Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 01-May-2019 | Report No: PIDISDSA27011

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Burundi	P166576	Burundi Health System Support-Additional Financing	P156012
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Health System Support Project ("KIRA")	AFRICA	01-Nov-2018	29-Mar-2019
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	MINISTRY OF FINANCE	Ministry of Health, Ministry of Health, Ministry of Health, Ministry of Health

Proposed Development Objective(s) Parent

To increase the use of quality Reproductive, Maternal, Neonatal, Child and Adolescent Health services, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Components

Use of Performance-based Payments to Support the Recipient's Free Health Care (FHC) Program
Implementation Support for the FHC program-related activities
Strengthening of Newly Integrated FHC Program Service Providers through financing of minor investments/renovations works for CHWs and nursing training schools
Contingency Emergency Response Component (CERC)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	12.70
Total Financing	8.30
of which IBRD/IDA	0.00
Financing Gap	4.40

DETAILS

Non-World Bank Group Financing	
Trust Funds	8.30
Global Alliance for Vaccine and Immunization	8.30

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

Burundi is a fragile country, affected by recurrent cycles of violence and political instability. Burundi's decade of civil war and its long period of recurring political insecurity have resulted in stagnant economic development, increased poverty, displacement of the local populations, and destruction of existing infrastructure. Progress in the peace process and the 2000 signing of the Arusha Peace Accords ushered in a period of fragile political stability which was interrupted by the crisis resulting from the 2015 elections. From 2004-2014, Burundi's annual Growth Domestic Product (GDP) growth steadily remained over 3 percent despite economic shocks and international financial crisis. However, since the 2015 political crisis, Burundi's GDP growth has contracted. The fragile political environment, declining food production due to climate shocks, reliance on modest revenues from key exports like coffee and tea, high public-debt, and low foreign currency reserves that restrict the importation of fuel and medicines all contributed to the deteriorating economic performance.[1] Net foreign direct investment has more than halved from 2.4 percent of GDP in 2014 to a projected 1.1 percent of GDP in 2017, while the suspension of foreign aid from some international donors, which accounts for up to 50 percent of the country's annual budget, adds additional fiscal strains. The International Monetary Fund (IMF) projects Burundi to have a real GDP growth rate of 0 percent in 2017, revising its previous projection of 6 percent real annual GDP growth between 2015-2034.[2,3]

[1] AfDB/OECD/UNDP. (2017). *African Economic Outlook 2017: Entrepreneurship and Industrialisation.* Paris, France: OECD Publishing.

[2] Regional Economic Outlook: Sub-Saharan Africa Fiscal Adjustment and Economic Diversification. *World Economic and Financial Surveys.*

[3] IMF/IDA. (2017). *Burundi: Sixth Review Under the Extended Credit Facility Arrangement, and Request for Extension and Augmentation of Access - Debt Sustainability Analysis Update.*

Burundi is one of the poorest countries in the world with a gross domestic product of $218 per capita (constant 2010 $); the country ranked 184 out of 188 countries in the 2015 Human Development Index. Close to 3 out of 4 Burundians are poor (72.9 percent live with less than US$1.9 per day) and 3.6 million Burundians (38.7 percent) in extreme poverty cannot meet the minimum nutritional requirements of 2,200 kilocalories per adult equivalent per day.[4] The predominantly rural population (88 percent) is dependent on small-scale subsistence agriculture as livelihoods, which is vulnerable to environmental degradation and shocks. Burundi has a population of 11.4 million and the second highest density in Sub-Saharan Africa (410 inhabitants/ km²).[5] Between 2010 and 2016/17, total fertility rate decreased from 6.4 to 5.5 children per women, but remains high. With a population growth rate of 3.1 percent, Burundi's population is expected to double every 21 years.

Sectoral and Institutional Context

Access to maternal, reproductive and child basic health services improved over the last decade, but mortality rates remain high relative to other sub-Saharan countries. Under five mortality was estimated at 78/1000 and the maternal mortality ratio at 392/100,000 in the recent 2016-17 DHS. The national introduction of free maternal and child health services and performance-based financing (PBF) in 2006 and 2010 respectively resulted in considerable improvements in access to care such as institutional deliveries which increased from 31.8 percent in 2005 to 85 percent in 2016-17 but in lower than expected gains in mortality reduction, due to high fertility. The 2015 political crisis and subsequent fiscal cuts have impacted coverage and use of basic services. For instance, pre-and post-natal consultations at District Hospitals by expectant mothers declined by 60 percent and 92 percent between 2014 and 2015 respectively, and fewer hospital consultations were conducted for children.[6] Coverage of family planning is lagging behind, and fertility is stubbornly high: between 2010 and 2016-17, modern contraceptive prevalence increased only from 18 to 23 percent. Burundi also has the second highest prevalence of stunting in the world (56 percent in 2016-17) and this rate remained almost unchanged over the last decade.

