1. Project Data

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Project Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>P093987</td>
<td>BF-Health Sector Sup. &amp; AIDS Proj (FY06)</td>
</tr>
</tbody>
</table>

Country          | Practice Area (Lead) | Additional Financing |
------------------|----------------------|----------------------|
Burkina Faso     | Health, Nutrition & Population | P110815,P125285 |

L/C/TF Number(s) | Closing Date (Original) | Total Project Cost (USD) |
-----------------|-------------------------|--------------------------|
IDA-41650,IDA-H4000,IDA-H7020,TF-99818 | 30-Jun-2010 | 101,720,000.00 |

Bank Approval Date | Closing Date (Actual) |
-------------------|-----------------------|
27-Apr-2006        | 31-Dec-2014           |

IBRD/IDA (USD) | Grants (USD) |
---------------|--------------|
Original Commitment | 98,700,000.00 | 3,029,158.00 |
Revised Commitment | 98,438,425.70 | 3,028,872.76 |
Actual            | 100,110,902.22 | 3,028,872.76 |

Sector(s)        | Theme(s)                              |
------------------|----------------------------------------|
Health (74%):Other social services (23%):Central Government (3%) | HIV/AIDS (29%):Health system performance (29%):Child health (14%):Malaria (14%):Population and reproductive health (14%) |

Prepared by      | Reviewed by | ICR Review Coordinator | Group |
------------------|-------------|-------------------------|-------|
Hjalte S. A. Sederlof | Judyth L. Twigg | Joy Behrens | IEGHC (Unit 2) |

2. Project Objectives and Components

a. Objectives

The Project Development Objective (PDO) as set out in the Financing Agreement (p. 5) was to support the implementation of the Recipient’s Program which aims at improving health and the fight against HIV/AIDS on the Recipient’s territory. The PDO in the Project Appraisal Document (PAD) was to support implementation of the Borrower’s health sector and multi-sectoral HIV/AIDS strategies, in order to accelerate progress toward the Millennium Development Goals (MDGs) for health, nutrition, and combating HIV/AIDS.

The PDO was revised in 2011 in connection with a second Additional Financing (P125285), and the new PDO as set out in the related Financing Agreement (p. 5) and the Project Paper (PP) was to improve access and quality of priority health, nutrition and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) services.
The achievement of objectives will be assessed using a split rating. Following IEG/OPCS guidelines, the assessment will draw on the original PDO in the Financing Agreement and the revised PDO in the Financing Agreement for the second Additional Financing. Achievement of objectives for the original PDO will be assessed against the following two objectives: improved health (e.g. health outcomes) and improved access and quality of HIV/AIDS services.

Achievement of objectives for the revised PDO will be assessed against the following three objectives: improved access and quality of priority health services; improved access and quality of priority nutrition services; and improved access and quality of improved HIV/AIDS services. Indicators were revised during implementation, to strengthen monitoring of results under the original PDO, and to monitor progress and measure results for the revised PDO. Core IDA indicators were also introduced. Some outcome targets were revised upward to reflect an extension of the Closing Date. As the targets were revised upward, the revision of targets will not be considered in the split rating.

b. Were the project objectives/key associated outcome targets revised during implementation?
Yes

Did the Board approve the revised objectives/key associated outcome targets?
Yes

Date of Board Approval
30-Jun-2011

c. Components
The project included two components:

Component 1. Support for health sector progress towards the MDGs (estimated cost at appraisal US$ 26.70 million; actual cost US$ 62.7 million). It had the following three sub-components:

1.1. Improving quality and utilization of maternal and child health services. The project was to support annual action plans to scale up integrated management of child illnesses (IMCI); improve quality and reduce costs for emergency obstetrical care and normal deliveries; support basic training and equipment for maternal and child health services; improve medical waste management; and enhance supervision, training, and outreach activities (including vaccination). Planning tools and guidelines for districts were to be strengthened to ensure funding for a minimum package of priority maternal and child health activities at facility and community levels. Incentives for provision of key services were to be strengthened through piloting of output-based payments. National and district level health promotion campaigns were to be supported.

