



## 1. Project Data

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| <b>Project ID</b><br>P119917   | <b>Project Name</b><br>BF-Reproductive Health Project (FY12) |
| <b>Country</b><br>Burkina Faso | <b>Practice Area(Lead)</b><br>Health, Nutrition & Population |

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|---|---|--|
| <b>L/C/TF Number(s)</b><br>IDA-D1080,IDA-H7510,TF-11678 | <b>Closing Date (Original)</b><br>31-Dec-2016 | <b>Total Project Cost (USD)</b><br>74,519,482.53 |
|---|---|--|

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|--|---|
| <b>Bank Approval Date</b><br>20-Dec-2011 | <b>Closing Date (Actual)</b><br>30-Jun-2018 |
|--|---|

|                     | <b>IBRD/IDA (USD)</b> | <b>Grants (USD)</b> |
|---------------------|-----------------------|---------------------|
| Original Commitment | 28,900,000.00         | 12,700,000.00       |
| Revised Commitment  | 76,312,322.85         | 12,679,198.28       |
| Actual              | 74,519,482.53         | 12,679,198.28       |

|   |                                       |  |                                |
|---|---------------------------------------|--|--------------------------------|
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## 2. Project Objectives and Components

### a. Objectives

The original PDO was stated as follows: “The objective of the Project is to improve the utilization and quality of reproductive health services in the Recipient’s territory, with a particular focus on selected regions of the Recipient” (Financial Agreement (FA) signed February 14th, 2012, page 5).

The PDO was revised in the 2016 Additional Financing (AF) and project restructuring to the following: “The objective of the Project is to improve the utilization and quality of maternal and child health, reproductive



health and HIV/AIDS services in the Recipient's territory with a particular focus on the poor and vulnerable".(AF FA, schedule 1, page 5).

This review will follow the approach used in the ICR, consistent with current OPCS Guidelines, and assess the project achievements against the PDO as revised in the 2016 Additional Financing (AF) and project restructuring. Following the Guidelines, a split rating is not warranted because the AF and Restructuring project did not materially change the project objectives, but simply increased the ambition of the project by including additional HIV/AIDS activities and increasing the scope of activities to increase access to health care by the poor. The "selected regions" referred to in the original PDO were mostly chosen because of their especially poor maternal and child health (MCH) indicators (PAD pp 18-20), which are correlates of poverty. This poverty-related focus is restated in a more explicit way in the final phrase of the revised PDO as a "particular focus on the poor and vulnerable." As in the ICR, this review will consider three aspects of the PDO: (i) improved utilization of maternal and child health, reproductive health and HIV/AIDS services, (ii) improved quality of maternal and child health, reproductive health and HIV/AIDS services, and (iii) the achievement of the activities that specifically targeted the poorest people.

**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**

15-Mar-2016

**c. Will a split evaluation be undertaken?**

No

**d. Components**

**1. Improving delivery and quality of a Package of Basic Health Services through Results-Based Financing** (appraisal US\$22.3 million, AF US\$21.7 million, actual US\$43.3 million). This component would provide Results-Based Financing (RBF) grants to health centers to deliver "Packages of Basic Health Services" in fifteen districts in six regions, covering one quarter of the population. RBF payments would be based on quantities of a specified list of reproductive, maternal, and child health services (assisted deliveries, family planning visits, immunizations, children under 5 curative consultations, adult curative care visits, antiretroviral treatment, malaria and tuberculosis treatment, etc), adjusted for quality measures. Health centers could use the RBF funds to pay health workers, buy equipment and drugs, training, outreach, etc., with the expectation that centers would aim to expand demand and use of the services. Although the project focus was on maternal and neonatal health, the RBF covered a broader package so that other services would not be neglected.

An international firm would provide technical support (at national and district levels) to help the Ministry of Health (MOH) develop and implement the RBF scheme, improve the health information system (HMIS), especially facility reporting, and monitor and verify the RBF payments, subcontracting local civil society organizations (CSOs) to check consistency between facility records and exit surveys of patients. Training for local stakeholders on the RBF was to be funded. A research study would evaluate different approaches



to delivering basic health services across the country, as the basis for rolling out the RBF approach country-wide.

**2. Critical inputs for reproductive health and HIV/AIDS services** (appraisal US\$19.3 million, AF US\$13.3 million, actual US\$33.3 million). National-level activities would include pre-service and in-service training for nurses, skilled birth attendants, and doctors on emergency obstetric and neonatal care, family planning, prevention of mother-to-child HIV transmission, integrated management of child illnesses, management of health services, etc.; and supervision of emergency obstetric and neo-natal care and family planning interventions. District-level activities would include drugs and equipment to improve obstetric and neonatal services (including ambulances, motorcycles, emergency delivery kits, drugs, contraceptives, equipment for waste management, etc.), and minor refurbishing of health centers and district hospitals and laboratories. To increase demand for family planning and reproductive health services, non-governmental organizations (NGOs) would be contracted to carry out information, education and communication (IEC) and behavioral change communication (BCC) activities at community level, in partnership with community-based organizations.