Public expenditures on health remain insufficient to ensure provision of basic health services. Compared to other low-income countries in Africa, the Government of Burundi dedicates a large share of its budget to the health sector mainly because of its commitment to Free Health Care. However, per capita expenditure (US$29.9 in 2013) is far from US$56 of total health expenditure per capita per year recommended by the Taskforce on Innovative Financing for Health Systems to ensure provision of basic health services. According to the National Health Account (NHA), households' out-of-pocket spending was over 30 percent in 2010. While this share decreased in 2013 to 19 percent of the current expenditure on health owing to social health protection schemes such as the Free Health Care (FHC) program, out-of-pocket spending still represents more than 50% of domestic sources of funds.

Burundi has inadequate human resources for health with an impact on quality of care. The country has an average of 1 medical doctor per 20,865 inhabitants and 1 nurse per 1,542 inhabitants (compared to 1 per 3,703 and 1 per 806, respectively, in Africa). In addition to an insufficient number of health workers, there is an inequitable distribution of health workers with fewer of them working in rural areas (50.5 percent of physicians and 21 percent of nurses are in Bujumbura).

Community health is seen as a promising approach for health promotion in Burundi but not yet fully implemented.

[4] World Bank (2016). *Burundi Poverty Assessment.*

[5] https://data.worldbank.org/indicator/EN.POP.DNST?locations=BI

[6] Fergulio, N., and Handley, G. (2017). Burundi: Delivering Health Services Under Fiscal Stress. *Public Expenditure Review.* Washington, D.C.: World Bank Group Publications.

Since its official launch in 2012, the community health strategy has led to (a) the recruitment of community health workers (CHWs), under the new Community Health Guidelines, in 100 percent of Provincial Health Offices (PHOs) and (b) the establishment of Groupings/Cooperatives of Community Health Workers (Groupement d'agents de santé communautaires, GCHWs) in all public health centers (HCs) and the training of 8,512 CHWs from 13 out of 18 health provinces. A PBF pilot took place at the community level in three provinces. An evaluation of the PBF pilot, by CORDAID, noted that thanks to the community approach, the proportion of cases referred during consultations in HCs is increasing for antenatal and postnatal consultations, delivery, FP, and voluntary screening of HIV/AIDS.

Serious challenges remain with the supply chain of drugs and other inputs resulting in stock-outs of drugs and inputs in health facilities. According to PBF annual reports, 55 percent, 35 percent, and 33 percent of health facilities experienced at least one stock out of one or more tracer drugs, respectively in 2013, 2014, and 2015.

The Government has implemented a Free Health Care Policy combined with PBF since 2010. FHC, PBF and focus on high impact interventions (prevention and primary health care) continue to be among top priorities in the Government's program (health and beyond). Burundi has been a pioneer in effectively removing financial barriers to health care services, especially for pregnant women and children, and has 10 years of experience in the implementation of FHC and PBF with six years of implementation at the national level. Free Health Care covers all pregnant women and under five children. Beneficiaries have access to all services available at public and contracted private facilities (health centers and hospitals).

The Government of Burundi is the largest contributor to the FHC/PBF program (commitment of at least 1.4% of its annual budget) followed by the World Bank (through the parent KIRA project and the now completed Health Sector Development Support Project). Other development partners have also aligned their activities with the FHC/PBF program even though the level of external support is reduced since the 2015 crisis. The main partners include the EU and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which has supported the community health program and had pledged continued financing of this initiative being scaled up under the KIRA project. The Belgian Cooperation provides assistance and performance-based payments to paramedical schools. Finally, GAVI, which supports the Expanded Program on Immunization, has included, under its third Health System Strengthening (HSS3) grant for 2018-2021, cofinancing of US$13 million to cover health facility and community PBF under the KIRA program. Until now, Gavi has been providing support to PBF in Burundi through international nongovernmental organizations (NGOs) but for technical and efficiency reasons, and to better harmonize its support for PBF in alignment with other partners, GAVI requested that the Bank manage its PBF program support to Burundi included in the HSS3 grant.

