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# PROJECT INFORMATION DOCUMENT (PID)
## CONCEPT STAGE

Report No.: AB4826

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|---|---|
| **Project Name** | Health System Performance |
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| **Sector** | Health (100%) |
| **Project ID** | P113202 |
| **Borrower(s)** | GOVERNMENT OF BENIN |
| **Implementing Agency** | Ministry of Health (Benin) |
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1. Key development issues and rationale for Bank involvement

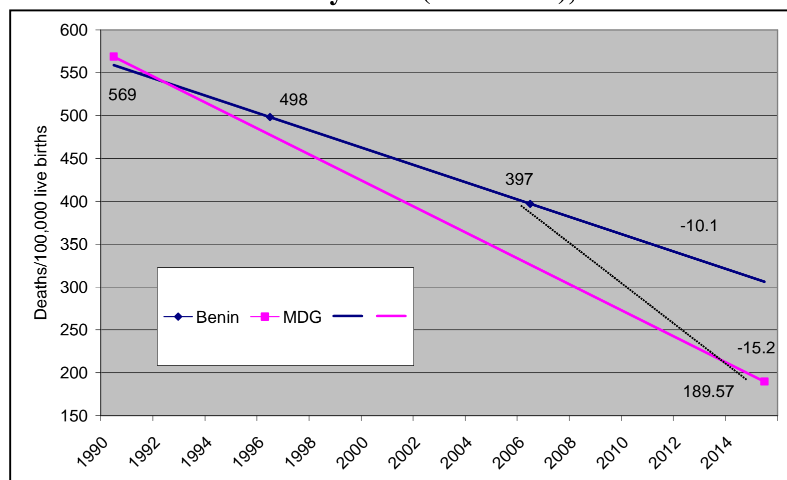
*Among health-related MDGs (Millennium Development Goals), maternal and neonatal health has been - so far - the most neglected one.*

1. **Some progress has been made recently regarding child health (MDG 4) and HIV-AIDS (MDG 6).** Regarding HIV-AIDS, overall prevalence is now stabilized at around 1.2% (DHS 2006). Furthermore, prevalence has diminished sharply during the last decade among the most at-risk groups (i.e. sex workers), decreasing from 41% in 1999 to 26% in 2006. This success can be largely attributed to the national HIV program, which is heavily supported by the WB and other donors. Regarding child health, progress has not been so fast. Child mortality decreased from 185 deaths per 1000 births in 1990 to 125 in 2006. A major concern is that, so far, nutrition issues have not been addressed seriously. On the bright side, regarding malaria-related child mortality, a recent survey on utilization of bed nets has found very promising results: the percentage of children sleeping under a bed net has jumped from 20% in 2006 to 56% in 2009, thanks to massive bed net distribution campaigns, mostly funded under the WB Malaria Control Booster Program and the US President's Malaria Initiative.

2. **Conversely, maternal and neonatal mortality (MDG 5) has decreased at a very slow pace and remains high.** The latest DHS (2006) found a maternal mortality ratio of 397 for 100,000 births, down from 498 in 1996. However, given the usual difficulties in measuring maternal mortality, confidence intervals are quite large and suggest that this decrease may not have occurred at all. It is also widely acknowledged that high maternal mortality rates are strongly correlated with high neonatal mortality. Benin is no exception in this regard. Neonatal mortality in Benin is the children mortality component that decreased the least in the recent years. The limited progress made in reducing maternal mortality is a major cause for this disappointing trend.

3. **Nevertheless, MDG No. 5 (maternal and neonatal mortality) may be within reach.** Benin is still lagging behind regarding the MDG level, which is set at 189 deaths for 100,000 births in 2015. However, a simple look at the current trend suggests that this objective is achievable. As illustrated in Figure 2 below, Benin will have to increase its maternal mortality reduction rate by a factor of 1.5, that is to say moving from a rate of -10% per year to -15%.

**Figure 1: Evolution of maternal mortality rates (1989-2006), with MDG reference**




Source: DHS 2006

*The high maternal mortality in Benin can be explained by the limited efforts in family planning, as well as by the weak performance of the overall health system.*

4. **Maternal mortality is partly explained by limited Government efforts in the area of family planning.** Contraception prevalence is still very low, even in comparison with other African countries.