### **Revised components**

In March 2016, AF of \$35 million was approved, the project scope broadened to expand the activities related to HIV/AIDS and focusing on the poor, funds reallocated, and the closing date extended by 18 months. The following additions were made:

Component 1: The list of services eligible for RBF payments was expanded to include services provided free of charge for the poorest (beneficiaries of community-based targeting and community-based health insurance, CBHI) and more HIV/AIDS-related services. A new sub-component, *Supporting Universal Health Coverage through improving financial access to health services for poor and indigent populations*, would fund expansions of promising pilots of CBHI and community-based targeting (CBT) conducted in the first years of the project, and reimburse facilities for lost revenue from fee exemptions for the poorest decile. The list of services provided free that could be reimbursed would be expanded.

Component 2: A new sub-component, *Strengthening creation of HIV/AIDS and STI demand for prevention and treatment among people living with HIV and AIDS, youth and women*, would fund efforts to increase demand for HIV prevention and treatment services, especially among high risk groups.

### **e. Comments on Project Cost, Financing, Borrower Contribution, and Dates**

**Project Costs, Financing, and Borrower Contribution:** Total project costs were estimated at US\$ 41.6 million at appraisal, financed by an IDA grant of US\$ 28.9 million, and a grant of US\$ 12.68 from the Health Results Innovation Trust Fund (HRI TF). There was no borrower contribution. AF through an IDA grant of US\$ 35 million was provided in 2016 to fill funding gaps for the RBF and the national HIV program, and help expand pilot strategies to subsidize health care for the poor through CBT and CBHI. After closing, total disbursement was US\$74.5 million, 97.3% of the total commitment of US\$76.6 million.

**Dates:** The project was approved in December 2011 and became effective on October 22, 2012. Following a Mid-Term Review (MTR) in July 2015, AF was approved on March 15, 2016, and the project restructured as described above. The closing date was extended from December 31, 2016 to June 30, 2018. At restructuring, US\$30.83 million had been disbursed. A second restructuring, approved January 29, 2018,



reallocated remaining funds from other sub-components to enable overdue RBF payments to be made. A government request to extend the project was denied because project performance had deteriorated, project funds had been almost fully used, and a new operation under preparation gave the opportunity to devise improved implementation arrangements.

### 3. Relevance of Objectives

#### Rationale

The relevance of objectives is rated High. The project **addressed serious shortcomings in health outcomes and access to health services**, described in the PAD (pp. 11-12) and ICR (page 5). At appraisal, Burkina Faso was performing poorly on Millennium Development Goals 4 (reducing child mortality) and 5 (reducing maternal mortality). Very high total fertility (an average of six pregnancies per woman) and rapid population growth (3.4 percent per year) contributed to poverty. Use of modern contraceptive methods was very low (15 percent contraceptive prevalence rate, DHS 2010), and unmet need was high: 33 percent of married women wanted to avoid or space pregnancies but used no contraception. High maternal mortality (307.3 per 100,000, RGPH 2006) was partly a result of poor access to care: only 67 percent of deliveries were assisted by skilled attendants (DHS 2010), and 26 percent of newborns and 72 percent of new mothers received postpartum care (DHS 2010). One in five children did not survive to age five. The PAD noted large disparities in access to services and health outcomes between rural and urban areas and across income quintiles. Service quality was undermined by demotivated public sector health workers due to low salaries, poorly developed career structures, limited accountability, inadequate skills, and insufficient equipment and drugs.

Throughout the project, the objectives **aligned with national priorities**, notably the emphasis on demographic issues in the third Poverty Reduction Strategy Paper for Burkina Faso (2011-2015); the goal of the Burkina-Faso National Economic and Social Plan 2016-2020 to “improve human capital”, specifically objective 2.1 to promote population health and accelerate the demographic transition; and the National Health Plan 2011-2020 strategic objective 2 to “improve health services delivery” by strengthening the supply of health services, improve the quality of MCH, and improve quality and motivation of human resources for health (objective 3.2). The CBHI activities supported by the project were a useful pilot for acting on the 2015 universal health insurance law (Law number 060-2015/CNT).

There was **clear consistency with the World Bank’s assistance strategy in the country over the life of the project**. Strategic Theme 2 of the 2010-2012 Country Assistance Strategy (CAS) was “Promoting shared growth through improved social service delivery”; CAS priorities and goals were “to better serve the needs of the poor; increase access to services; strengthen institutional capacity; upgrade quality and effectiveness of services delivery; enhance the role of the private sector in achieving important public health goals; and decentralize through enhanced participation of the local bodies and the community.” At project closing, the objectives remained fully consistent with the Bank’s Country Partnership Strategy for Burkina-Faso (2018-2023) objective 2.2: Expand access to reproductive health and nutrition. The project aligned with the Bank’s Health, Nutrition, and Population (HNP) 2007 strategy, and the 2016 “Updates to the Priority Directions for the HNP Global Practice” (notably “ensuring equitable access to affordable, quality HNP services,” slide 8), as well as the Reproductive Health Action Plan (2010-2015) focus on improving access to quality family planning and reproductive health services.



The PAD and ICR provided no discussion of the level of ambition or feasibility of the targets. The project aimed for substantial improvements, in a context of political and social instability and high illiteracy and poverty. The **project built on previous Bank assistance to the Government** to set up a pooled fund (*panier commun*) to support the delivery of a minimum package of health services.