New orientations aiming at better health interventions and outcomes were introduced in the new National Health Policy (NHP) (2016-2025) following a review in 2016 of the five-year National Health Development Plan - NHDP (2011-2015). This new NHP is structured around: (i) universal health coverage, to improve equity in health, efficiency and sustainability; (ii) quality health services; (iii) public policies to promote and protect the health of communities, particularly vulnerable groups; and (iv) leadership to improve the competence and accountability of health authorities and actors. The Government of Burundi is also committed to address malnutrition and demographic challenges as national priorities.

C. Proposed Development Objective(s)

Original PDO

To increase the use of quality Reproductive, Maternal, Neonatal, Child and Adolescent Health services, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Current PDO

To increase the use of quality Reproductive, Maternal, Neonatal, Child and Adolescent Health services, and, in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Key Results

There is no change in the PDO indicators for the AF compared to the parent project but the expected number of beneficiaries (target) increased. The PDO indicators are:

(a) People who have received essential health, nutrition, and population (HNP) services:

(i) Children fully immunized (number)
(ii) Women and children who have received basic nutrition services (number)
(iii) Deliveries attended by skilled health personnel (number)

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

An intermediate results indicator will be created for "Number of Children Child who have received all the required vaccines: BCG, Oral Poliovirus Vaccines (3 doses), Pentavalent (3 doses), Rotavirus vaccines (2 doses), pneumococcal conjugate vaccine (PCV13) (3 doses), Measles-Rubella vaccines (2 doses) and 4th dose of Diphtheria Pertussis Tetanus vaccine before their second birthday".

D. Project Description

The AF will provide additional funds to finance existing activities under the parent project as described below:

Component 1A: The AF will provide additional resources for transfer of resources to health facilities to pay for the free package of health services in Bujumbura, Bururi, Gitega, Kayanza, Kirundo, Mwaro and Rumonge provinces. Transfers will reimburse health facilities for the provision of preventative and curative services that are part of the national PBF program and are listed in the PBF Procedures Manual. These include primary health care and preventative services for pregnant women, delivery of babies and post-partum care, care for under-five children, family planning services, and malaria treatment. Furthermore, the additional financing will allow for higher unit rates of immunization related indicators to increase the offer and utilization of quality immunization services. Implementation of activities will be carried out according to the guidelines presented in the national PBF Procedures Manual. The manual will be revised to reflect the increased focus on immunization and all changes will have to be approved by the World Bank. Among others, the increased immunization focus is envisaged mainly in two areas: (i) the cold chain related quality criteria; and (ii) supervision as the performance framework at district level will be revised to include the following indicators related to: cold chain assessment; the state of functionality of the equipment; and active surveillance for Acute Flaccid Paralysis (AFP)/ measles. In addition, the funds will be used to: (i) resume the reporting forums to health facilities and Health Provinces and District Offices on results of technical quality assessments, community surveys and changes in indicators (including vaccination indicators) that were discontinued due to lack of resources; (ii) improve monitoring activities for evaluation of the implementation of Performance Based Financing including exit surveys to measure client satisfaction and perceived quality of care; and (iii) strengthen the capacities of Community Health Worker Groupings and stakeholders involved in Community PBF in Kirundo and Muyinga Provinces.

Component 1B: The project will support transfers to community health workers for a specific package of community-based health services through the PBF approach in Kirundo and Muyinga provinces. The package of services is defined in the Community PBF Procedures Manual and includes sensitization, screening of malnutrition and other health conditions, referral to health facilities, tracking missed cases including children missing an immunization appointment, and community-based distribution of contraception methods. Expanding community PBF to more provinces due to this AF will result in increasing the number of involved CHW which in turn will translate into more people sensitized on key health interventions including immunization, and more appointment missed children tracked and returned to immunization calendar along with service quality improvement even beyond the coverage area as the changes introduced through the project will be applied to the whole country.

Component 1D: The project will support incentivizing the Gavi PIU and the management team of the Expanded Program of Immunization (EPI). Both units will be paid based on performance that will be measured quarterly by using a dedicated performance framework, to manage Gavi resources allocated to direct support to health system strengthening for the former and to coordinate immunization activities nationwide for the latter.