5. **High maternal mortality can also be related to both supply-side and demand-side issues within the health system:** (i) on the supply-side, the Benin health system provides low quality care, not only for lack of resources (especially in rural areas), but also for lack of adequate incentives regarding health facilities and health workers; and (ii) on the demand-side, the only mechanism in place for fee exemption is mostly misused, once again because of inadequate incentives for health care facilities and health workers. These health system weaknesses are further detailed below.

*On the supply-side, low quality care is a major contributor to high maternal mortality.*

6. **On average, utilization of maternal services is very high, suggesting that demand for maternal services is not a major bottleneck, at least for the overall population.** It is widely acknowledged that increasing the rate of deliveries attended by qualified staff is the key intervention for reducing maternal mortality. But, in this regard, Benin is facing a paradox. It has one of the highest rates of assisted deliveries in Sub Saharan Africa (76% according to DHS 2006), while maternal mortality is still high, close to 400 deaths for 100,000 births.

7. **The unexpected relation between utilization of maternal services and maternal mortality can be explained by the low quality of maternal care.** To better assess the scope of this quality issue, a study (Saizonou 2006) was carried out in 4 referral hospitals, where over 50% of maternal deaths in the country occur. The study found that 60% of these maternal deaths were caused by low quality of care and could have been avoided.

8. **One of the reasons behind this low quality care is the lack of adequate resources in many health care facilities**, as confirmed by the latest health sector review (2009, World Bank). While the geographical density of these health facilities is high (therefore there is no need for building new ones), many facilities are still not functional. Namely, they may not have enough equipment and qualified staff for providing quality care. Indeed, the latest assessment (Gbangbade 2003a), to be updated in 2009, revealed that only 7% of health facilities were able to provide adequate Basic Emergency Obstetrical Care (BEmOC).

9. Essential equipment may be either missing or not functional. Regarding health workers, unequal geographical distribution and high absenteeism appear to be the key issues. Worse, even when a sufficient number of qualified staff is present in a given facility, their skills and knowledge can be pretty weak. For instance, a survey (Gbangbade 2003b) found that only 54% of health workers in referral centers knew how to diagnose and manage eclampsia, although it is a leading cause of maternal mortality.

*10.* **But the low quality of maternal and neonatal care is also – and probably more - related to inadequate incentives for health care facilities and health workers.** Adding more resources in maternal care will probably not be enough for achieving tangible results. Currently, neither health care facilities nor health workers have any incentives to promote quality of care or for to even merely pay attention to patients. As a result, performance of health workers and facilities is weak, even when resources are adequate. For instance, drug stock outs appear to be mostly a performance problem rather than a resource problem.

*On the demand-side, high maternal mortality is also explained by the low utilization of maternal services by poor women.*

11. **While utilization of maternal care services is quite high among the general population, poor people are facing major difficulties for accessing these services.** Indeed, in the poorest quintile of the population, the assisted delivery rate is only 55% (DHS 2006). The main reasons for this situation are: (i) high user fees and informal payments (affordability); (ii) cultural obstacles (acceptability); and (iii) fear of being poorly treated by health workers (responsiveness). At least two of these factors (affordability and responsiveness) are closely related to the lack of patient focus among health workers. A sad example is given by the fact that the only pro-poor mechanism (the Health Equity Fund) has been widely misused. This fund was set up in 2005 (Health Equity Fund or *Fonds Sanitaire des Indigents*) and is managed directly by health care facilities. It should normally fund fee exemptions for poor people. In fact, as health workers do not have any incentives to provide adequate care to the neediest patients, these health workers mostly use the Fund's budget to exempt their friends and relatives.

*Issues in maternal care services are illustrative of a broader problem, namely the weak performance of the entire health system.*

12. **In Benin, the health system does not suffer from a major lack of inputs, at least in terms of density of infrastructure and health workers.** According to the National Health Accounts (2006), the Government of Benin allocates about 8% of its budget to the health sector. This is equivalent to 2% of GDP. While this financing level is rather low, it is in line with the African average. Moreover, the density in health care facilities (or infrastructure) is roughly acceptable, given that 86% of the population is less than 5 km away from such a facility. Consequently, the population does not face major hurdles in terms of geographical accessibility. Regarding health workers, in comparison to other SSA countries, Benin does not experience a severe shortage of health workers. In fact, for doctors, there is even a situation of overproduction resulting in underemployment. However, as seen earlier, these health workers still receive limited training, and rarely on-the-job.