1.2. Scaling up the malaria response and control of communicable diseases. As part of the Roll Back Malaria initiative and the Bank’s Africa Region’s Malaria Booster Program, IDA’s contribution to the pooled health fund was to support community and district-level malaria prevention and treatment activities, integrated into district and community action plans and financed through pooled funds at the district level. In addition, the project was to finance key commodities for malaria control, with a particular focus on children under five and pregnant women. To scale up coverage before the next malaria season, beginning in June 2006, up to US$ 3 million for bed net purchases was to be eligible for retroactive financing under the Credit, with additional nets and bed net retreatment kits to be ordered soon after Credit effectiveness. The project was to support finalizing the next phase of the country’s Malaria Strategy (2006-2009). It was also to provide flexible support to allow rapid response to epidemics, monitor the bird flu situation with government and partners, and support integration of bird flu responses into annual work programs.

1.3. Scaling up AIDS treatment. The project was to seek to ensure continuity of AIDS treatments to persons under current programs. Treatment was to be financed and executed through the Ministry of Health, with policy coordination and oversight provided by the National AIDS Council.

Component 2. Support for National Multi-Sectoral HIV/AIDS strategy (estimated cost at appraisal US$ 21 million; actual cost US$ 41.2 million). It had the following two sub-components:

2.1. HIV prevention and behavior change. The project was to support scaling up coverage of HIV prevention programs among high-risk groups (commercial sex workers, miners, truckers, youth) through non-governmental organizations (NGOs) and community-based organizations (CBOs); develop and implement an integrated “second generation” HIV/AIDS behavior change communications strategy for both vulnerable groups and the general population; and support community- and village-level awareness-raising activities. The project also was to support scaling up voluntary testing and counseling for local NGOs and associations; strengthening of HIV/AIDS and reproductive health programs for in- and out-of-school youth; and training, supervision, and monitoring of treatment and prevention of sexually transmitted infections (STI) in the public and private sectors.
2.2. Mitigate socio-economic consequences of HIV/AIDS epidemic. The project was to support national efforts to strengthen care and support for persons infected and affected, in the context of the national Social Protection strategy. This was to include support to the Ministry of Social Affairs (MSA) to strengthen its role in policy and monitoring, as well as direct support for NGOs, CBOs, and communities/villages for care and support for orphans and vulnerable children and persons living with HIV/AIDS.

Revised components
A First Additional Financing (AF1) for the project in the amount of US$ 15 million was approved in June 2008. It helped finance costs associated with (i) the need to accelerate essential nutrition activities at the community level in response to a worsening malnutrition problem, and (ii) control of a meningitis outbreak. The activities formed a new sub-component 1.4 under project Component 1. The community-based nutrition activities were to be implemented in at least five high-risk regions. While the PDO remained unchanged, the results framework was adjusted to (i) include new performance indicators on nutrition outcomes and effective meningitis control measures; (ii) simplify the original results framework by removing some of the original indicators that had limited relevance; and (iii) adjust the targets to reflect a new Closing Date (see below).

A Second Additional Financing (AF2) in the amount of US$ 36 million was approved in June 2011. It was to support sub-component 1.4 under Component 1, introduced under AF1, with part of the additional financing helping to finance the costs associated with the scaling up of the community nutrition activities nationally. It was also to support Component 2, by covering a financing gap for implementing the HIV/AIDS strategy. The IDA Grant was to be co-financed by a trust fund grant of US$3.03 million from the Spanish Program for Africa, administered by IDA. The trust fund grant covered the cost of laboratory equipment for local offices of the National AIDS Council. With the introduction of AF2, the PDO was reformulated to clarify the intent of the original PDO. Most outcome indicators were retained, but some were dropped or replaced with more precise or more relevant indicators. Outcome targets were revised upwards, as appropriate, in line with the extension of the Closing Date.

