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COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)
CONCEPT STAGE

Report No.: PIDISDSC16858

Date Prepared/Updated: 24-May-2016

I. BASIC INFORMATION

A. Basic Project Data

Country:	Burundi	**Project ID:**	P156012
		Parent Project ID (if any):	
Project Name:	Health System Support Project ("KIRA") (P156012)		
Region:	AFRICA		
Estimated Appraisal Date:	29-Nov-2016	**Estimated Board Date:**	23-Feb-2017
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Borrower(s):	MINISTRY OF FINANCE		
Implementing Agency:	Ministry of Health, Ministry of Health, Ministry of Health, Ministry of Health		

Financing (in USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	44.00
IDA Grant	50.00
Bilateral Agencies (unidentified)	60.00
Financing Gap	6.00
Total Project Cost	160.00

Environmental Category:	B - Partial Assessment
Concept Review Decision:	Track II - The review did authorize the preparation to continue
Is this a Repeater project?	No
Other Decision (as needed):	

B. Introduction and Context

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Country Context

Burundi is a landlocked country bordered by DRC to the West, Rwanda to the North, and Tanzania to the East and South. The country's Southwestern border is adjacent to Lake Tanganyika which plays an important role in the country economy in terms of fishing, transport and tourism.

In 2014, the population of Burundi was estimated at 9.5 million, having almost quadrupled since 1950. This fast population growth is destined to continue for the foreseeable future given persistently high fertility rates: the 2010 DHS estimated the total fertility rate at 6.4 children per woman, down only marginally from 6.9 in 1987. Given this sharp increase, the population is very young, with almost half of the Burundians below age 15. As a consequence, the youth dependency ratio (the ratio of people younger than 15 to the working-age population) reached 84.4% in 2014, working-age population accounted for only slightly more than half (51.7%) of the total population and only 40% of the total population was in the labor force.

With an average demographic density of 421 inhabitants per km2 in 2014 (compared to the world average of 56 inhabitants per km2, bringing Burundi into the 88th percentile of the distribution), Burundi is one of the most densely populated countries in Africa. The current demographic situation creates a challenge at all levels for a poor country with limited resources.

Burundi remains one of the poorest countries in the world. In 2014, approximately two Burundians out of three could not satisfy their daily basic needs (food and non-food), with a monetary poverty rate of 64.6% of the total population. However, between 2005 and early 2015, Burundi had experienced relative political stability and improved socio-economic conditions. The breakthrough in the peace process and reduction in violence, combined with better macroeconomic management and important aid inflows, triggered the rebound in economic performance: GDP per capita, while still very low, increased from US$166 to US$336 (current US$) between 2006 and 2014.

Violence exploded again in April 2015. Protests rallied after the ruling party (CNDD-FDD) announced that President Pierre Nkurunziza would seek a third term in office. An attempted Coup d'Etat on May 13th, 2015 failed to depose Nkurunziza and triggered a severe political crisis. As of August 2015, over 175,000 people fled the country, primarily into settlements in neighboring countries. In addition, development agencies suspect thousands have moved from urban areas to more remote locations. This political instability has a huge negative impact on the economy and social conditions, especially of the most vulnerable.

The impact on the health sector has been very negative. Despite the resilience of the sector, in some urban areas, utilization of services decreased, especially in the capital city Bujumbura (from 98% to 22% between May 2015 and September 2015). Moreover, the stock-out of drugs in many public health facilities forced patients, users, and free health care beneficiaries, irrespective of their ability to pay, to buy essential drugs from private pharmacies. According to UNICEF estimates, this situation affected more than 1 million under-5 children and 400,000 pregnant women in 2015.

Sectoral and Institutional Context

Inspired by the Government►(s 2025 Vision, the Minister of Health (MOH) developed a ►(2005-2015 National Health Policy►(which was accompanied by two National Health Development Plans ►(NHDP (Plan National de DÃ©veloppement Sanitaire, PNDS) for the

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periods of 2006-2010 and of 2011-2015.

