current risk assessment which is substantial**,** we envisage at least two supervision missions per year. The ISR will include a FM rating of the project. An implementation support mission will be carried before effectiveness to ensure the project readiness. To the extent possible, mixed on-site supervision missions will be undertaken with procurement monitoring and evaluation and disbursement colleagues and will cover the activities implemented by the Project as well as those contracted to UNFPA. The supervision intensity will be adjusted over time taking into account the project FM performance and FM risk level.

Table 1.4: Implementation support plan

FM Activity	Frequency
Desk reviews	
Interim financial reports review	Quarterly
Audit report review of the program	Annually
Interim internal control reports	Bi-annual
Review of other relevant information	Continuous as they become available
On site visits	
Review of overall operation of the FM system	Annual (two missions/year)
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed
Transaction reviews	As needed
Capacity building support	
FM training sessions	During implementation and when needed.

Disbursement

39. **Disbursements** under this project will be carried out in accordance with the provisions of the Disbursement Guidelines ("World Bank Disbursement Guidelines for Projects, dated February 1, 2017"), the Disbursement Letters and the Financing Agreements. An initial advance up to the ceiling of the DA will be made into the DA, and subsequent disbursements will be made against submission of Statements of Expenditures (SOE) reporting on the use of the initial/previous advance. The E-signature of Withdrawal Application (WA) will be used by the project and WA will be prepared on a monthly basis. The other methods of disbursing the funds (reimbursement, direct payment) will also be available to the project. The ceiling of the DA will be stated in the DFIL. Withdrawal applications will be accompanied by all records required by the Bank in the Disbursement Letter. All supporting documentation will be retained at MoH and must be made available for periodic review by Bank' missions and external auditors.

40. **Disbursement of funds to UNFPA:** Upon signing of the agreement between the government and UNFPA, application for withdrawal of proceeds will be prepared by the Project and submitted to IDA. The special World Bank disbursement procedures will be used to establish a "Blanket Commitment" to allow the amount to be advanced. Funds withdrawn from the IDA grant account will be deposited directly into the UN bank account provided by UNFPA for the project activities to be implemented by the UN agency. The amount advanced will be documented through the quarterly unaudited Interim Financial Reports as actual expenditures are incurred by the UNFPA.

41. **Payments to other implementation Agencies and services providers:** the DAF will make payments to other implementing Agencies in regard to the specified activities in the components of the project. Payments will

be made in accordance with the payment modalities, as specified in the respective contracts/conventions. In addition to these supporting documents, the DAF will consider the findings of the internal and external auditors while approving the payments. The DAF will reserve the right to verify the expenditures ex-post, and refunds might be requested for non-respect of contractual/convention clauses.

42. **Local taxes**: Funds will be disbursed in accordance with project categories of expenditures and components, as shown in the Financing Agreement. Financing of each category of expenditure/component will be authorized as indicated in the Financing Agreement and will be inclusive of taxes according to the current country financing parameters approved for Burkina Faso.

Procurement

Strategy and Approach for Implementation Support

43. The proposed implementation plan is based on experiences and lessons learned from previous Bank projects in Burkina Faso's health sector, such as the Reproductive Health Project. While the previous Reproductive Health Project used a Project Implementation Unit (PADS), the proposed HSRP project will be using government structures for implementation that will be embedded inside government departments and managed by the Government. The fiduciary and technical capacity will be strengthened, with skills, experience and staff from the PADS being transferred or providing punctual implementation support to key directorates such as the DAF and DMP. Program implementation rests under the responsibility of MOH with targeted and continuous implementation support and technical advice from the World Bank and development partners. The Bank's implementation support will broadly consist of:
    - 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.
    - On-going monitoring of implementation progress, including regularly reviewing key outcome and intermediate indicators, and identification of bottlenecks.
    - Monitoring risks and identification of corresponding mitigation measures.
    - Close coordination with other donors and development partners to leverage resources, ensure coordination of efforts, and avoid duplication.

44. **Further, implementation support will include the provision of capacity strengthening in procurement, financial management and governance and anti-corruption.** 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 on-site visits done by the Bank's fiduciary staff at least twice a year. Reliance will also be placed on the annual audit reports produced by the Controller. 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 Bank whenever deemed necessary.

Implementation support plan and resource requirements

45. **The implementation support plan and resource requirements for the proposed project are provided in the following tables.**

Table 1.5: Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	Capacity building for strategic purchasing	SP expert	200,000 (IDA)	
	Capacity building on FM, procurement, internal audit and safeguard implementation and compliance	FM and procurement staff, and consultants		
12-48 months	Implementation support	Same as above	150,000 each subsequent year	

Table 1.6: Skills mix required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Task team leader	15 SWs annually	Field trips as required	International
Procurement	5 SWs annually	Field trips as required	Country office based
FM Specialist	5 SWs annually	Field trips as required.	Country office based
Nutrition Specialist	6 SW annually	Field trip as required	Washington based
Environment specialist	1 SW annually	Field trip as required	Country Office based
Indigenous people and Health Specialist	2 SW annually	Field trip as required	Country Office based
M&E Specialist	4 SW annually	Field trips as required	Country office based
PBF/Strategic Purchasing Specialist	8 SW annually	Field trips as required	International
Health financing specialist	10 SW annually	Field trips as required	DC based
Disease surveillance specialist	6 SW annually	Field trip as required	International
Economist	4 SW annually	Field trip as required	DC based
Governance Specialist	1 SW annually	Field trips as required	Country office based
Administrative Support	6 SW annually	Field trips as required	5 weeks Country office based 1 week DC based

ANNEX 2: Map of Burkina Faso

COUNTRY: Burkina Faso
Health Services Reinforcement Project