## Rating

High

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1

#### Objective

To improve utilization of maternal and child health, reproductive health and HIV/AIDS services

#### Rationale

The theory of change was that utilization of services would be increased by activities to boost both demand and supply. Demand would be increased by contracting NGOs and CSOs to inform and educate communities about the availability and benefits of the services and encourage their use. The RBF scheme would motivate and support service providers by giving them financial incentives, training, technical assistance, supportive supervision, and regular monitoring and feedback. Facilities would receive equipment, drugs and supplies, as well as additional funds through the RBF and relative autonomy in how the funds were used. Typical experience with RBF programs in other countries is that facilities use the funds for activities that improve their ability to provide services and also boost use of services, such as hiring additional staff, doing more outreach into the communities they serve, and providing small payments to traditional midwives when they refer women to the facility.

#### Outputs and Intermediate Results

1. The RBF program was implemented in about 600 primary and secondary care health facilities in 15 health districts in 6 regions, covering a population of around 4.9 million (at the end of the project), 25 percent of the population of Burkina-Faso.

- Unit prices were set for a range of basic services based on estimated costs, and quality indicators were devised.
- Three agencies were hired to manage the RBF contracts with facilities, including verifying payment claims.
- In 2013 and early 2014, 3,604 health staff and 194 community verification agents were trained on the RBF.
- Local community organizations were contracted to conduct RBF beneficiary surveys.



- Vehicles for supervision and outreach were purchased (152 bicycles, 21 field supervision vehicles, 15 ambulances).
- A cloud computing system was set up ([www.fbrburkina.org](http://www.fbrburkina.org)) to enable RBF data to be submitted and reviewed efficiently.
- RBF payments to health facilities began at the end of 2014. Payments were made on time for the first two years, but delayed in 2016 and 2017, preventing the project meeting the intermediate indicator target of at least 80 percent of facilities receiving their RBF payments on time.

2. NGOs were recruited to promote demand for family planning and reproductive health services and HIV/AIDS services.
3. Clinical skills training was provided to nurses, doctors, and skilled birth attendants.
4. Equipment, drugs, and other supplies, especially for obstetric and neo-natal services, were provided to facilities.
5. To promote use of HIV/AIDS services, especially among high-risk groups, local experienced NGOs were contracted to deliver targeted IEC and BCC to youth, women, sex workers, truckers, and other groups at high risk of infection, using messages and activities appropriate to the target groups and local context.
6. Voluntary counselling and HIV testing was scaled up.

## Outcomes

### Maternal health services

The percentage of women who received a postnatal consultation between the 6th day and 6th week of delivery was 58.7 percent, which exceeded the target of 42 percent. (PDO Indicator)

Utilization of ante-natal care services declined over the project. The 69 percent of pregnant women receiving at least two antenatal care visits was below the target of 86.5 percent and had fallen from the 74.5 percent achieved in 2015 (AF Project Paper Annex 1). Similarly, the 75 percent of pregnant women who received at least two doses of anti-tetanus immunization in 2017 fell far short of even the revised target of 86 percent (the original target was 98 percent), and was lower than the 82 percent achieved in 2015 (AF Project Paper Annex 1).

The percentage of Cesarean sections among planned pregnancies rose from the baseline of 1.3 percent to 2.43 percent, compared to a revised target of 3.1 percent. (The original target was 4.5 percent.) The ICR computed this as partially achieved, but as the actual increase from the baseline was only 61 percent of the targeted increase, and therefore this is considered as not achieved.

### Reproductive health services

The number of new acceptors of modern contraceptive methods reached 586,980, 76 percent of the target of 770,000. (PDO Indicator)



### **Child health services**

A cumulative total of 585,566 children were immunized, 68 percent of the target of 860,000. (PDO Indicator)

### **HIV/AIDS services**

A total of 874,064 pregnant women received voluntary counseling and testing services, over 98 percent of the target of 889,090. This helped to identify the 5,348 pregnant women living with HIV who received antiretroviral (ARV) drugs under the project to reduce the risk of mother-to-child transmission, 87 percent of the target of 6,135. (PDO Indicator)

**Rating:** Modest, taking account of the levels of achievement relative to the targets set. The ICR did not provide additional data beyond the project indicators.

### **Rating**

Modest

## **OBJECTIVE 2**

### **Objective**

To improve the quality of maternal and child health, reproductive health and HIV/AIDS services

### **Rationale**

The theory of change expected the quality of services to be improved as a result of in-service and pre-service training to improve providers' skills; enhanced motivation and accountability resulting from the RBF program; and quarterly monitoring of facility performance against a checklist of quality-related items. Using the quality score to adjust the amount of RBF payments was expected to provide a financial incentive for improving and maintaining quality. Annual surveys of patients to ask about their satisfaction with services received and any grievances were expected to provide feedback to facilities that would also help lead to improved service quality.

### **Outputs and Intermediate Results**

1. Pre-service training was provided to 120 midwives and nurses, and in-service training to several thousand health workers. The intermediate indicator reported that a total of 3,700 health personnel received training, 93% of the target of 4,000.
2. Facilities were provided with drugs and equipment to improve obstetric and neo-natal services. Teaching aids to improve quality of training were distributed to the five regional nursing hospitals.
3. A quality checklist was administered every quarter to health facilities and used to adjust the RBF payments earned by facilities.