d. Comments on Project Cost, Financing, Borrower Contribution, and Dates
Project costs: At appraisal, total project costs were estimated at US$ 47.70 million. Actual costs at project closing were US$ 101.73 million.
Financing: The initial IDA Credit of US$ 47.70 million was approved on March 30, 2006. A first Additional Financing (AF1) of US$ 15 million was approved on June 5, 2008, and a second on June 30, 2011. At the time of approval of AF2, US$ 3.03 million from the Spanish Program for Africa was also approved, to be administered through an IDA trust fund. Project financing supported two strategies – health and HIV/AIDS – in two separate pooling arrangements with the Government and a number of donors. The pooling arrangement for health totaled US$ 61.8 million (IDA 12 percent), and for HIV/AIDS totaled US$ 25.5 million (IDA 76 percent). Altogether seven participants contributed to each: Government, IDA, Sweden, the Netherlands, the United Nations Population Fund (UNFPA), African Development Fund (AFD), United Nations Children's Fund (UNICEF), and Germany contributed to the health pool; and the Government, IDA, UNAIDS, the United Nations Development Programme (UNDP), UNICEF, Denmark, and the Netherlands contributed to the HIV/AIDS pool. Outside the pooling arrangement, over a dozen countries and agencies contributed to the two strategies. Likewise, the additional financing for nutrition under AF1 and AF2 (US$ 15.5 million) was funded outside the pooling arrangements.
Dates: The Closing Date of the original project was July 30, 2010. Under AF1, it was extended to January 31, 2013, and under AF2 to December 31, 2014, at which time the project closed.

3. Relevance of Objectives & Design

a. Relevance of Objectives

The PDOs were highly relevant to the country situation, and to Government and Bank strategies. Despite steady progress on key health issues during the implementation of the project – child and maternal mortality and HIV/AIDS prevalence have declined, and key nutrition interventions have increased -- results still fall short of the Millennium Development Goals (MDGs) for the country. The strategic context for the project is provided by the Government's Health Sector Strategy and its National HIV/AIDS Strategy, and a medium-term expenditure framework for health, all of which provide the Government and donors, including the Bank, with an overall financing framework for pooling resources and providing coordinated support to the health sector. The Bank's latest Country Partnership Strategy (CPS) for the period FY13-15 explicitly specifies continued support for policies that are linked to health and nutrition MDGs: “the Bank will work to scale up maternal and child health care, support interventions against malnutrition [...]. The Bank will also help to reinforce the health medium-term expenditure framework (MTEF) to ensure that resource allocations are linked to MDG priorities” (CPS, p. 31). In sum, both the original and
revised objectives remain highly relevant to country conditions, Bank strategy, and Government strategy.

Rating  
Revised Rating  
High  
High

b. Relevance of Design

Project design was consistent with the original and revised PDO. Activities plausibly supported attainment of project objectives through their focus on access and quality of service provision, and on system reform: the engagement of broad district-level public, private, and third sector entities in the provision of project-supported services, while at the same time helping strengthen human and physical capacity and systems for decentralized service provision (the “outputs” of the project, i.e. the so-called cross-cutting reforms discussed in some detail in the PAD). Activities were supported by two separately managed pooled funding mechanisms, one supporting priority health and nutrition activities managed by the Ministry of Health (MOH), and the other for HIV/AIDS by the National AIDS Council. At the time of project design, a series of Poverty Reduction Strategy Credits (PRSC) were under way, in part substituting for direct lending in the health sector. In that context, the project was to serve as a means of addressing operational challenges in a flexible way that may not have been as feasible through the PRSC mechanism. The results framework for the original and the revised PDO included a clear statement of objectives linked to project activities. In the revised PDO, the links were more direct than in the original PDO, which paired an overarching objective of “improved health” with a process objective, “provision of HIV/AIDS services.” A better balance between outcomes and intermediate outcomes from the start might have avoided a revision of the PDO along the way.

Rating  
Revised Rating  
Substantial  
Substantial

4. Achievement of Objectives (Efficacy)

Objective 1

Objective  
Improve health

Rationale  
For all objectives, when assessing efficacy, the results cannot altogether be attributed to the project. In addition to IDA financing and pooled donor funds that provided direct support to project components, un-pooled resources of over a dozen countries and agencies also financed the country’s health, nutrition, and HIV/AIDS strategies. Their interventions are likely to have contributed to project outcomes, although it is not possible to extract evidence of their specific influence.