The policy framework of the health sector in Burundi has gradually been strengthened, and in fact the country is quite advanced in terms of introducing new and far-reaching policy reforms, which are often quite innovative. This has been happening since 2006, when Burundi introduced a national policy of Free Health Care (FHC) for pregnant women and under-5 children as well as a national policy of contracting. The latter was the basis for the introduction of Results-Based Financing (RBF) pilots in Burundi, and in 2010 Burundi became only the second country in Sub-Saharan Africa (after Rwanda) to introduce RBF at a national scale in the health sector. Other key strategies and policies have also been introduced for other areas within the health sector (new human resources policy, decentralization, and the creation of health districts).

An evaluation of the first NHDP (2006 - 2010) revealed significant improvements in certain indicators (see table below), in particular the reduction in under-five mortality rate, enhanced disease control, and better availability and utilization of maternal and child health services. These results were validated by the 2010 Demographic and Health Survey (DHS). They demonstrate the impact of a number of policies and reforms undertaken during the same period. This is particularly true regarding those related to decentralization and FHC for pregnant women and children under-five which were implemented in tandem with the Results Based Financing program (FHC-RBF). Finally, it should be noted that government spending on health rose sharply from about US$1.1 per capita in 2006 to almost US$6 in 2011.

Table 1: Positive evolution of health indicators between 2005 and 2010, Burundi

Indicators	2005	2010
Maternal Mortality	615	499
Under Five Mortality	176	96
% of births assisted by skilled personnel	34%	60%
Children (12-23 months) completely vaccinated	45%	83%
Contraceptive prevalence rate	8%	18%

Sources: MICS 2005 and DHS 2010

Despite these improvements in health outcomes, many challenges remain, particularly in the area of maternal mortality (499 per 100,000 live births) and under-five mortality (96 per 1,000 live births) as well as high levels of mortality related to communicable and non-communicable diseases. The burden of disease remains dominated by infectious communicable diseases and other illnesses that are amenable to simple preventive interventions. Respiratory tract infections, malaria, and waterborne diseases, particularly diarrhea, are the main killers of children. Among adults, AIDS is the second leading declared cause of death (although, given the stigma attached, it is likely to be under-reported). Likewise, malnutrition is a serious concern as Burundi has 58 percent stunting in children under the age of 5 years, the highest in the world, and rates have increased since 1987 (56%) to 2010 (58%).

The second NHDP (covering 2011-2015) consolidates the key aspects of these policies and strategies, and articulates a vision for the sector in a coordinated manner. The second HSDP is fully costed, and in addition detailed multi-year sub-costing exercises have been undertaken for key policies such as the FHC policy and the national RBF program, with their results feeding into the second NHDP exercise. The two programs (FHC and RBF) were merged in 2010. As part of

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the new consolidated program (RBF-FHC), the mechanism for paying health facilities has been streamlined and much improved, and health facilities are paid between 35 days and 45 days. This, in turn, has increased the quality of health care offered, and the latter has also improved since the national RBF-FHC program pays health facilities based on a range of quality indicators.

World Bank Engagement in Burundi➢(s Health Sector

The WB is supporting this consolidated program (RBF-FHC) through the Health Sector Development Support Project (HSDSP ➢(P101160). The HSDSP project was originally approved in 2009 and currently has a total financing envelope of US$84.8 million. The original grant (equivalent to US$25 million, IDA-H4880) became effective on September 30, 2009. The project received two additional financings (AF): (i) first AF of US$ 14.8 million under the Health Results Innovation Trust Fund (HRITF) which became effective on October 12, 2012 (TF012526); and (ii) second AF of US$ 45 million co-financed by IDA(US$ 25 million, IDA-H8080) and HRITF (US$ 20 million, TF013043) both of which became effective on April 8, 2013. The original grant and the first AF closed on August 31, 2014 while the second AF (both IDA and HRITF) is due to close on June 30, 2017. The Project Development Objective (PDO) is to increase the use of a defined package of health services by pregnant women, children under the age of five andcouples of reproductive age.