## Outcomes

Only one PDO indicator was used to assess changes in the quality of services: the proportion of births assisted by skilled personnel. The ICR reported the target as substantially (90 percent) achieved, comparing the end result of 79 percent of births assisted by skilled personnel, against a revised target of 88 percent. However, in this calculation, the ICR did not follow OPCS Guidelines for assessing achievement. The PAD gave the baseline as 69 percent, not 0 as shown in ICR Annex 1. The end result of 79 percent is an increase of 10 percentage points, only 53 percent of the target increase of 19 percentage points. This means that this target was not achieved. (The original target of 80 percent had been well exceeded in 2015, with 86 percent of births attended by skilled personnel when the AF was processed, as reported in Annex 1 of the AF Project Paper.)

The intermediate indicator of quality, the percent of facilities with no contraceptive stock-outs in the last three months, increased from the baseline of 71 percent to 90 percent, 65 percent of the target increase to 100 percent, which is considered partly achieved. The other intermediate indicator that the ICR linked to the quality objective, number of health personnel trained (substantially achieved), is listed above among the project outputs.

The ICR noted that the RBF approach includes a strong focus on quality improvement. Items in the quality checklist administered every quarter to health facilities showed good improvements between the start of the RBF (quarter 1 of 2014) and the end of 2017 (ICR Annex 1, Figure 3). The quality score for maternal and reproductive health services (antenatal care, assisted delivery, and family planning) about doubled, from between 31 and 36 percent to 75 and 78 percent. Management of childhood illnesses quality was high at the start of the RBF (79 percent) and ended at much the same level, but was lower for most of the RBF, falling to 50 percent in some quarters. The ICR reported that the RBF technical quality score related to monitoring of people living with HIV who were on ARV treatment showed little improvement; the annual average score was 39 percent in 2015 and 39.75 percent in 2017 (ICR, page 17). When looked at by level of facility, the overall quality scores showed marked improvement from 2014 to 2016, and then some decline, but still ended in 2017 well above the starting level (ICR Appendix 1 Figure 4, p39). Primary health clinics began at 45 percent, peaked at 79 percent, and ended at 77 percent. District hospitals began at 47 percent, peaked at 76 percent, and ended at 69 percent. Regional hospitals started at only 34 percent, improved steadily during the first year of the project, and then sustained a rating of 63-64 percent for most of the rest of the program.

The ICR reported that the impact evaluation (IE) found a mixed picture in comparing RBF facilities and the facilities included as controls: the same level of availability of power and safe water in RBF facilities at baseline and endline but decreased availability at control facilities; RBF facilities had greater improvements in ante-natal care routine services (no details given), but RBF participation appeared to have no effect on drug availability and negative impacts on quality of child care services and perceived quality of care. In a phone conversation on December 5, 2019 with the ICR Reviewer, the last project TTL noted that there were puzzling inconsistencies in the IE results.

**Rating:** Modest, based on the RBF quality checklist data. The project indicators by themselves would suggest only a negligible rating, but the RBF quality data collected quarterly showed sizable and mostly sustained gains.





**Rating**  
Modest

### **OBJECTIVE 3**

#### **Objective**

To increase utilization and quality of maternal and child health, reproductive health and HIV/AIDS services for the poor and vulnerable

#### **Rationale**

The theory of change assumed that the demand-promoting activities, combined with exempting the poorest ten percent of people in each community from paying fees, and setting up CBHI, would result in increased use of health services by the poor and vulnerable. (The revised PDO makes explicit the project emphasis on the poor and vulnerable, but this was not considered a material change in the project, which from the start included activities specifically targeting the poorest.)

#### **Outputs and Intermediate Results**

1. Project support enabled CBHI to be expanded to cover 40 percent of communes across Burkina-Faso. Enrollment in the 17 health insurance schemes put in place in the *Boucle du Mouhoun* region began in May 2015. CBHI identification cards began to be distributed in November 2015.
2. Between March 2017 and March 2018, 71 new health mutuals were set up, and nine regional unions were set up under a contract with the NGO ASMADE to support the health mutual roll-out.
3. The project supported CBT, in which communities were asked to identify the poorest 10 percent of their members, for whom health services fees were waived. The RBF program reimbursed providers for the waived fees.
4. A study was done to compare CBT and proxy-means testing as mechanisms to identify the poor.

#### **Outcomes**

At completion, 130,550 poor people had been identified as eligible to receive health services free of charge; this was 131 percent of the target number of 100,000 people. (PDO indicator) The Intermediate Result Indicator was substantially achieved: 14 percent of the target population were enrolled in a CBHI scheme, against a target of 15 percent (93 percent). The ICR noted that the project helped build the foundation for the expected roll-out of a national health insurance scheme.

Removing financial barriers to accessing health care is often extremely important, but does not necessarily result in increased utilization of services. The IE found that in RBF facilities, use of modern family planning among the poorest 20 percent was 7.6 percentage points higher than at the control group facilities, with larger differences where the RBF program was combined with demand-side interventions (CBHI or subsidization of



services provided to the poorest). The IE did not find differences in changed utilization of other maternal or reproductive health services or of preventive child services among the poorest between the RBF facilities and those in the control groups. The IE found some (unspecified level of) impact in reduced prevalence of severe acute child malnutrition among the poorest 20 percent in the RBF facilities, which suggests increased use and/or quality of services to address child malnutrition.

The ICR noted (page 18) that no data were available for assessing whether the quality of care for the poor and vulnerable improved differently from the overall assessment of the quality of care.