13. **But, beyond some gaps in training, the major bottleneck to achieve better health outcomes is the limited performance of the health system in using its available inputs.** Three specific problems can illustrate this situation. They are all related to institutional deficiencies.

14. **First, mechanisms to ensure accountability of health workers and health care facilities (and therefore to create adequate incentives) are extremely weak.** Among health workers, absenteeism, corruption, dual job holding, drug pilfering and unresponsiveness to patient needs are widespread. Sanctions are never enforced. Promotions and rewards are rare and have little relation to actual performance (which is not measured, anyway). As said earlier, there is also evidence that even when health workers have adequate skills and knowledge, they do not work at full capacity and therefore provide health care services at a low level of quality. Similarly, health care facilities receive limited funding (about 22% of their annual recurrent costs) from the Government. Even these small amounts are mostly discretionary, and not based on local health care needs. Consequently, these facilities have become *de facto* autonomous and strive to survive in maximizing revenues coming from user fees and from informal payments.

15. **Second, obstacles related to financial accessibility have not been seriously addressed.** There is no health insurance system in the country. Many efforts have been put in the development of "*health mutuals*", but, despite heavy technical and financial support from various NGOs and donors, they cover less than 1% of the population. The only mechanism for risk pooling is the above-mentioned Health Equity Fund (HEF). However, it suffers from (i) a limited budget; (ii) an allocation procedure that does not take into account population needs across regions; (iii) the absence of reliable mechanism to identify the poorest; and (iv) a lack of community involvement in monitoring its activities, which explains why most funding does not reach the poorest.

16. **Third, allocative efficiency of the Government health budget is limited.** Existing plans (for instance, the 10-year national development plan) and budgets (i.e. MTEF) are still not evidence-based. They mostly focus on expenditures that have little relation with MDGs. These plans and budget mostly comprise training programs for central and regional MoH[1] officials,

[1] Ministry of Health.

investments in building construction and rehabilitation, purchase of imaging equipment and so forth. Budgets are not clearly related to any plan. Furthermore, plans and budgets are not comprehensive. In addition, planning and budgeting processes have not yet been decentralized. Regarding planning, whereas a process for deconcentrated planning has been designed, it is not yet in place. Regarding budgeting, despite some recent progress, the MoH still controls and spends more than 60% of the health budget at central level. Not only Government funding for health care facilities (especially in rural areas) remains limited, but also MoH budget allocations to the regions are not based on their actual health care needs. Similarly, the distribution of health workers is highly biased towards urban areas. No policy exists to address this misallocation issue.

***Government health policy priorities***

17. **The Benin Government fully shares these views on the weaknesses of the health system.** An important milestone has been the *Etats Généraux* in November 2007. More than 600 stakeholders from the entire health sector attended a 3-day forum and reached the conclusion that major changes in governance and institutional design were necessary. These changes have also been requested by donors, as several recent sectors reports (including the 2009 World Bank Health Country Status Report) have pinpointed the same issues.

18. **Accordingly, in order to enhance health system performance, the Ministry of Health is now engaged in the preparation of three important moves**, notably (i) the implementation of a Result-Based Financing (RBF) mechanism to restore the accountability of health facilities and health workers; (ii) the reform of the Health Equity Fund along with the implementation of a health card system to better identify the poorest, so as to increase financial accessibility to health services; and (iii) the revision of its planning, budgeting and management processes as well as the preparation of a Sector Wide Approach (SWAp) aiming at improving the allocative efficiency of the health budget. These three key priorities in health system strengthening (HSS) are described below.

*Restoring accountability of health facilities and health workers through a Result-Based Financing (RBF) mechanism.*

19. **The Government is committed to implement new mechanisms to restore accountability of health care facilities and of their health workers, especially with Result-Based Financing.** In 2007, Benin launched a Result-Based Financing (RBF) experiment in 3 districts out of 34. It consisted in transferring financial bonuses to health care facilities (and their staff) on the basis of achieved results. This experiment is currently redesigned and will be scaled-up in 8 districts, with the support of a Norwegian grant ($9 million), managed by the Bank. This mechanism (in its improved version) is expected to create incentives for performance (i.e. quality of care, productivity and responsiveness) for both health care facilities and health workers.

*Increasing financial accessibility to health services.*

20. **Among several policy options in health financing, a reform of Health Equity Fund is considered for the coming months.** The reform aims at increasing the role of community representatives in order to reduce misuse of this fund.

