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CR. 1607-BUR

Report No. P-4086-BUR

REPORT AND RECOMMENDATION

OF THE

PRESIDENT OF THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

TO THE

EXECUTIVE DIRECTORS

ON A PROPOSED CREDIT

OF

SDR 26.9 MILLION

TO

BURKINA FASO

FOR A

HEALTH SERVICES DEVELOPMENT PROJECT

May 14, 1985

CURRENCY EQUIVALENTS

Currency Unit = CFA Franc (CFAF)

US$1.0 = CFAF 490
CFAF 1 = US$0.0020
CFAF 1 Million = US$2,041

WEIGHTS AND MEASURES

Metric System

FISCAL YEAR

January 1 - December 31

GLOSSARY OF ACRONYMS

CSPS	:	Center for Health and Social Promotion (Centre de Santé et de Promotion Sociale)
DEPSS	:	Directorate of Health Studies, Planning and Statistics (Direction des Etudes, de la Planification et des Statistiques Sanitaires)
DPSP	:	Provincial Directorate of Public Health (Direction Provinciale de la Santé du Ministère de la Santé Publique)
FEER	:	Rural Water and Equipment Fund (Fonds de l'Eau et de l'Equipement Rural)
FEFS	:	Health Services Equipment Fund (Fonds d'Equipement des Formations Sanitaires)
ONAP	:	National Office of Pharmaceutical Supplies (Office National d'Approvisionnement Pharmaceutique)
MOPH	:	Ministry of Public Health
PMU	:	Project Management Unit (Cellule de Gestion du Projet)
PPF	:	Project Preparation Facility

BURKINA

HEALTH SERVICES DEVELOPMENT PROJECT

CREDIT AND PROJECT SUMMARY

Borrower: Burkina Faso

Beneficiary: Ministry of Public Health

Amount: SDR 26.9 million (US$26.6 million equivalent)

Terms: Standard

Project Objectives: The major objectives of the project are to:

(a) Strengthen basic health and family planning services, with initial emphasis on the control of communicable diseases and the treatment of malaria;

(b) Further formulate national health and population policies and promote their application; and

(c) Strengthen the institutional capability of the Ministry of Public Health in planning, evaluation and project implementation and monitoring.

Benefits: The project would improve the quality and accessibility of health and family planning services for about 4 million persons (over half the total population), with about 60 percent of children 0-4 years being effectively protected against major childhood communicable diseases. The skill and performance of about 1,000 health workers in rural areas would improve. Essential drugs are expected to be more widely available throughout the country at lower cost, while partial cost recovery will be introduced more widely into the health system. The nascent family planning program would be strengthened. Improved health policy formulation, planning and donor coordination are expected.

Risks: Risks include the Government's lack of experience in implementing a nationwide health project and the possibility that, due to Burkina's precarious financial situation, the Government may be unable to support fully incremental recurrent costs at the end of the project. By relying on and strengthening experienced local agencies, together with technical assistance where appropriate, the risk of unsatisfactory project implementation would be reduced. Cost containment and cost recovery measures, to be set in place through the project, as well as frequent IDA consultation with the Government on steps to be taken to mobilize additional resources for the health sector, are expected to assist the Government to meet recurrent cost requirements.

Estimated Project Costs: [a] (Net of taxes and duties from which the project would be exempt.)

	Local	Foreign	Total
	US$ million		
1. Strengthening of Basic Health and Family Planning Services			
- Development of Immunization and Malaria Programs	0.8	3.1	4.0
- In-Service Training of Health Personnel	0.1	0.3	0.5
- Strengthening of Health Infrastructure	4.4	4.9	9.3
2. Development of National Health and Population Policies and Programs			
- Policy Development Studies	0.1	0.4	0.5
- Implementation of Sub-projects Resulting From Special Studies, and for Population Activities	1.8	3.2	5.0
3. Strengthening of Ministry of Public Health	1.2	2.2	3.4 [b]
TOTAL BASE COST	8.4	14.2	22.6
Physical Contingencies	0.5	0.7	1.2
Price Contingencies	2.1	2.1	4.2
TOTAL PROJECT COST	11.0	17.0	28.0
Financing Plan:			
IDA	9.6	17.0	26.6
Government	1.4	-	1.4
TOTAL	11.0	17.0	28.0

a/ Totals may not add up due to rounding.
b/ Includes a US$0.8 million PPF advance.