**Rating:** Modest. Although one target was exceeded and the other almost fully met, fees are not the only barriers to care faced by poor people. The IE data suggest an increased use by the poor of modern contraception and perhaps child nutrition services, but not of other maternal and child health or HIV/AIDS services.

**Rating**  
Modest

## **OVERALL EFFICACY**

### **Rationale**

#### **Attribution of Results to the Project**

The ICR did not provide information that would enable an assessment of the extent to which outcomes are likely to be attributable to the project. It mentions “initiatives from other donors to improve modern contraceptive prevalence” (page 21). The PAD and AF Project Paper noted that the health sector was also supported by other development partners, notably United Nations Population Fund, UNICEF (the lead agency for the donor group in the pooled funding for the health sector), the German Cooperation, French Cooperation, and the Global Fund, as well as the World Bank Sahel Women's Empowerment and Demographics Project, and (in the initial years) an HIV/AIDS project. There is no information on whether this other support might have contributed to the reported results.

The ICR also did not offer much comment on the counterfactual of what might have happened to the utilization and quality of health services by the overall population or the poor in the absence of the project. There was no information on the extent to which the RBF program increased the revenues and operational budgets of the participating facilities and control group facilities. Information comparing changes in utilization in the districts covered and not covered by the project might have been interesting but are not provided. The ICR noted that a nation-wide fee exemption policy for pregnant women and children under 5 years was introduced in 2016 (ICR, page 21). This might be expected to have increased their use of services independently of project activities. The ICR did not discuss the likely impact of this policy on relevant project indicators, beyond noting that the additional reimbursements provided under the new policy might have reinforced the incentive provided by the RBF to deliver the covered services (ICR, page 22). Annual trend



data on the utilization indicators is not provided, but might have provided insights into the contribution of the project and how it was affected by the change in policy, especially regarding benefits for the poor.

The overall rating of project efficacy is modest because relatively few of the indicator targets were fully achieved, and in several cases, the increases in utilization fell far short of the increases that the project had hoped to achieve.

**Overall Efficacy Rating**

Modest

**Primary Reason**

Low achievement

**5. Efficiency**

**Ex-ante analysis of efficiency.** The PAD (Annex 8, pp. 75-76) presented a cost-benefit analysis (CBA) of the economic soundness of the project, taking account of direct costs and benefits. The CBA estimated an economic rate of return of around 35 percent, assuming a benefit stream lasting ten years and a 10 percent discount rate. There was no explanation of the list of benefits included, or of the basis for estimating the stream of benefits or for assigning monetary values. No details were provided of a sensitivity analysis that was said to have “also resulted in a positive NPV when the discount rate was altered.” This makes it impossible to comment on the reliability of the CBA estimate.

**Ex-post analysis of efficiency.** The ICR did not attempt to calculate a CBA or other quantitative summary measure of project efficiency. It made a case for allocative efficiency, based on the choice of the health services that were the focus of the project. There is well-accepted global evidence that the reproductive, maternal, child, and HIV/AIDS interventions supported by the project are highly cost-effective. For instance, training of community health workers and midwives cost US\$150 to US1,000 per disability-adjusted life-year (DALY) averted depending on the national context, similar to a package of safe motherhood initiatives that includes ante-natal and post-natal care by trained health attendants (the definitive summary source for the global data is cited: *Disease Control Priorities Handbook 3*, volume 2, chapter 17; DALY is a summary measure of the burden of disease, expressed as the number of years lost due to ill-health, disability or early death). The ICR stated that the project costs were “minimal” and estimated the project cost per capita for the covered population (ICR, page 46). However, the level of costs is not a measure of efficiency in itself.

The ICR asserted that **implementation efficiency** was substantial, noting (page 19) that “the Project was implemented in a difficult context, considering the political instability and security issues in-country, but still managed to disburse more than 98 percent of the allocated financing [...] (original IDA Grant, HRI TF Trust Funds and AF) and all planned activities were implemented.” However, the ICR offered few details to support the assertion. The AF Project Paper supported this assessment, at least until 2016. However, the disruption to project implementation in 2016 and 2017 seems not to have been given appropriate weight in the ICR. Project coordination was handled by the MOH’s existing Health Development Support Program -- *Programme d’Appui du Développement Sanitaire* (PADS) -- that also coordinated projects funded by other donors, and managed the pooled funds for health provided by various donors. The ICR noted that the initially well-functioning PADS was affected by changes in leadership and staff that decreased its performance (ICR, pp. 21, 22). The RBF technical unit lost influence after being moved from the General Secretariat to a technical directorate (ICR, page 21). Poor coordination in MOH and funding shortfalls led to delays in RBF payments that undermined provider motivation. Additionally, mid-2016, the National Purchasing Center for generic and essential drugs experienced an



unprecedented institutional crisis that led to a national medicines stock-out including contraceptive and AAV vaccines in 2017 (ICR, page 22).

### Efficiency Rating

Modest

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:

|              | Rate Available? | Point value (%) | *Coverage/Scope (%)                               |
|--------------|-----------------|-----------------|---|
| Appraisal    | ✓               | 35.00           | 100.00<br><input type="checkbox"/> Not Applicable |
| ICR Estimate |                 | 0               | 0<br><input type="checkbox"/> Not Applicable      |

\* Refers to percent of total project cost for which ERR/FRR was calculated.