Component 2: The project will support verification and counter verification processes for PBF payments at health facility and community levels by grassroot organizations. This includes internal control and verification mechanisms, as well as third-party external verifications conducted each semester by an external agency, on a randomly selected sample of health facilities, and on patients selected randomly from the registers of these health facilities in covered provinces. Furthermore, trainings will be organized to strengthen capacities of additional trainers, health workers and CHW in Kirundo and Muyinga provinces. The additional funds on this component will allow to fill the financial gap related to verification costs as only IDA and the Government resources can cover such costs while the needs are continuously increasing as new health facilities are enrolled each year. More specifically, the additional funds will contribute to: (i) performance evaluations of and performance based payments to Health province and district offices and to provincial verification and validation committees; (ii) improvised assessments of quality at the health facility level; (iii) the implementation of quality competitions at the health facility level; and (iv) the capacity building of local associations responsible for carrying out community surveys under PBF at the level of the HFs and the Community PBF .

Component 3: The project will support the CHWs associations (Groupement d'Agents de Santé Communautaire (GASC)) newly enrolled in Community PBF sub-program in Kirundo and Muyinga provinces by providing them with a kit that includes, among others, bicycles, umbrellas, boots, medicine boxes, gears, hats, and white coats.

E. Implementation

Institutional and Implementation Arrangements

The implementation arrangements for the proposed AF will remain the same. Institutional arrangements will remain unchanged with continued implementation of the Project through the MoH PBF technical unit which has shown strong capacities in management even in the current fragile context. Additional experts will be recruited (planned under the parent project) to effectively implement the new activities related to community health and the health information system. In terms of governance, these arrangements are appropriate since the audit reports and evaluation missions have not disclosed any cases of fraud or corruption in the ongoing project neither before nor during the crisis. The Department in charge of Health Services (DGS) will ensure the overall coordination of the KIRA Project. It will also be responsible for the implementation of some subcomponents of the Project. Two other MoH departments: The General Directorate of Resources (DGR) and the General Directorate of Planning (DGP) will be responsible for implementing the remaining Project activities. The DGR will also assume the role of the deputy coordinator in charge of fiduciary aspects of the project. In the

absence of the head of the DGS, the DGR director will assume the function of acting KIRA Project coordinator. In addition to its function as the general coordinator of the Project, **the DGS** will have other responsibilities such as the following: (a) Supervise the PBF Technical Unit in all activities related to results based payments to health facilities; (b) Supervise the PBF Technical Unit in all activities related to PBF payments to public health programs and CHWs; (c) Implement and monitor activities related to environmental and social safeguards. **The DGR** will assume the function of deputy coordinator and will be charged with the following responsibilities: (a) Oversee financial management and procurement; (b) Serve as KIRA Project technical focal point for the Ministry of Finance; (c) Co-implement, with the PBF Technical Unit, all activities related to results-based payments including nursing schools and regulatory bodies. **The DGP** will be in charge of (a) the KIRA Project monitoring and evaluation and (b) co-implementation, with the PBF Technical Unit, of all activities relating to results-based payments to the NHIS. Finally, **the PBF technical unit** will coordinate, implement, and monitor the FHC/PBF program. Hence, the PBF Technical Unit will continue to be the technical focal point for the World Bank team in charge of the KIRA Project. Although other departments are co-responsible for the implementation of various results-based payment subcomponents under the Project, the ultimate responsibility of PBF implementation is assumed by the PBF Technical Unit.

G**AVI's RSS project is implemented through a Project Management Unit (UGP in French) and the Expanded Program of Immunization (EPI) department of the MoH.** As part of the RSS project, the Project Management Unit's capacities will be strengthened (staff and tools) to ensure good management. A human resource review is underway to assess: profiles and job descriptions and skills required for the necessary posts. Consultants will also participate in the selection process; develop a skills distribution plan between the Project Management Unit and the EPI to strengthen them; define the mechanisms and operating procedures required to make the Project Management Unit more effective; and Update the Unit's Procedures Manual. The Additional Financing will also integrate the Central PBF in the consolidated plan and for the EPI units and GAVI's Project Management Unit. Part of the staff of these units will be paid according to previously defined indicators and based on a scale that will be updated in line with the various levels in force in Burundi.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project supports health centers, nursing schools, community health workers, and hospitals throughout the country.