Outputs  
The ICR, Annex 2, contains a detailed table of the main physical outputs of the project. They consisted of project performance agreements with public and private entities, non-governmental and civil society organizations (NGOs, CSOs), and communities to procure goods and provide agreed services to the targeted beneficiaries. By 2009, all regional health directorates and health districts had annual work plans that underpinned outcomes in the main areas of intervention. Moreover, some 8,500 community health workers were trained by the project, against a target of 9,000, and the share of health centers meeting staffing norms had risen from 75 percent in 2010 to 90 percent by the end of the project. The number of children under five with access to a basic package of health, nutrition, or services reached 1.92 million in 2014, roughly equaling the original target of 1.94 million; baseline 1.6 million

Intermediate outcomes  
Improvements in the quality and utilization of maternal and child health services (the ICR provides data to 2010)
Independent Evaluation Group (IEG)
BF-Health Sector Sup. & AIDS Proj (FY06)(P093987)

Implementation Completion Report (ICR) Review

• Share of women with two or more prenatal consultations during pregnancy reached 91 percent in 2010, compared to a target of 70 percent; baseline 63 percent; (MDG goal 100 percent)
• Share of births attended by skilled personnel at health facilities reached 67 percent in 2010, compared to a target of 38 percent for 2010; baseline 33 percent (MDG goal 60 percent)
• Share of infants less than six months exclusively breast-fed in the past 24 hours reached 26 percent in 2010, compared to a target of 10 percent for 2010; baseline 7 percent
• Share of children under one receiving third dose of pentavalent vaccine (DTC3) reached 89.5 percent in 2010, compared to an original target of 91 percent; baseline 79 percent
• Share of rural children under five who participate in monthly community-based health and nutrition activities reached 23 percent in 2011, compared to a target of 10 percent; baseline zero
• Share of children 6-59 months receiving Vitamin A supplement in past six months reached 63 percent in 2010, compared to a target of 91 percent; baseline 67 percent

Outcomes (the ICR provides data to 2010)
Outcomes in terms of improved health (and nutrition) were recorded against progress on the principal MDGs affected by the project.

• MDG1: halve the 1990 proportion of people suffering from hunger
  • The share of underweight children under 5 decreased from 37.4 percent in 2006 to 34.6 percent in 2010; 2015 target 17 percent
• MDG4: reduce the 1990 under 5 mortality by two thirds
  • Infant mortality per 1000 declined from 81 in 2003 to 65 in 2010 and, according to the World Development Indicators, 61 in 2015 (2015 target 40)
  • Child measles immunization increased from 75 percent in 2006 to 87 percent in 2010; 2015 target 80 percent
  • Under 5 mortality per 1000 decreased from 188 in 2006 to 129 in 2010 and, according to the World Development Indicators, 89 in 2015 (2015 target 68)
• MDG 5: reduce maternal mortality by three quarters
  • Maternal mortality per 100,000 reached 341 in 2010; 2015 target 141.5

Because progress toward health-related MDGs did not approach targets, achievement of this objective is rated Modest.

Rating
Modest

Revised Objective
Objective not revised

Revised Rationale
Objective not revised

Revised Rating
Not Rated/Not Applicable

Objective 2

Objective
Improve the fight against HIV/AIDS on the Recipient's territory/improve access and quality of priority HIV/AIDS services

Rationale

Outputs listed above under Objective 1.

Outcomes:

Improvements in quality and treatment of HIV/AIDS and STIs
Number and share of HIV positive pregnant women receiving prevention of mother-to-child transmission treatment reached 4,487 (92 percent) in 2014, compared to a target of 2,000 (20 percent); 2010 baseline of 3,597 (90.5 percent)
Number of persons taking HIV test reached 330,000 in 2014, compared to a target of 425,000; 2010 baseline 247,000
Number of HIV-infected people receiving antiretroviral treatment reached 46,000 in 2014, compared to a target of 20,000; 2010 baseline 31,500
Number of pregnant women tested for HIV reached 706,000 in 2014, compared to a target of 300,000; baseline n.a.

Improvements in knowledge of HIV prevention and adoption of lower risk behaviors
Number and share of commercial sex workers reached through preventive activities reached 16,250, or 103 percent in 2014, compared to a target of 13,000 (75 percent); baseline 3,500 (42 percent)
Share of reported condom use at last sexual contact among commercial sex workers with paying clients reached 98 percent in 2014, compared to a target of 90 percent; 2010 baseline 97 percent (it is not clear why the target was lower than baseline)
Number of men having sex with men reached with preventive interventions reached 2,100 in 2014, compared with a target of 1,250; baseline n.a.

Rating

Substantial

Revised Objective

Objective not revised

Revised Rationale

Objective not revised

Revised Rating

Not Rated/Not Applicable

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Objective 3

Objective

Improve access and quality of priority health services

Rationale

This objective was added when the project was restructured.