### 6. Outcome

Relevance of objectives is rated High because they addressed important development challenges, and aligned fully with country conditions and with current Bank and government strategy. The achievement of the project objectives is rated Modest due to shortfalls in achieving several project targets, and unanswered questions of attribution (the presence of other donors but lack of information on the extent of their contribution). Efficiency is rated Modest due to significant disruption in implementation in the final two years of the project. Had the project ended as originally planned in 2016, its strong design, and promising initial years of implementation as described in the AF Project Paper, suggest that a more positive outcome rating would have been warranted. Taking account of the disruption to project implementation in 2016 and 2017, the Outcome rating is Moderately Unsatisfactory, indicative of significant shortcomings.

#### a. Outcome Rating

Moderately Unsatisfactory

### 7. Risk to Development Outcome

Several factors suggest a moderate risk to development outcome. The project objectives are consistent with national policies to expand access to affordable health care, reduce mortality, slow the high population growth rate, and improve health outcomes. A new World Bank-financed Project approved in July 2018 (Health Services Reinforcement Project, P164696, US\$80 million, 2018-2023) continues the effort to "increase the quality and utilization of health services with a particular focus on maternal, child, and adolescent health, nutrition, and disease surveillance," and incorporates the lessons learned from the RBF approach. Burkina-Faso has also joined the Global Financing Facility for Every Woman Every Child, and is



developing an “investment case” to identify priority high-impact interventions to improve health outcomes for women and children. Other major donors are also continuing their support to health care in the country.

On the other hand, several factors pose a risk to development outcomes. The security situation in the country, high levels of poverty, and low literacy all add to the difficulty of achieving goals in health. In addition, constrained budgets and capacity make it difficult to expand access rapidly and maintain service quality, as the project performance in its final years -- as facilities coped with the new policy of free health care for all pregnant women and young children -- demonstrates.

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

The project addressed an important development challenge. It was clearly focused on maternal and child health, and informed by the latest sector data from the Demographic and Health Survey 2010 and the evaluation of needs in emergency obstetric and neo-natal care (2011, World Bank, UNFPA, UNICEF and WHO). The technical design drew on the promising results of an RBF pre-pilot in three health districts in Burkina-Faso, and international experience with RBF; it reflected RBF best practice (providing for decentralized decision-making and autonomy of health facilities, a robust data reporting system, independent verification by external entities, explaining how the RBF program would work and training stakeholders in their roles, and training health workers and supervisors). The choice of health services to include was strategic; in addition to evidence-based high-impact interventions in maternal and child care, other basic health services were also included, to avoid their being neglected. The project design included strong technical assistance, training, and careful preparation and planning, to mitigate the risks identified with introducing RBF in a relatively low-capacity setting. The second component complemented and supported the RBF by funding critical inputs (equipment, drugs, training, supervision) needed to provide MCH services and improve their quality, as well as funding community-level activities to enhance demand. The PAD clearly summarized the key lessons that informed the project design (PAD, pp 18-20).

Project design was simple, and implementation arrangements were clearly described. The project used existing financial management and disbursement arrangements that were already being used for the Bank-financed Health Sector Support and AIDS Project. The implementation unit (*Programme d'Appui au Développement Sanitaire*, PADS) used by many donors was functioning reasonably well, and the legal covenants required staff to be hired to strengthen its capacity, build a strong RBF technical team, and ensure readiness for implementing the RBF. A recent procurement assessment had found the PADS procurement department to be “well experienced in Bank procedures” (PAD), and a draft procurement plan had been prepared before the project was approved.

The PAD noted that the results framework used existing indicators and data to the extent possible, for efficiency and consistency with the project's efforts to build on and strengthen existing data collection mechanisms. This is good practice, but, as noted below, the RF could have included better measures of quality. Other monitoring and evaluation arrangements were sound, combining the strong monitoring and evaluation arrangements required for RBF, and a well-designed impact evaluation that was part of the early planning.



## Quality-at-Entry Rating

Satisfactory

### b. Quality of supervision

There was strong continuity in team leadership, with a smooth transition when the co-TTL took over as TTL in 2017. Throughout the project, the TTL or a co-TTL was based in-country, facilitating close supervision and communication with the borrower. Regular Implementation Status and Results Reports were filed, and the ICR noted that they provided good details on implementation status, progress towards achievement of the PDO, and key issues. The project team included an international expert on RBF, and arranged for Burkina Faso to participate in RBF peer learning exchanges with other countries. The Mid-Term Review reached clear conclusions and recommendations and justified AF.

The Bank team faced a challenging situation from 2016. The clear focus of the project on using RBF to increase use and improve quality of maternal and reproductive health services was compromised by changes in MOH leadership and policy. Even with the AF, the RBF component ran short of funds, sooner than would have been the case had the MOH not insisted on allocating some of the AF to a new HIV/AIDS sub-component to help fill gaps left by the closing of the AIDS project. In order to fulfill the new government's promises to the population, free care for all pregnant women and under-five children was rapidly implemented, without the verification of reporting and accompanying supervisory support and attention to quality that was a feature of the RBF. The new Minister also replaced the experienced staff in the PADS and RBF technical unit. The Bank responded to the resulting decline in PADS performance with specific missions to tackle the issue, and management meetings with the Minister of Health and the Minister of Economy, Finance and Development. The team had the difficult challenge of disagreeing with the MOH, denying a request to further extend the closing date, and insisting on reallocating all unspent funds to long overdue RBF payments to facilities. It took many months of weekly reminders and discussion to elicit a request for reallocation near the end of the project.