G. Environmental and Social Safeguards Specialists on the Team

Tracy Hart, Environmental Specialist
Felipe Jacome, Social Specialist
Peter F. B. A. Lafere, Social Specialist
Alexis Manirambona, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	OP/BP 4.01 Environmental Assessment is triggered due to biomedical waste generated during the implementation of KIRA-AF. In addition, various environmental impacts could happen on the site during rehabilitation of existing health facilities. Impacts will be manageable through safeguards instruments already in place (ESMF and MWMP) and which were updated for the purpose of the Additional Financing. Those instruments present mitigation measures, specify role and responsibilities and facilitate documentation during implementation.
Performance Standards for Private Sector Activities OP/BP 4.03	No	There are no activities implemented by the private sector.
Natural Habitats OP/BP 4.04	No	OP 4.04 is not triggered on this project because the activities are focused with existing health centers to improve quality of health services and population access to the health in general.
Forests OP/BP 4.36	No	The project will not be concerned with the management of forests.
Pest Management OP 4.09	No	The project will not be concerned with the purchase of pests and pesticides. The project has developed a Medical Waste Management Plan in compliance with OP 4.01.
Physical Cultural Resources OP/BP 4.11	No	As with the parent project, it is expected that the AF will not involve any sites with archaeological, paleontological, historical, religious or other area of unique natural value as defined under the policy.
Indigenous Peoples OP/BP 4.10	Yes	OP 4.10 is triggered given that the Project seeks to specifically increase the use of health services by the Batwa, one of the most vulnerable groups in Burundian society.
Involuntary Resettlement OP/BP 4.12	No	OP4.12 on Involuntary Resettlement is not applicable for the AF as no works are expected.
Safety of Dams OP/BP 4.37	No	There are no dam related activities in the project
Projects on International Waterways OP/BP 7.50	No	The project is not on an international waterway
Projects in Disputed Areas OP/BP 7.60	No	The project is not in a disputed area

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The project aims at increasing quality of health services and population access to healthcare in general. It will involve delivery of an essential package like immunizations, medicines, and vitamin supplementation; provision of essential package of equipment to health facilities such health centers, nursing schools, community health workers, and hospitals throughout the country.
These activities will lead to intensive use of health facilities in terms of water, sanitation and safety that could involve diverse kinds of impacts and risks related to biomedical waste with infected materials. These could generate environmental impacts inside the health facilities and among the community. Those impacts and risks primarily affect personnel in medical facilities in charge of handling the proper disposal of medical waste such as health workers, notwithstanding general public, to the extent that waste is not well disposed of on specific-site nor safely contained in appropriate disposal. In addition, the rehabilitation of existing health centers and hospitals could also cause negative impacts and risks on environment like increased levels of dust, noise, and other carbon emissions from civil works, the generation of solid wastes, the traffic disturbance and accident risks during the construction; health and safety issues for workers.

The identified potential positive environmental impacts are: (i) the health facilities improvement (beautification of the premises); (ii) reducing the contamination of soil and sources of potable water; (iii) reduction of air pollution. The potential positive social impacts are (i) increased use of health services; (ii) improving of the population health; (iii) increasing cohesion and social inclusion by the health workers groups; and (iv) improving self-esteem in communities, including the Batwa community.

Overall, environmental and social impacts and risks of expected activities for the project are moderate and the project is classified as a category B Project. The proposed project requires no exceptions to the World Bank's safeguards policies on environmental and social impacts. The two environmental and social Safeguard Policies applicable to this operation are: OP 4.01 (Environmental Assessment), and OP 4.10 Indigenous People. OP4.12 on Involuntary Resettlement is not applicable for the AF, as renovation works under Component 3 will be strictly limited to improvement works on existing buildings.

The Ministry of Health in Burundi has prepared an Environmental and Social Management Framework (ESMF); a Medical Waste Management Plan including the expired pharmaceutical products (MWMP) as well as an Indigenous Peoples Plan (IPP) for Batwa group for the parent project. The ESMF and MWMP prepared for the parent project were updated for this additional financing to mitigate all environmental issues during the life cycle of the project.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Rehabilitating existing facilities, as well as increasing the quality of, and access to, health care, can both lead to a more intensive use of the facilities, resulting in increased need for water, sanitation, and hygiene for these sites. Similarly, an increase in health service access will lead to increased waste and effluent flows.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
There are technological alternatives regarding the way in which waste is sorted and disposed of, the type of

incineration to be adopted/scaled-up, and the type of services to be provided at different levels of the medical care system.