Burundi has a national RBF program which was rolled out across the country in 2010. It has one of the longest histories of RBF implementation having begun different pilot programs in 2006 prior to national scale-up in 2010. The program is a combination of FHC and RBF. FHC began in 2006, but payment on a fee for service basis to health facilities created an onerous burden on the facilities, involved high transaction costs and suffered long payment delays. From 2010, FHC financing is being channeled through the RBF; and this has greatly streamlined the process. Both public and private health facilities are contracted for the delivery of a package of services. A total of 644 health centers and 55 hospitals are currently involved in the program. Payments are provided based on the quantity, quality and equity of services. The program package includes indicators on Maternal and Child Health, Reproductive Health, Tuberculosis, HIV-AIDS, Malaria, preventive care, and basic ambulatory health care and inpatient services. Additional financing (IDA and HRITF) was provided to the project in 2013 to expand the PBF package by introducing indicators focused on family planning and improving nutritional outcomes.

Health facilities submit invoices containing service delivery data on each of the indicators to the provincial verification & validation committees (PVVCs). Each health facility➢(s invoice is verified prior to payment, by a team composed of civil servants and personnel contracted by NGOs. There are also additional layers of verification at the provincial and national level. Counter-verification of a random sample of health facilities is performed by a third party. Community Based Organizations are contracted to verify at the household level to confirm that reported services were indeed received. There is also a counter-verification at the household level. Quality is assessed both objectively (using a quality check-list at the health facility), and subjectively (through patient satisfaction surveys).

National Household and health facility surveys are conducted approximately every 3 years. The first household survey (PMS) and Facility Survey were performed in 2009/2010 prior to national roll out of PBF, and a second round was conducted in 2012 to monitor the effectiveness of the PBF. Reports of these surveys are available.

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The PBF data and HMIS are separate; but the national PBF team reviews the HMIS data to verify that it correlates with the indicator data reported by health facilities.

More than 60% of the program➢(s cost is covering free health care services while the remaining cost is used as RBF bonuses to improve quality of services and to motivate the personnel. The allocation for the staff represents only 30% of the total bonuses cost (versus 70% for the health facilities).

Unlike many SSA countries, Burundi RBF-FHC program➢(s overheads do not exceed 13% and technical assistance cost 5%.

The FHC-RBF program (the main reform during the last 10 years) has had a very positive impact on the health system. A remarkable improvement in some of the key indicators can be noted by comparison from the last comparable household surveys PMS I and II 2009 and 2012 (DHS is not used because it is related to 2010) and the health facility surveys conducted in 2009 and 2012. Below are some examples of progress in the key indicators:

- pregnant women receiving antenatal care increased from 95% in 2009 to 97% in 2012;
- contraceptive prevalence rate was at 22.7% in 2009 but reached more than 31% in 2012;
- children fully immunized increased from 65.4% in 2009 to 70.3% in 2012;
- average number of visits to a health provider by under five children increased from 1.68 visits in 2009 to 2.2 in 2012;
- assisted delivery increased from 64.4% in 2009 to 81.6% in 2012.

Moreover, the Burundi health sector improved its performance in two particular areas, namely: HIV/AIDS and Nutrition. According to UNAIDS estimates for 2013 the prevalence rate of HIV infection is 1.0% in adults aged 15 to 49, versus 1.4% in 2010 (DHS) and 3.6% in 2007 (Sero-prevalence Survey). Chronic malnutrition rate in children aged 6-59 months decreased from 58% (DHS 2010), to 52% in 2012 (HHS) and 48.8% in 2014 according to national nutritional survey conducted in February 2014.

The FHC-RBF program has played a positive role in improving health equity. According to a study on equity undertaken by the WB and Ministry of Health, the program had an impact on reducing inequalities between rich and poor households, especially for Maternal and Child Health. For many MCH services (except complete prenatal care - see the Graphic below), the poorest and the richest are equally using health services.

Utilization of maternal and child services in Burundi: Inequalities between income groups

Source: PMS 2 and Health Equity Study (2015), MoH and WB

Despite the critical political and economic situation, the Government of Burundi is committed to pay its share in the FHC-RBF program, and ongoing operational work in the HNP sector has largely remained uninterrupted. In addition to the government➢(s commitment, the project institutional arrangements played a positive role in the project execution. In effect, the HSDSP project has the highest disbursement rate among all WB projects in Burundi (see below the

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cumulative disbursement graph).

Health System Challenges

Despite the positive results in the health sector, it has been noted that in terms of the yearly evolution after 2013, the level of progress of some key indicators has been plateauing. This could result in an eventual lower marginal effect of the current national PBF program on the health outcomes of the population (indeed some of the key indicators such as antenatal care are high already so incremental gains are harder to achieve). In addition, some indicators that are outside the scope of this project are actually deteriorating, such as those related to child health (especially TB, Diarrhea and Acute Respiratory Infections).