21. **In parallel, the MoH plans to implement a health card.** This electronic card would provide a reliable means of identification for people, especially for the poorest. Such a "passive identification"[2] mechanism would ensure that only the poorest be exempted from health services fees. At a later stage, the health card would be a major component of a possible national insurance scheme, as currently being discussed in country.

*Improving allocative efficiency of the health budget, through new planning, budgeting and management processes as well as through a Sector Wide Approach (SWAp).*

22. **The MoH has recently engaged in a complete change of its planning and budgeting processes, notably to ensure that health plans are evidence-based, comprehensive and decentralized.** With heavy support from joint TA by the Bank, UNICEF and Belgium, the MoH has prepared a new 3-year sector plan (2010-2012). To make sure that it is evidence-based, the MBB[3] methodology has been used. Similarly, to ensure that there is only "one health plan" in Benin, all activities planned under vertical programs will be included in this national plan. A methodology for "decentralized health planning" has been developed, with USAID support. Accordingly, district health plans will be prepared, first to implement this national-3-year plan (2010-2012) and, later, to inform the next 3-year plan (2013-2015). In addition, the MoH is starting to develop improved formulas for allocating budget to regions and to health care facilities.

***23.*** **Finally, both the Government and donors are willing to enter quickly into a Sector Wide Approach.** Benin is already a member of the International Partnership Initiative (IHP+) and is committed to prepare and sign a Compact with major donors in the coming months.

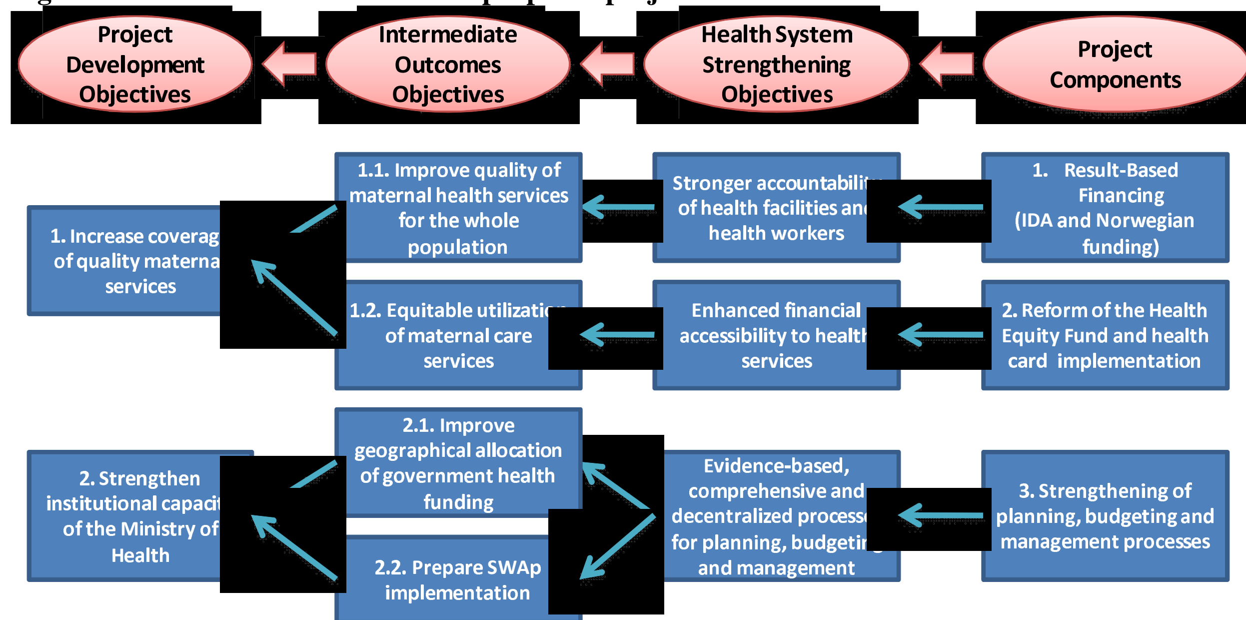
***Rationale for Bank Involvement and linkage to Country Assistance Strategy***

24. **The proposed project would support Benin efforts to strengthen its health system, under the 3 above-mentioned components,** namely (i) RBF mechanism, (ii) improvements in financial accessibility, and (iii) revision of planning and budget processes and preparation of a SWAp. This project would combine both investments and technical assistance. As maternal and neonatal health is highly influenced by the performance of a health system, maternal and neonatal indicators would be used to measure the final results of the project. The overall causal

[2] So far, poorest people are identified in an active way (by the Health Equity Fund). Namely, they get exempted from user fees only on a case-by-case basis. This assessment is done every time when they attend a health care facility. Such an "active" way to identify the poorest gives considerable power to local officials (i.e. health workers) to grant (or not) fee exemption.
Conversely, a passive identification system imply that the poorest people are identified on a permanent basis. They would receive free care simply upon presenting their health card.
[3] Marginal Budgeting for Bottlenecks.

chain of the proposed project is presented below and is detailed further in the next parts of this note.