Outputs, in addition to the outputs listed above under Objective 1:
Share of rural children under five who participate in monthly community-based health and nutrition activities reached 79 percent in 2014, compared to a target of 65 percent; 2011 baseline 23 percent

Outcomes:
Share of women with two or more prenatal consultations during pregnancy reached 93 percent in 2014, compared to a target of 75 percent for 2014; PAD baseline (2006) 62.9 percent
Share of births attended by skilled personnel at health facilities reached 82 percent in 2014, compared to a target of 65 percent for 2014; PAD baseline (2006) 33 percent
Share of infants less than six months exclusively breast-fed in the past 24 hours reached 50 percent in 2014, compared to a target of 15
percent for 2014; 2006 baseline 6.8 percent
Share of children under one receiving third dose of pentavalent vaccine (DTC3) reached 102 percent in 2014, compared to a target of 91 percent for 2014; PAD (2006) baseline 57 percent
Number of children 12-23 months completely immunized reached 709,000 in 2014, compared to an original target of 651,000; baseline (2010) 648,000

Rating
Substantial

Revised Objective
Objective not revised

Revised Rationale
Objective not revised

Revised Rating
Not Rated/Not Applicable

Objective 4

Objective
Improve access and quality of priority nutrition services

Rationale
This objective was added when the project was restructured.

Outputs listed above under Objective 1.

Outcomes:
Share of children under five with diarrhea receiving oral rehydration therapy reached 50 percent in 2014, compared to a target of 23 percent; 2010 baseline 21 percent
Share of postpartum women receiving vitamin A supplement within eight weeks of delivery reached 78 percent in 2014 compared to an original target 70 percent; 2010 baseline 57 percent
Share of children 6-59 months receiving Vitamin A supplement in past six months reached 91 percent in 2014, compared to target of 80 percent; 2006 baseline 67.1 percent
Share of children under five with severe acute malnutrition being treated according to the new protocol reached 90 percent in 2014, compared to a target of 50 percent; 2010 baseline 30 percent
Share of newborns put to the breast within the first hour of birth reached 42 percent in 2014, compared to a target of 30 percent; 2010 baseline 20 percent

Rating
Substantial
5. Efficiency

The ICR undertakes a methodical analysis of the efficiency of the project along several dimensions – allocative, productive, implementation, and technical efficiency. At the same time, it recognizes limitations due to issues of attribution, as significant un-pooled donor resources also supported national health and HIV/AIDS programs. These may overstate project outcomes. In terms of allocative efficiency, the project prioritized activities that were known to be cost effective and that were strategic priorities for the development of the health sector in the country. Productive efficiency was enhanced by the application of cost-effective procurement methods that were likely to yield relatively low-cost contracting. Project implementation arrangements were efficient as they pooled funding and harmonized procedures for timely disbursements; and drew on a public-private mix for service delivery. For technical efficiency, the ICR drew on comparative international analysis (Jamison et al. Disease Control Priorities in Developing Countries, 2008). An estimate of DALYs gained varied between 770,000 and 1.5 million.

Efficiency Rating
Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

<table>
<thead>
<tr>
<th>Rate Available?</th>
<th>Point value (%)</th>
<th>*Coverage/Scope (%)</th>
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</thead>
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<td>Appraisal</td>
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</tr>
<tr>
<td>ICR Estimate</td>
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* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

The ratings for outcomes under the original objectives are: high relevance of objectives, as the project's objectives remain relevant to the country situation as well as Burkina’s health and HIV/AIDS strategies and the Bank’s CPS for Burkina; substantial relevance of project design, reflecting a sound causal chain between design and PDO; modest achievement of the improved health objective; and substantial achievement of the HIV/AIDS objective. Efficiency is rated substantial. The outcome rating under the original objectives is moderately satisfactory.

The ratings for outcomes under the revised objectives are: high relevance of the project's objectives to the country situation and Government and Bank strategies; substantial relevance for design; substantial achievement of each of the three objectives under the revised PDO (improved access and quality of priority health services, improved access and quality of priority nutrition services, and improve access and quality of priority HIV/AIDS services). Efficiency is rated substantial. Based on these ratings, the outcome rating under the revised objectives is
satisfactory.
The final outcome rating is determined by the ratings for outcome under the original and revised objectives, weighted by the percentage of the grant that disbursed before and after the restructurings. The grant had disbursed 56 percent of project costs under the original PDO, and 44 percent under the revised PDO.
The weighted value under the original objective is calculated as follows: 4 for moderately satisfactory x 56 percent of total disbursements before revision = 2.24. The weighted value under the restructuring is 5 for satisfactory x 44 percent = 2.2.
The weighted average score is 2.24+2.2= 4.44, or 4 when rounded to the nearest whole number. Therefore, the overall outcome rating is moderately satisfactory, reflecting moderate shortcomings in the project's preparation and implementation.