Many factors can explain this situation: scarcity of human resources, especially physicians; high cost of drugs and medical devices; very weak Nursing Schools; meagre domestic financial resources; intrinsic weaknesses related to the current RBF-FHC.

In effect, some financing policies were developed to support the Government►(s strategy in making services available to the whole population at large. However, these interventions fall short of mitigating the full financial barriers observed in Burundi. The 2013 National Health Accounts show that the total health expenditure per capita amounts to almost US$30 per year of which a mere 13% is financed by the Government. The remaining balance comes from external aid (62%), household out-of-pocket spending (19%; almost 50% of domestic resources), and other private sources (6%).

Regarding FHC-PBF, the program is currently facing a financial constraint. The cumulative deficit for 2013 was approximately US$ 8 million. The reasons behind this are mainly threefold. First, a significant increase in the PBF payments between 2012 and 2013 as stated above is due to the increase in invoices submitted by health facilities and an increase in tariffs (bonuses) for certain indicators, especially for hospitals which face critical financial management issues and tight budgets due to unreimbursed expenses from other prepayment and insurance schemes. In addition, there are serious political and trade union pressures to increase rates and bonuses. In one year, between 2012 and 2013, payment to health facilities increased from 28.4 billion FBu to 45.8 billion FBu, or an increase of 62%. Second, while the Financing Agreement (FA) signed between the World Bank and the Government requires a commitment from the Government to allocate 1.4% of its annual general budget to the FHC-PBF program as a precondition for disbursement of IDA/HRITF financing, the reduction in the Government►(s overall budget has decreased automatically their nominal contribution (but 1.4% has been always respected even in 2015). Third, although important contributions are made by other development partners (DPs), some have reduced their financial contribution to the national FHC-PBF program between 2013 and 2015, resulting in an exacerbation of the overall deficit. To note, the World Bank-financed HSDSP is the second largest contributor to the program contributing approximately 40% (versus 45% from the Government).

The lack of predictability in funding poses a major threat to the sustainability of the FHC-RBF program. In addition to a budget reallocation done under the IDA AF to reorient the funding

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towards payment to facilities rather than other activities, several other measures have been envisaged to address this issue: (i) the Government advocated DPs to increase their contributions in vain (because of the political situation); (ii) the Ministry of Health (MoH) reduced PBF indicator tariffs (indicators directly linked to FHC for pregnant women and children under five are not affected) and prepared and implemented a fairly good cost containment strategy (that will be reinforced in the future); and (iii) in order to address the overall health financing issue, a Health Financing Strategy is currently being developed under the leadership of the Government, building on the Bank supported Health Financing Study that was conducted in 2014.

There is a weak buy-in by other actors not directly benefiting from the FHC-PBF program and lack of complete autonomy by health facilities. As the FHC-RBF Program is largely focused on implementing entities and health care providers, this has created a lack of interest and motivation among certain actors that are not directly involved in the program. In addition, the program➢(s heavy focus on health care providers (who are indeed crucial to the health system as they provide care to the population), including channeling of financial means, has caused certain negligence at other levels of the health system (some regulatory authorities and public health programs for example).

A recent study on verification/counter-verification conducted in Burundi highlighted that some error rates of declared services are still at around 30% although there were no significant differences between verification and counter-verification. For hospitals, the difference was greater.

Other health system issues that affect performance of the FHC-RBF include:
- Overlap between the minimum package of services (provided at health center level) and complementary package of services (provided at hospital level) resulting in an inefficient referral and counter referral mechanism;
- There is no community-based RBF (despite the evidence that Community Health Workers play a positive role in nutrition, family planning and other strategic health programs);
- Issues related to drug supply chain such as stock outs, high costs;
- The quality of medical and paramedical training is very modest (nursing schools).