**Figure 2: Overall result chain for the proposed project**




25. **A first justification for Bank involvement is that no other donor has the technical and management capacity for supporting complex interventions in health system strengthening, such as RBF.** Currently, the WB is the only organization with a fully dedicated health RBF team and with experience in designing and implementing large-scale RBF projects (e.g. Rwanda). In addition, for the RBF component, most funding will come from a Trust Fund that is managed by the Bank. Likewise, regarding interventions on financial accessibility, no other organization can match the WB experience in better targeting poor population segments and in rolling out health card systems.

26. **Second, Bank leadership and leverage are essential to sustain current efforts in donor harmonization and SWAp preparation.** During the past 2 years, especially with the joint preparation of the Health Country Status Report, Bank involvement has already had a catalytic effect on the donor harmonization process. In a nutshell, there is now an opportunity for preparing the first Health SWAp in Benin.

27. **Third, the proposed project – and especially its performance component – would foster synergies with other existing WB projects in Benin.** For instance, although the accountability (RBF) component is mostly focusing on maternal and neonatal health, indicators related to malaria prevention and treatment would also be included as a basis to determine the level of RBF bonuses received by health care facilities and workers. This should improve the impact of the current Malaria Control Booster Program (P096482).

28. **Fourth, the project would enhance the impact of the PRSC series in the Health Sector**. Since 2004, the Benin PRSC series has consistently focused on improving accountability, decentralization and financial accessibility within the health system. For instance,

two of the key PRSC objectives were (i) the introduction of performance contracts between the MoH and health districts and (ii) the nationwide roll-out of the Health Equity Fund (HEF). Thanks to the PRSC series, all these objectives have been achieved. However, as seen earlier, the impact of these policies has been limited, mostly because little technical support was provided to the MoH to design and implement these policies. Therefore, the proposed project will nicely complement PRSC series through the provision of this much needed capacity building.

29. **Finally, as the CAS focuses on better governance and effectiveness in the public sector, the project provides a promising illustration of how such objectives can be implemented in one sector.** The CAS plans to direct WB support toward increasing "access to basic services" and, more specifically, toward "improving health services". But more importantly, the CAS key objective is to improve governance in a country plagued by corruption and rent-seeking. This health project is an opportunity to increase accountability and efficiency in one sector and, consequently, to draw lessons that could be used in others sectors.

30. For the same reasons, the proposed project is fully consistent with the HNP strategy (2007) and the Africa Action Plan.

## 2. Proposed objective(s)

31. The project would support the longer term objective of reducing maternal and neonatal mortality and would, as a result, contribute to reach the MDG No. 5.

*Proposed Project Development Objectives (PDOs)*:

32. **The first PDO would consist in increasing the coverage of quality maternal services.** The PDO would be broken down in two intermediate outcomes: (i) improving the quality of maternal health services for the whole population, and (ii) enhancing the utilization of these services by the poorest. Although the project would reinforce the health system as a whole and have an impact on several health MDGs, this PDO is – conservatively - limited to maternal care, as this MDG would be most directly influenced by such an Health System Strengthening (HSS) project.[4]

33. **The second PDO is to strengthen the institutional capacity of the Ministry of Health**. This PDO is also composed of two intermediate outcomes: (i) improving the geographical allocation of Government health funding and (ii) preparing for SWAp implementation.

[4] Detailed causal chains for the first PDO are presented in annex 2 and 3.