## Quality of Supervision Rating

Satisfactory

## Overall Bank Performance Rating

Satisfactory

## 9. M&E Design, Implementation, & Utilization

### a. M&E Design

The M&E design had many strengths. Regarding **monitoring design**: the indicators drew from the national HMIS to avoid creating a parallel data collection system for the project; the project included training and technical support to help strengthen routine data collection and results reporting; a robust verification mechanism was planned in which local independent third parties would be hired to verify the accuracy of the reported data every three months and to further verify quantitative and qualitative indicator data every



six months, including by interviewing samples of patients in targeted household surveys. The third party verifiers, in turn, would be overseen by the international firm to be hired to provide technical support for the RBF program. The results framework (PAD Annex 1) provided details on data sources and a clear description of each indicator, as well as baseline data for all the indicators, apart from one intermediate indicator on the percentage of women satisfied with the quality of care they received, that would be measured in the baseline survey for the IE. The PAD (Annex 1, page 31) referenced a recent World Bank assessment of M&E quality in investment operations, whose findings and recommendations were explicitly incorporated in the project M&E design. The changes to the PDO with the AF and project restructuring appropriately reflected the addition of sub-components on HIV/AIDS prevention and the expansion of pilot strategies to increase utilization of health services among the very poor and expanded list of the services provided to the poor free of charge. Most indicators in the RF were changed from rates to numbers; instead of percentages of a defined sub-population, they were changed to simple numbers of the targeted group. This made the targets easier to understand and progress easier to monitor, and was consistent with the way routine data on health services were reported by facilities, and with the Bank's core indicators in health.

**Evaluation design** was also strong: A well-designed prospective, randomized IE was an integral part of project planning. The IE would compare districts in the RBF program with control districts that would receive similar additional funding not linked to results, to be able to separately assess the impact of the results focus and of the additional resources. Provision was made for timely collection of baseline data, and adequate grant funding was identified to enable the IE to be carried out by an international firm that would work with and thus strengthen the capacity of a research institute in Burkina Faso.

The **main shortcomings in the M&E design** were the rather parsimonious measures of quality of services and of the equity focus, despite the revisions to the RF that were done as part of the 2016 restructuring. It is surprising that the project did not include an indicator for quality using the quality data collected regularly as part of the RBF monitoring. The only indicators for the equity focus were the number of people identified to receive health services free of charge, and percent of target population enrolled in CBHI schemes, which do not measure changes in utilization of services.

## **b. M&E Implementation**

**Monitoring:** All of the required data were collected and reported regularly, and used as intended for calculating the RBF payments earned by facilities. A web-based RBF data portal ([www.fbrburkina.org](http://www.fbrburkina.org)) was set up and populated with data retrospective to the start of the pre-pilot in 2011. The portal made data entry and monitoring efficient and easy. Anyone with internet access could easily see all RBF data by region and even download the data. The very clear user interface/dashboard made it easy for stakeholders to see their progress and that of other districts. There were annual reviews of progress by district staff and activity planning for the following year. The MOH produced regular project progress reports as intended. The RBF technical unit's detailed Annual RBF reports from 2014 to 2017 provided results achieved by health facilities and trends, and compared the RBF intervention districts with control health districts and the national average. The unit also reviewed the unit prices used each year, as required (ICR, page 23).

**Evaluation:** In 2015, the CBT pilots in the project were jointly evaluated with the Bank's Social Protection Team, to compare the approach to an alternative approach of proxy-means testing used by the Safety



Nets Project. The findings were used to inform national policy discussions about how best to target the poor.

The RBF IE was completed (although the project closing had to be extended to enable the completion under the revised timetable agreed at the MTR). Baseline data were collected between October 2013 and March 2014. End-line data were collected between April and June 2017 in 12 of the 15 districts where the RBF was implemented, excluding the three districts where the pre-pilot took place. The initial results were reviewed and discussed at a retreat in Heidelberg with selected stakeholders and implementers, and then the results were presented at several in-country workshops with national, regional, and district level implementers. An additional qualitative study was done to better understand the findings of the IE.

There were three main shortcomings in implementing the M&E as designed: (1) Instead of hiring independent agents to verify facility data reporting, to save money, the MOH tasked local health staff with verification responsibility. (2) The MOH stopped maintaining the RBF data portal, and it ceased functioning towards the end of the project. This was a visible aspect of the overall breakdown in implementing the RBF program in the last years of the project. (3) Some of the IE findings seemed inconsistent. For example, related indicators showed different trends. This reduces confidence in the reliability of the end-line data and makes it difficult to assess the success of the RBF program or to derive useful lessons from the pilot.

### **c. M&E Utilization**

The design of the RBF pilot at the start of the project used data from the evaluation of the pre-pilot in three districts (2011 through 2013) to motivate a revised RBF technical design. Changes were made in the pilot compared to the pre-pilot in the way contracting and verification were handled, the list of services covered, and the quality assessment tools, and performance contracts were introduced for relevant central MOH units.