Estimated Disbursements:

	FY86	FY87	FY88	FY89	FY90	FY91
			US$ million			
Annual	2.4	3.7	5.3	5.9	5.6	3.7
Cumulative	2.4	6.1	11.4	17.3	22.9	26.6

Appraisal Report: 5352-BUR

Economic Rate of Return: Not Applicable

Project Completion Date: January 31, 1991

Map: No. IBRD 18565

INTERNATIONAL DEVELOPMENT ASSOCIATION

REPORT AND RECOMMENDATION OF THE PRESIDENT TO THE EXECUTIVE DIRECTORS ON A PROPOSED CREDIT TO BURKINA FASO FOR A HEALTH SERVICES DEVELOPMENT PROJECT

1. I submit the following report and recommendation on a proposed development credit to Burkina Faso in an amount of SDR 26.9 million (US$26.6 million equivalent) on standard IDA terms to help finance a Health Services Development Project.

PART I - THE ECONOMY 1/

2. A country Economic Memorandum entitled "Upper Volta: Investment in Human Resources" (4040-UV) was distributed to the Executive Directors on September 5, 1983. The following paragraphs are based on this report and on subsequent economic updates by Bank Staff.

Background

3. With a GNP per capita of US$180 in 1983, Burkina (population 6.7 million) is one of the poorest countries in the world. As in most of the Sahelian region, this poverty is largely the result of a limited resource endowment. Soils are generally shallow, poorly structured, and easily depleted by traditional methods of cultivation. Rainfall is scarce and highly variable both among regions and from year to year. The lack of a permanent water flow in the country's river system severely limits the potential for irrigation and hydroelectric power. The cost of mining known mineral deposits (e.g. zinc, silver, phosphorus) is relatively high. The country's landlocked position, scarcity of roads, and long distances from seaports further constrain the country's development potential in all sectors.

4. An estimated 80-90 percent of the population depends for its livelihood on the predominantly subsistence-oriented agriculture and livestock sectors. Concentration of over half of the population on the central plateau has resulted in declining fallow periods, rapid deforestation, and deteriorating soil fertility in this region. The impoverishment of the central region has given rise to spontaneous resettlement to the south and west, areas recently freed of riverblindness (onchocerciasis), and to emigration to coastal countries, primarily the Ivory Coast. Approximately 0.6 percent of the population emigrates each year and roughly half of the emigrants are working age males. Emigration has provided the required safety valve for population pressure and has resulted in an annual

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1/ Parts I and II are substantially the same as those in the Primary Education President's Report.

inflow of remittances of about 8 percent of GDP. Both demographic movements, however, represent only partial and temporary solutions to the challenge of raising the living standard of the population, which is growing at approximately 2 percent annually (adjusted for emigration).

Past Economic Performance and Recent Developments

5. The 1970's were good years for Burkina's economy. Outperforming other Sahelian countries, the country's GDP grew at an annual 3.9 percent in real terms between 1970 and 1979 and GDP per capita at 2 percent. These favorable trends were due to relative political stability, increased inflows of foreign aid and workers' remittances (the latter accounting for most of the gains in national income), and the expanded production of cotton, the country's major export crop. Also, Government economic policies were generally judicious. The three ruling administrations of the 1970's avoided major errors in the selection of investments, kept the economy free from price distortions, and stayed well within the conservative financial policy guidelines of the West African Monetary Union (WAMU), of which Burkina is a member. There was, however, one area of weakness in Burkina's otherwise creditable economic performance during the 1970's, namely, the inadequate planning of capital and recurrent public expenditure. This led to a neglect of certain sectors such as health and education, and, in the second part of the decade, to budgetary deficits amounting to 1-1.5 percent of GDP.

6. A string of adverse developments in the 1980-1983 period caused a reversal of the 1970's trends and helped plunge Burkina's economy into a severe recession. A rapid turnover of governments led to a climate of political instability which, in turn, slowed down the inflow of both foreign aid and workers' remittances - the two major stimulants of demand in Burkina's modern sector. In addition, because of irregular and below average precipitation, cereal harvests fell steadily from the peak reached in 1981, thus substantially reducing outputs in agriculture, the country's traditional sector. Public economic and financial policies deteriorated as well in 1980-1983, a period when the Government undertook questionable investments and inordinately expanded its debt burden by borrowing from local banks and contracting foreign loans on non-concessionary terms. The budget deficits brought about by these policies and by falling custom revenues led to mounting reciprocal arrears between the Treasury and the state enterprises and contributed to further exacerbate demand for bank credits. All told, between 1980 and 1982, investment fell approximately 50 percent, GDP stagnated, and the budget deficit increased to 4.2 percent of GDP by 1983.

7. The present Government, which came to power in August 1983, initially directed its energies almost exclusively to establishing a solid political base. In mid-1984, however, the country's worsening economic conditions compelled the Government to redirect its attention to the economic front and to delineate a preliminary set of development and

financial stabilization policies. Thus, the new Government announced that it would place increased emphasis on rural and human resources development, tighten budgetary expenditures, and start elaborating a National Development Plan.