34. PDOs and their respective indicators are presented in the table below.

**Table 1: Project Monitoring and Evaluation Framework**

| Project Development Objectives (PDOs) | Intermediate Outcomes | Indicators | Project Components |
|---|---|---|---|
| 1. **Increase coverage of quality maternal services** | 1.1. Improve quality of maternal health services for the whole population | • Case-fatality rate in maternal care facilities | Component 1 (Result-Based Financing) |
| | 1.2. Enhance financial accessibility of maternal health services | • Rate of assisted deliveries (by qualified staff) among the poorest quintile of population<br>• C-section rate, among the poorest quintile of population | Component 2 (Support to improved financial accessibility) |
| 2. **Strengthen institutional capacity of the Ministry of Health** | 2.1. Improve geographical allocation of Government health funding | • Share of the MoH budget allocated to health districts. | Component 3 (Technical assistance to institutional strengthening) |
| | 2.2. Prepare the implementation of a SWAp | • Number of SWAp "building blocks" in place | |

3. Preliminary description

*Design Principles*

35. The project is expected to be a Specific Investment Loan (SIL), financed under an IDA grant of $15 million and a Norwegian grant of $9 million. In addition, UNICEF, Belgium and The European Union would contribute to the same activities, for an estimated total amount of $13 million. Bank support is planned for 4 years (2010-2013).

***Alternative lending products considered and reasons for rejection***

36. **A sectoral budget support (possibly with pooled funding) was considered, but deemed premature.** The Government and several donors have explicitly indicated their desire to enter into a SWAp arrangement. However, no basket funding is currently planned, given MoH weaknesses in financial management. MoH is indeed the ministry with the lowest rate in budget execution. As a result, a full SWAp (with basket funding) is still premature in Benin. Still, the proposed project would help the MoH fix these financial management issues and would prepare the development of a SWAp. The project would also reinforce existing coordination arrangements between a core group of donors (i.e. pre-SWAp donors), especially regarding planning, monitoring and technical assistance.

***Project Components***

37. The preliminary project design envisages the following 4 components:

- **Component 1. Result-Based Financing: (US$16 million)**

This component would be financed by IDA ($7 million) and the Norwegian RBF Trust Fund ($9 million)[5]. It would support RBF implementation in 8 selected health districts.[6] This support would have the following two dimensions:

Sub-component 1A: Financing of RBF bonuses ($14 million):
This sub-component would directly contribute to the payment of RBF bonuses.

- **In selected RBF districts, all health care facilities would contract with health district authorities in order to receive a bonus proportional to achieved results.** Each of these health care facilities would have to negotiate and sign an annual RBF contract (formerly "performance contracts") with their health district authority. These contracts would define the indicators and targets to be reached. The results achieved against these targets would then be assessed by a third party every 6 months.
- **RBF indicators are mostly focused on maternal health.** As indicated earlier, maternal health is the neglected MDG in Benin. It is also the most influenced by the performance of the health system. For these two reasons, most RBF indicators would be related to maternal health. Three sets of RBF indicators have been defined and discussed with Government. A first group of indicators would measure the quality of maternal care. A second would look at the utilization of maternal care among the poorest women. Finally, a third would include the utilization of non maternal services (i.e. child visits, immunizations etc.), to ensure that health care facilities are not neglecting other services.
- **To avoid the "numbers game", an independent third party would collect primary data to measure achieved results.** As there is a high probability that RBF facilities would manipulate their routine data to artificially increase their results (and therefore their bonuses), an independent organization would be selected and paid by the Bank (with Norwegian funding). Every 6 months, this organization would collect data in health care facilities, by using both routine data and random surveys to check the accuracy of reported routine data. In addition, this organization would conduct annually a household survey, facilities audits, and exit patients' surveys.
- **Health care facilities would be allowed to use RBF bonuses for (i) various investments and training and (ii) bonuses to health workers.** As already agreed with the MoH and union leaders, a first part of RBF bonuses (at least 40% of each bonus) would be used to purchase equipment, carry out minor rehabilitations, organize clinical training sessions and fund Information, Education and Communication (IEC) activities. The second part of the bonus (up to 60%) would serve to pay bonuses to all health workers. The amount received by each individual would depend on only two variables: (i) the total RBF bonus received by the facility according to its results; and (ii) the base salary of this

[5] It is worth noting that Benin obtained this $9 million grant from Norway through an international competitive process. After selection, the Benin RBF design (described in this note) has been assessed and further developed with the support of the global RBF team (HNP hub).
[6] These 8 districts will be the RBF districts (4 controls and 4 treatments). They are not selected yet.

health worker. Individual performance (which is not measured) will not be taken into account, at least at this stage.