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

There is a small unit responsible for environmental and social safeguards in the Directorate of Health Promotion, Hygiene and Sanitation (DPSHA), under the coordination of the Directorate General of Health Services and the Fight against AIDS. This unit includes highly-skilled personnel with experience with World Bank safeguards policies. The DPSHA supervises its own portfolio, including donor-funded projects, on a quarterly basis with respect to medical waste management and other environmental management issues, and documents this supervision. DPSHA updated the ESMF and MWMP from the parent project for the AF activities as necessary. The Ministry of Health continues to implement its long-term plan for implementation of the national medical waste plan, which includes upgrading of the incineration infrastructure and more comprehensive sorting and management of other wastes (e.g. glass vials, human / maternal waste).

As part of the implementation of the IPP under the previous Bank-financed HSDSP, the Ministry of Health carried out various activities targeted at improving Batwa access to public health care. These activities included targeted sensitization and mobilization activities focused on health, nutrition, personal hygiene, civic registration of marriages and births in order to facilitate acquisition of relevant documentation to access health care. Through these activities, 6,000 Batwas obtained medical assistance cards, which enables them to gain access to public health care services. Batwa representation in local health committees, at management and implementation levels has also increased. Batwas also make up just over 5% of the 12,000 community health workers nationwide.

The Ministry of Health prepared a national Indigenous Peoples Plan (IPP) for the parent project which will applies to the Additional Financing as well. The national IPP focuses on the acquisition of medical assistance cards for Batwas who did not benefit from HSDSP activities. To this end, the assistance of the Batwas already engaged in the public health services will be solicited to ensure that the specific needs of the community are addressed. These specific needs, as expressed during consultations in four provinces - Gitega, Karusi, Kirundo and Ruyigi - in September 2016, relate to personal hygiene, sexual and reproductive health, early pregnancy and sexual violence towards Batwa women. Other issues that came out during the consultations regard access to education and employment opportunities, child nutrition and discrimination. The IPP improves on the implementation monitoring of the implementation of actions aimed at the Batwas by developing specific monitoring indicators. It also establishes a Batwa-specific grievance redress mechanism (GRM) that fits into the overall project GRM. The DPSHA of the Ministry of Health is responsible for implementing the IPP. The IPP proposes that the DPSHA implements these activities with the support of a third party consultant, provincial and district health authorities.

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

During the preparation of the parent project, intensive public consultations and participation were held in a sample of health centers and with Batwas groups. Safeguard documents (i.e. ESMF, MWMP and IPP) were disclosed in-country on December 13, 2016 and at Bank InfoShop on December 14, 2016.

The revised ESMF and MWMP for the additional financing were disclosed in-country on October 19, 2018 and on WB Website on October 25.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
18-Oct-2018	25-Oct-2018	

"In country" Disclosure

Burundi
19-Oct-2018

Comments

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
18-Oct-2018	25-Oct-2018

"In country" Disclosure

Burundi
19-Oct-2018

Comments

If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
No

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?
Yes
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?
Yes
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?
Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes
Have costs related to safeguard policy measures been included in the project cost?
Yes
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

CONTACT POINT

World Bank

Alain-Desire Karibwami
Senior Health Specialist

Laurence Elisabeth Marie-Paule Lannes
Sr Economist (Health)

Borrower/Client/Recipient

MINISTRY OF FINANCE
Marie Salome Ndabahariye
Permanent Secretary

Implementing Agencies

Ministry of Health
Elam Senkomo
Permanent Secretary
senkomoelam@gmail.com

Ministry of Health
Thadée Ndikumana
Minister of Health
ndikumanathaddee@gmail.com

Ministry of Health
Pierre Claver Ndayihereje
General Director of Planning
ndayiclaver2017@gmail.com

Ministry of Health
Roger Ndikumagenge
General Director of Resources
ndikumagenge.roger@yahoo.fr

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Alain-Desire Karibwami Laurence Elisabeth Marie-Paule Lannes

Approved By

Safeguards Advisor:	Nathalie S. Munzberg	01-May-2019
Practice Manager/Manager:	Magnus Lindelow	01-May-2019
Country Director:	Preeti Arora	06-May-2019