Removing bottlenecks in the health system is crucial to improving the performance of health facilities and consequently the success of the FHC-RBF program that the World Bank is supporting. The Government has prepared a new National H ealth Development Plan (PNDS 2016-2020) which focuses on universal health coverage and health system strengthening through: (i) consolidation of the FHC-RBF program; (ii) improving human resources policy (including the quality of paramedical training), (iii) better regulation of pharmaceuticals and supply of health services (comprising the referral system), (iv) strengthening public health programs, including Nutrition, Family Planning and Maternal & Child Health , (v) improving the overall governance of the health system and (vi) enhancing indigents scheme and enlargement of health insurance to wider sections of rural and informal workers and their families.

The Kira project will support the government and the civil society involved in the FHC-RBF to remove main bottlenecks described above in order to improve the current program and to move to a new generation of RBF based on a solid cost containment strategy and a stronger verification and counter verification system. The project will be a good instrument to strengthen the Burundi health system.

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The new project KIRA will build on the current project activities and achievements, which constitute a solid foundation, while trying to increase the impact on the performance of the health system. Indeed, it is necessary not only to maintain the good results already obtained (maternity services), but also (i) to improve other strategic programs such as immunization, family planning, tuberculosis , malaria and HIV-AIDS ... (ii) to foster the fight against malnutrition and (iii) to boost the quality of health services at the primary level and in hospitals.

Thus, in addition to the direct support to health facilities (like the current project), KIRA will target the following entities:
- Nursing school to improve the training quality and therefore enhance trained staff➢(s skills and competencies.
- Regulatory bodies such as Human Resources Department, Information System Directorate, Health Directorate, and Medicine Directorate: The goal is to provide indirect support to health facilities by (i) improving the national health information system, (ii) developing and implementing a health services quality policy, (iii) assuring a better distribution of health workers, (iv) making staff available to health facilities, (v) improving pharmaceutical policy, (vi) and increasing drugs availability and containing their costs...
- Public health programs (not supported by other Developing Partners), namely the National Reproductive Health Program and the National Nutrition Program. This support aims to improve the provision of health facilities with required inputs and to enhance the two programs➢(supervision, coaching, training and technical support activities.
- The RBF National Cell: to improve the FHC-RBF procedures manual , to prepare and implement a more robust cost containment policy, and to enhance verification and counter-verification mechanisms.
- Community Health Workers: will be grouped in cooperatives in order to reduce the number of transactions / payments. The objective is to boost the community health approach, to improve prevention at the lowest level of Burundi health system, and to strengthen the referral system between the community and health centers.

Relationship to CAS/CPS/CPF

The development of the new proposed second generation RBF project (with a robust verification and counter-verification, better cost containment strategy, and more emphasis on quality) and Free Health Care is a part of the Performance and Learning Review (February 2015) of the HNP Section of the CAS 2013-2016. The CAS for Burundi has two strategic pillars: first, improving competitiveness by establishing an enabling environment for inclusive growth and poverty reduction; and second, increasing resilience by consolidating social stability. The KIRA (wealth and good health in Kirundi) project would contribute to the fight against poverty and to increased resilience. The PLR highlighted that the Bank engagement in the health sector is expected to move to the next stage of reforms (building on the successful RBF program to increase access to services), with a focus on improving quality and financial sustainability. Removing bottlenecks in the health system will be crucial to improving the performance of health facilities. In addition, there is an urgent need to put in place a sustainable funding mechanism. For this reason, the PLR suggests a shift in the approach towards supporting the health sector through expanding the performance-based payment that is currently applied to personnel in the health system to include

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community health workers, community representatives, national health management system, regulatory authorities, public health programs, etc.

Other international partners, especially GAVI, Belgium Cooperation, EU and UNICEF are interested in the RBF and Community Health Workers Strategy. Since 2010, many development partners have supported RBF and FHC. During their meetings with the WB, they expressed their interest to continue their support to this program and also to the new Community Health Workers Strategy. Nevertheless, because of the current political situation, some DPs are channeling their funds through UN organizations or International NGOs such as CORDAID. The team could not get a clear idea on the magnitude of this financial support.

C. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

To increase the quality and use of health services by pregnant women, adolescents, children under the age of five, and couples of reproductive age.

Key Results (From PCN)

- Pregnant women receiving antenatal care during a visit to a health provider (number)
- Births attended by skilled professional (number)
- Children 12-23 months fully immunized (number)
- Direct project beneficiaries
- Pregnant/lactating women, adolescent girls, and children under the age of five reached by basic nutrition services

The key results including intermediate outcome indicators will be refined during the preparation.