The MTR was completed as scheduled in July 2015, and its recommendations were acted upon. Importantly, the MTR identified the need for AF if the RBF pilot were to continue to 2017. The RBF data were used to justify the request for AF in 2016. The Project Paper reported that the data showed “a slow but steady increase in the quantity and quality of health services during the first two years of the scale-up (increase in the poor’s access to health services, increase in contraceptive prevalence and maternal services),” and included a graph showing trends in the quality scores rising from below 40% (except for the South-West region which began around 50%) to 60-80% (Project Paper, pp. 15-16). The Project Paper also reported that around 130,000 people in areas served by randomly selected health facilities had been identified by communities as being in the poorest decile, and exempted from fees. (The random selection was part of the evaluation design to assess the impact of interventions to reduce financial barriers for the poor.)

Regional level workshops were held annually to review the RBF results and enable facility staff to discuss how they could improve their service provision. The data were also used to adjust the incentives and revise the RBF operational manual.





## M&E Quality Rating

Substantial

### 10. Other Issues

#### a. Safeguards

The project was in compliance with World Bank safeguard policies. Consistent with OP 4.01 on Environmental Assessment, the project was classified as Environmental Category “B” because of the expected increase in medical waste. An Environmental Assessment Report including a Medical Waste Management Plan (MWMP) was prepared and disclosed in country in March 2011. The MWMP was regularly monitored during project implementation and found satisfactory. Factors related to waste management were monitored as part of the RBF quality check list. Some health facilities used their RBF bonuses to improve hazardous medical waste management and bought incinerators. No construction works were planned under the project (only minor refurbishing).

The project posed no social safeguards risk. It had a positive social impact by improving access to health care services, especially for the poorest. Annual community client satisfaction surveys asked about patient satisfaction and grievances with health services, and provided feedback to health facilities on ways to improve service delivery.

The ICR noted that mechanisms were in place for grievances related to fiduciary aspects, such as procurement processes by the PADS.

#### b. Fiduciary Compliance

Fiduciary performance was good until 2016, with project procurement, financing, and management handled by competent teams with experience in Bank procedures, within the PADS. The PADS was also responsible for other World Bank projects and projects funded by other major donors. The HIV/AIDS sub-component 2.4 added in the 2016 restructuring was managed and implemented by the national HIV/AIDS authority (the *Secrétariat Permanent du Conseil national de lutte contre le SIDA et les IST/STI*), which had, with the PADS, competently managed the Health Sector Support and AIDS Project (P093987) that closed in December 2014.

In 2016 the high-performing project coordinator and other PADS and RBF unit staff were removed. Performance on procurement and financial management deteriorated and were downgraded to moderately satisfactory in late 2016. Long delays in making RBF payments undermined the program. Procurement for activities related to the reproductive health subcomponents of Component 2 also were significantly delayed (those related to HIV/AIDS and Universal Health Coverage were timely).

Audits were completed on time and audit reports were unqualified.



**c. Unintended impacts (Positive or Negative)**

None reported.

**d. Other**

None.

**11. Ratings**

| Ratings          | ICR                       | IEG                       | Reason for Disagreements/Comment |
|------------------|---------------------------|---------------------------|----------------------------------|
| Outcome          | Moderately Unsatisfactory | Moderately Unsatisfactory |                                  |
| Bank Performance | Satisfactory              | Satisfactory              |                                  |
| Quality of M&E   | Substantial               | Substantial               |                                  |
| Quality of ICR   | ---                       | Modest                    |                                  |

**12. Lessons**

Although the lessons in the ICR are well-grounded in the project experience, rather than select from them, this review offers a different lesson that reflects on the difficulty in evaluation posed by a discontinuity in the performance of a reform program.

**If a change in policy undermines implementation of an RBF pilot before it is completed, the evaluation plan may need to be reconsidered.** The RBF pilot in Burkina Faso showed promising results in its initial years, when the MOH was strongly committed to the approach, the competent RBF technical unit was well placed in the ministry to influence decisions, and there was adequate funding. The change in these circumstances in 2016 undermined implementation of the RBF and affected the trajectory of the results of the project. The Impact Evaluation took place a year later, in 2017. The final level of achievements were the result of both the promising initial years of the program when it functioned as designed, and the disruptions. It would have been useful if the design of the evaluation could have tried to disentangle the two.

**13. Assessment Recommended?**

No

**14. Comments on Quality of ICR**



The ICR was concise, clear, and candid, especially in noting the implementation issues, and mostly followed guidelines. The lessons and recommendations were thoughtfully selected. However, more information could have been provided on project outputs (especially in Table B of Annex 1) and outcomes, and to complement the data on the project indicators, to provide a less cursory assessment of efficacy. The assessment of the achievement of one of the PDO indicators and one intermediate indicator incorrectly calculated the actual value as a simple percentage of the target, instead of calculating the actual increase from the baseline as a percentage of the targeted increase. The ICR did not discuss the reliability of the data, and Annex 1 did not name the data sources and was not explicit as to the time period and geographic scope they cover. No mention was made of the Demographic and Health Survey that was expected to be done at the end of the project, and which might have enriched the assessment of project performance. Especially in light of the significant changes in 2016 that undermined the RBF pilot, data trends over the years of the project – similar to the graphs on quality in Annex 1 – would have offered useful insights. The ICR also could have had a more extensive discussion on attribution issues, especially given the many other donors active in health.

**a. Quality of ICR Rating**

Modest