8. Assessment of Bank Performance

a. Quality-at-Entry
The project drew on extensive prior Bank experience in the health sector in Burkina, both at the level of disease control and in terms of health systems reform (the latter reflected in the series of PRSC projects). It was further underpinned by a strong information base, including a number of Demographic and Health Surveys (DHS), a public expenditure review, national health accounts, and a developing health information system. The project also had the advantage of working with a strongly committed Government and in the framework of two national strategies (health and HIV/AIDS). That said, little attention appears to have been paid to eventual synergies between the PRSCs and the project, even though the former also envisioned supporting health systems reform. A broadly articulated PDO and a large number of related indicators gave the impression of a relatively cumbersome project, and this was subsequently confirmed through the revisions that were introduced. More attention could have been paid to the measurability of indicators and, simply, their high number for some outcomes.

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
Project supervision missions were regular and appropriately staffed, and had the benefit of in-country presence. Supervision was proactive in addressing issues as they arose, as reflected in the Additional Financings, adjustments to the indicators, and attention to safeguards. As was the case during preparation, there seems to have been insufficient attention paid to the potential advantages that the PRSC might have brought to the table, albeit one project dealt with policy and the other with service provision. Collaboration with Government and stakeholders appears to have been positive.
Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. Assessment of Borrower Performance

a. Government Performance

There was strong Government ownership of the health medium-term expenditure framework and the health and HIV/AIDS strategies, and consequently the project, throughout the project period. This created an enabling environment that facilitated project preparation and implementation, and certainly must have supported efforts related to decentralization of service provision to community levels.

Government Performance Rating
Satisfactory

b. Implementing Agency Performance

The two implementing agencies were the MOH and the National AIDS Council and within them, project management units established under earlier projects. They both had qualified staff with low turnover. Collaboration between the two was established through a Memorandum of Understanding, and it worked smoothly. Decentralization appears to have caused some difficulties for both agencies, creating some tension with local entities.

Implementing Agency Performance Rating
Moderately Satisfactory

Overall Borrower Performance Rating
Moderately Satisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design

Initially, the PDO could have been clearer, but this was corrected by AF2. Indicators reflected objectives, and in most instances they were measurable; where this was not the case, they were revised or dropped during implementation. In some instances, new indicators were introduced to adjust to the changes in emphasis that were introduced with AF1 and AF2. In addition to the routine data collection system, i.e. the Health Management Information System (HMIS), M&E design was enhanced by progress reporting from the community level. Baselines and targets were initially set at the start of the project, and adjusted (or new indicators introduced) at the beginning of AF1 and AF2.
b. M&E Implementation

Initially, the data for many indicators turned out to be difficult to collect, analyze, and process. Where this was the case, indicators were adjusted at the introduction of AF1 and AF2. Project implementation brought about revisions to key elements of the HMIS system: data collection tools, their harmonization with the MIS, consensus on priority indicators, a new masterplan, and a dictionary of metadata.

c. M&E Utilization

Results were made widely available and used to organize planning and supervision of annual work plans. A results-based financing (RBF) pilot was incorporated into a Bank-funded reproductive health project for scaling up.

M&E Quality Rating

Substantial

11. Other Issues

a. Safeguards

Based on considerations of contaminated health care waste handling, storage, and disposal, the original project was classified as a Category B operation. The first AF was classified as Category C, while the second AF was classified as Category B.