D. Concept Description

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The proposed Project is an RBF Pilot based on the National Health RBF-Free Health Care Program but also on the new strategic purchasing vision of the Ministry of Health. In effect, removing bottlenecks in the health system is crucial for improving the performance of health facilities and consequently the success of the RBF-FHC program. For this reason, the Government considers it important to shift the approach towards strategic purchasing and expand the performance-based payment that is currently applied to health facility workers to other actors in the health system. These include:

- Community health workers, community representatives and other groups in remote areas that are linked to the health system at the community levels;
- Health administration at all levels (central, provincial and district) that manages HR aspects, regulation including treatment and reference/counter-reference systems, quality policy, HMIS?.
- Public health programs concerned with FHC, including reproductive health, maternal health, infant and neonatal health, nutrition, HIV/AIDS, malaria?..
- Schools responsible for training health personnel including nurses, health technicians, midwives and paramedics; etc.

In Burundi, there are already some pilot experiences of introducing PBF to other actors in the health system, such as the Pilot of Community-based PBF (financed by Cordaid), as well as contracting the central level administration and public health schools and paying based on performance (financed by Belgian cooperation). These experiences would provide good lessons in expanding the PBF towards more strategic purchasing. While the graph below is still an initial

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proposal for an extended PBF, the MTR will provide an opportunity to assess in depth whether this approach is towards the right direction, how the design should look and the implications on the health system.

The proposed operation comprises three components that aim to improve access to quality health services (covering the whole country). The interventions are targeting community health workers (CHWs), health facilities (health centers and hospitals), local NGOs, Nursing Schools, regulatory entities, but also pregnant women and children in order to enhance both supply and demand sides of the health system.

Component 1: Performance Based Financing (PBF) Payments: US$ xxxM

The first component, which accounts for the bulk of the project funds (US$xxxx million), will pay bonuses to CHWs, health facilities, nursing schools, public health program, and regulatory entities according to their performance.

This component, is subdivided into three sub-components:

- The sub-component 1A will pay PBF bonuses to public and private for nonprofit health facilities, health centers and hospitals, for provision of pre-identified services in the RBF-FHC package. Health services to be paid for through the RBF mechanism include, among others, nutrition services, primary health care and preventive services for pregnant women, deliveries and post-partum care, immunization services, care for children under the age of 5, family planning, Malaria, HIV-AIDS, TB? The RBF payments will be linked directly to both quantitative and qualitative pre-defined indicators.

- The sub-component 1B will pay PBF bonuses to CHWs through their cooperatives (Groupements d?Agents de SantÃ© Communautaires ? GASC) for providing selected preventive, promotional, referral and basic curative health services.

- The sub-component 1C will pay PBF bonuses to Nursing Schools, Public Health Programs (especially Nutrition and Reproductive Health), the Health Management Information System, and regulatory authorities dealing with strategic issues such as Human Resources, Drugs...

Component 2: Support to the RBF process and technics, and increase health services demand: US $xxx million

The second component will support the external verification and payment processes. It will also be used for technical assistance and capacity building since new activities will be introduced. Finally, it will finance selected local NGOs that can foster the demand for better health utilization at community level.

It will support Ministry of Health and other entities involved in RBF, including NGOs (supply and demand sides) in various areas that include M&E, PFM and Procurement, health management information system, and RBF technics and database management, IEC? The component also supports verification activities ? including internal and external controls ? for the reported levels of services, the quality score? to mitigate the risk of falsifications and errors in reporting.

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This component, is subdivided into three sub-components:

- The sub-component 2A will support the verification and counter verification processes

- The sub-component 2B will support the project and the PBF-FHC program management

- The sub-component 1C will finance community-based activities to increase health service demand, promote healthy behavior, and help particularly vulnerable groups to access health services.

Component 3: Financial support to newly integrated activities and entities in the RBF-FHC program: US$xxx million

- This component will pay one time small grants to entities newly integrated in the RBF program such as Nursing Schools, Public Health Programs, the HMIS, Regulatory authorities/ administration? These payments will be in form of lump sums. They will finance light equipment and infrastructure investments in order to upgrade concerned entities and systems before starting the PBF process (and once investment plans are approved by the National PBF Unit).

II. SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

B. Borrower's Institutional Capacity for Safeguard Policies

The project is national level. The Ministry of Health disposes a draft National Strategic on the Biomedical Waste Management Plan and a general principle on the management of importation of medicine and elimination of expired medicines in the Country. Their application is still in earlier stage and implementation manual and guidance are not operational.
There is limited Borrower environmental and social safeguard capacity, in spite of the implementation of several health projects in the sector, in recent years, in particular, in carrying out projects environmental and social function. These and other constraints to implementing the project safeguard requirements will be assessed and addressed in the context of the preparation on the Environmental and Social Management Framework (ESMF) and Resettlement Policy Framework (RPF). The project is set out to strengthen, as necessary, relevant stakeholders➢(capacity to meet its safeguard requirements. In other words, the project shall implement any capacity strengthening measures that will be identified in environmental and social instruments applicable to this operation. The ongoing health project with Bank➢(s financing has strengthened the health center in districts with the construction of 15 incinerators with capacity building to the health worked on the medical waste management. The Ministry of Health capacity for safeguard policies should be strengthened. However, the task team thinks that the MoH needs technical support from the current consultant in the ongoing Bank➢(s support in the sector and the World Bank Safeguard team.

C. Environmental and Social Safeguards Specialists on the Team

Ishanlosen Odiaua (GEN05)

Paul-Jean Feno (GEN07)

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D. POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	As the RBF intervention will increase quality of health services and population access to the health in general; delivery of essential package like immunizations, vitamin supplementation to both pregnant women and children with procurement and delivery of relevant health commodities (drugs); delivery of essential package of equipment to health facilities to improve the service to a minimum acceptable standard; and support to community nutrition activities. In view of the above, no major civil works that could lead to potential negative environmental and social impacts will be undertaken in the proposed operation. However, it is possible that, during implementation some repairs/ rehabilitation of existing facilities and construction of fences may be undertaken. It is therefore expected that with improvements in health services delivery, the production of both medical and pharmaceutical waste in the various care centers and pharmacies in the country would ultimately increase accordingly. Taken altogether, it is therefore obvious that this could involve various kinds of risks associated with the inappropriate handling and disposal infected materials that could therefore increase the environmental pollution. These risks primarily affect personnel in medical facilities in charge of handling the proper disposal of medical waste, families whose basic income derive from the triage of waste, notwithstanding the general public, to the extent that waste is not disposed of on-site nor safely contained in protected areas. If not properly dealt with, preferably at early stages, these activities may have some environmental and human impacts that could then hinder the overall project outcomes. OP 4.01 is triggered because of the potential environmental impacts resulting from project activities. However, those impacts are expected to be minimal, site-specific and manageable to an accepted level. Due to the difficulty inherent in defining what the real environmental impacts of envisioned sub-projects are, and determining what mitigation measures to put in place, an Environmental and Social Management Framework (ESMF) will be developed by the Borrower. The ESMF will formulate standard

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		methods and procedures, along with institutional arrangements for screening, review, approval and implementation and monitoring of specific EMPs, including the preparation of environmental clauses to be inserted in contractors➢(bidding documents for any civil works conducted to the health facilities rehabilitation. The ESMF will be disclosed in-country and at Bank InfoShop, upon review and clearance by the Bank➢(s, prior to appraisal.
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	Yes	KIRA project will develop an updated Indigenous Peoples Plan (IPP) for the Batwa. It will be based on the current IPP and also on a new assessment during the preparation of the project.
Involuntary Resettlement OP/ BP 4.12	Yes	Component 3 of the project which include small grants to institutions and the financing of light infrastructure, are likely to induce land acquisition. A resettlement policy framework (RPF) would be the adequate instrument to prepare during project preparation.
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/ BP 7.60	No	

E. Safeguard Preparation Plan

1. Tentative target date for preparing the PAD Stage ISDS

30-Jun-2016

2. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the PAD-stage ISDS.

1. A situation analysis will be needed regarding waste management and a plan, including costing, to implement the new waste management policy.
2. Assessment of the Batwa's access to health services.
3. Indigenous Peoples Plan (IPP) for the Batwa.

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III. Contact point

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1 Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at

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the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.