Sub-component 1B: Support to RBF implementation and supervision ($2 million):
To ensure smooth implementation of RBF, this sub-component would support three types of activities:

(a) Capacity building for the RBF units at the MoH: Training and equipment would be provided to MoH units in charge of managing the RBF pilot. Managers at regional and local levels would also benefit from these activities.
(b) Training programs in clinical skills and management of health services: An expected early outcome from RBF is that health facilities would quickly realize that RBF targets cannot be achieved without improving (i) clinical skills of health workers (especially in diagnosis and treatment of obstetrical complications, as well as in referral processes) and (ii) team management skills of managers. Therefore, two specific programs would be created to provide on-the-job training. The highly successful experience of USAID in managing the third stage of obstetrical labor would be used to design the first training program. The second program will focus on refreshing management skills of managers of health facilities.
(c) Communication and best practice sharing: Various communication activities would be conducted prior and during RBF experiment. Before starting RBF, information would be provided to health workers to explain RBF targets and mechanisms, and to community leaders to help them empower communities to demand more “results” from their local health care facilities. During RBF implementation, regional workshops would be organized to allow RBF health care facilities to share their results and – more importantly – to share the best processes put in place.

- **Component 2. Support to Improved Financial Accessibility: (US$6.5 million)**

    - Sub-component 2A: Strengthening of the Health Equity Fund (HEF) ($0.3 million):

      The project would support HEF reform, including (i) the development and the implementation of a new formula for allocating MoH funding to the HEF (across health districts) (ii) a new governance structure for local HEF (i.e. enhancing involvement of local communities in the management of the HEF).
    - Sub-component 2B: Pilot implementation of a passive identification system of poor people ($6.2 million):

      In a limited number of health districts (about 10), this component would support the implementation of a health card system (with biometric control). A survey would identify poor people who would then be given a health card. This component would fund the survey as well as the enrollment process in selected districts.

- **Component 3. Technical Assistance for Institutional Strengthening: (US$1 million)**

  This component would help improve four institutional processes at the MoH: planning, budgeting, monitoring and management. These four functions would each be addressed through a sub-component. The objectives here are to make these processes more efficient, to enhance deconcentration of the health system and to lay the foundations for a SWAp ("one plan, one budget and one M&E system"). For this component, the proposed IDA financing is limited, as it complements technical assistance funded by several Trust Funds (e.g. GAVI) and other donors (UNICEF, Belgium and the EU).

  - Sub-component 3A: Support to improved planning processes ($0.4 million):

    Through training and consulting services, the sub-component would help design and implement a strategic planning process centered on three-year plans and with the following features. First, the plans would be unique and comprehensive. They would describe activities of all MoH departments and programs as well as of donor-funded activities. Second, they would be evidence-based and use MBB analyses. Finally, they would be decentralized, i.e. each three-year plan would have to be the result of planning efforts conducted in each health district. These local planning efforts would use a simplified version of the MBB model .

  - Sub-component 3B: Support to improved budgeting processes ($0.2 million):

    This sub-component would support new budgeting processes to ensure that budgets (such as MTEF, program budgets and annual budgets) are fully consistent with planning processes. It would also support the development and the implementation of new allocation formulas, in order to increase the amount and the efficiency of Government funding to health districts.

    In addition, this sub-component would support the strengthening and the reengineering of MoH processes for financial management, which are a key bottleneck in budget execution.

  - Sub-component 3C: Support to improved monitoring processes ($0.1 million):

    One of the features of a SWAp is to have a common and streamlined M&E system. Therefore, this sub-component would support several improvements of the M&E system, including (i) the merger of overlapping M&E processes, (ii) the development of additional data collection and analysis, and (iii) the strengthening of national capacity in impact evaluation.

  - Sub-component 3D: Support to improved management processes ($0.3 million):

    Improving the three above-mentioned processes (planning, budgeting and monitoring) requires also changing and strengthening management processes. Consequently, this sub-component would support (i) the preparation and implementation of new rules to strengthen the management of local health districts, and (ii) the strengthening of local management capacities.

- **Component 4. Program Management: (US$0.5 million)**

This component would finance the administrative requirements such as program coordination, monitoring and financial reporting related to the program.

4. Safeguard policies that might apply: To be determined

5. Tentative financing

| Source: | | ($m.) |
|---|---|---|
| BORROWER/RECIPIENT | | 0 |
| International Development Association (IDA) | | 15 |
| Norway RBF trust fund | | 9 |
| | Total | 24 |

6. Contact point

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