In 2005, an assessment of existing policies and practices was conducted, a Medical Waste Management Plan (MWMP) formulated, and a detailed action plan prepared with the broad participation of future stakeholders in its implementation. The plans emphasized the need for (a) changes in attitudes (among health workers and decision makers), (b) adoption of an appropriate legal and regulatory framework, and (c) development and adequate financing of measures for effective and efficient management of medical waste. Throughout project implementation, compliance with environmental safeguards was rated Satisfactory or Moderately Satisfactory. However, the basic tools for implementing the strategy at hospital level were not adopted until 2008, and staff sensitization and training was sporadic. In 2008, the MOH identified poorly defined responsibilities and a lack of resources as reasons for the slow implementation. Measures were introduced to improve performance. In 2011, the MWMP was evaluated and updated for the period 2011–2015. Many of the problems (organizational, financial, technical, and attitudinal) noted in earlier assessments persisted. In October 2014, a supervision mission concluded that (a) appropriate medical waste management structures were not present in most health facilities (except for hospitals); (b) maintenance of incinerators was absent and the majority were not functioning; (c) materials, training, and financial resources were inadequate; and (d) transport and disposal were poorly organized. A Bank assessment of the 2011–2015 plan found that only two thirds of the planned activities had been achieved or partially achieved.

b. Fiduciary Compliance

Procurement. The procurement capabilities of the MOH project management unit, to be complemented by recruitment of an internationally qualified procurement consultant, were judged at appraisal to be satisfactory. Periodic reviews of both project management units by the Bank's fiduciary services indicated persistent shortcomings: delayed procurement planning, lengthy bid evaluations, weak contract administration, and poor document management. Action plans were regularly prepared, implemented, and monitored. Risk was generally rated Moderate but elevated to Substantial during the assessment of May 2014. It was mitigated by the recruitment of a new experienced procurement specialist for the project.

Financial Management. Financial management assessments over the life of the project were generally positive for Component 1; weaknesses were noted for Component 2, including in staffing, record keeping, and financial monitoring. In addition, Component 2 had issues with ineligible expenditures in 2008, but these were resolved and not repeated. All of the audits for both components were unqualified.
c. Unintended impacts (Positive or Negative)
   None reported.

d. Other
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### 12. Ratings

<table>
<thead>
<tr>
<th>Ratings</th>
<th>ICR</th>
<th>IEG</th>
<th>Reason for Disagreements/Comment</th>
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<tbody>
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<td>Outcome</td>
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<td>Moderately Satisfactory</td>
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</tr>
<tr>
<td>Risk to Development Outcome</td>
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<td>Modest</td>
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<tr>
<td>Bank Performance</td>
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<td>Moderately Satisfactory</td>
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<tr>
<td>Borrower Performance</td>
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<td>Moderately Satisfactory</td>
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</tr>
<tr>
<td>Quality of ICR</td>
<td>Substantial</td>
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</tbody>
</table>

**Note**

When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.

The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

### 13. Lessons

Lessons drawn from the ICR (pp. 43-44):

**Establishing an enabling environment for program achievement may be easier than sustaining it.** Projects are most effective when political leadership provides an enabling environment for program achievement and program achievement provides a justification for continued political commitment. Burkina Faso succeeded in combining several reinforcing elements for the enabling environment: political and strategic orientation; institutional arrangements (harmonized procedures, participatory decision making including all stakeholders); fiduciary and administrative modalities (pooled funding, decentralization); and programmatic decisions and results (community-based services). Sustaining a contribution to these mutually reinforcing relationships is particularly difficult for external funding agencies, as over time: (a) changing leadership within these agencies requires constant consensus building; (b) perceptions of the utility of investing time in sector coordination and harmonization differ; and (c) pressures to link individual agency financing with specific results can become critical. Despite Burkina Faso’s continued support for the strategic orientations above, there has been a gradual attrition of support from the partners for certain key elements (and for pooled funding in particular). Such evolving priorities may have potential implications for the expansion of the RBF initiative currently being financed by the Bank.

**Government ownership and leadership is a core requirement for successful institutional arrangements.** Establishing the institutional framework for program implementation is an essential step during the preparation phase. Project implementation arrangements may also compensate for a lack of sectoral reform. Because key country reform elements (such as decentralization, human and financial resource management, procurement, and so on) advance slowly, projects often provide a means to achieve the reforms. Many of the project’s initiatives were in advance of the country’s general politico-administrative agenda and enabled the sector to demonstrate both the potential strengths and weaknesses of the proposed reforms. This was the case, for example, in the successful effort to decentralize management in the health sector.

### 14. Assessment Recommended?
15. Comments on Quality of ICR

The evidence in the ICR is sufficient to assess key elements, and it includes both description and analysis. The report is internally consistent, well articulated, and in line with ICR guidelines

a. Quality of ICR Rating
   Substantial