8. A first concrete step to implement these policies was the launching of a "programme populaire" comprising a "self-help" program of small investments and operations at the village level (construction of small dams, grain storage, health and education facilities). A second important step was the passing of an "austerity budget" for 1985 calling for cuts in expenditures (other than investment) and increases in revenues. Thus, in a rapid succession of fiscal measures, the Government introduced taxes on land title and on cattle, raised the tax on alcohol, and required employees in both public and private sectors to forego their "13th-month" bonus payment as well as between 1/12 and 1/24 of their basic salaries in favor of the Treasury. However, the Government has also taken steps to suppress rental payments and establish new land tenure arrangements, measures which are likely to prove counterproductive.

9. Although it is difficult to assess the final impact of the foregoing measures on the economy and on public finances, preliminary data indicate that economic growth has not yet revived. This is not surprising given the continuation of drought conditions in Burkina, which caused a 7 percent drop in 1984 cereals output (vis-a-vis the already depressed average of the two preceding years), and the persistence of an unstable political climate, which has adversely affected both foreign aid and workers' remittances. As for public finances, the budget deficit appears to have remained at 4 percent of GDP in 1984 despite the austerity budget, as the economic slowdown caused revenues to drop further.

Economic Policy Issues

10. While some of the recent measures are preliminary steps in the right direction and do indicate the Government's willingness to undertake reforms, the redressing of the economic and public finance situation requires a range of complementary policy changes in the areas of investment planning, financial management, and public enterprises. Corrective action in these areas could also pave the way for a possible IMF standby arrangement.

11. Investment Planning. Burkina's public sector has never shown great enthusiasm for planning its investments. Continuing in this tradition, the current Government is proposing to embark on a number of highly visible, large-scale projects without having made a serious analysis of their economic merits or budgetary implications. The largest and most controversial of the proposed projects, representing a total cost of about US$320 million, is the Tambao project involving the Ouagadougou-Kaya-Dori railroad extension, development of a manganese deposit at Tambao and construction of related infrastructure. Although more appropriate in the Burkinabè context, the recently launched "programme populaire" appears overambitious as well, when viewed against the rural communities' limited implementation capacity.

12. Recently, however, the new Government has appeared to be giving increased consideration to economic planning and has asked the Bank Resident Mission to help. Clearly, one of the major goals of any planning process should be the definition of a realistic and well-conceived investment program, i.e. one which would channel investment resources towards priority uses, and would be commensurate with the country's absorptive capacity. The objective ranking of investment proposals according to clearly defined development priorities, estimated economic impact, and budgetary implications would undoubtedly lead to a shift of attention from some high-risk propositions (e.g., Tambao) currently contemplated by the Government to sounder project proposals, such as exist in the agriculture, transportation and human resources fields. The definition of a sound investment program could serve to rationalize not only the use of domestic resources but also that of external aid, which has financed 80-90 percent of Burkina's public investment in recent years. Such a program would be a valuable instrument for improved aid coordination; it would provide the donor community with a sounder basis for its decisions and would afford the Burkinabè Government the opportunity of taking an increasingly firmer hand in directing external assistance towards national economic priorities.

13. Financial Management. Burkina's Public Finances are - and will for some years continue to be - severely strained by the peaking of debt service payments. While this peaking is primarily due to the expiration of grace periods on foreign concessional loans obtained after the 1973-74 drought, it also reflects payments due on non-commercial external and internal debt incurred in the 1980-1982 period (para. 6). Debt-service payments due in 1984 amounted to CFAF 12 billion, with a further increase projected for subsequent years.

14. Restoring balance to the public finances requires a number of actions - complementary to those recently taken by the Government - on both expenditure and revenue sides. Thus expenditure cutbacks should be extended to defense spending and public transfers, notably student stipends. Non-concessional debt incurred in the 1980-82 period will probably need to be rescheduled, and new borrowing closely monitored. Despite the limited tax base, some scope exists for increasing budgetary revenues by raising import taxes and/or the indicative prices of imported consumption goods and petroleum products. Improved tax collection could also prove to be an important source of increased revenues.

15. Putting the public finances in order would also require a strengthening of such essential functions as budgeting, accounting and financial control, particularly in the areas of external debt and public recruitment. The Government has recently proceeded to tighten control of personnel expenditures, procurement, and technical assistance contracts. An important complementary measure would now be the establishment of a budgetary and accounting system to monitor the external financing of public investment and the associated counterpart and recurrent costs obligations for the Government. A close watch also needs to be kept on the evolution

of debt service obligations to avoid the recent recurrence of late payments to foreign creditors. In addition, Burkinabè authorities should consider elaborating annual investment budgets (para. 12) which would allow them to adjust investment levels, from year to year, to the country's changing circumstances and evolving economic parameters.

16. Public Enterprises. Burkina has several major parastatals which are managed quite efficiently and, in fact, could serve as models for similar entities in the West Africa region - notably OPT and ONE, the telecommunications and water utilities, respectively, and SOFITEX, the cotton marketing organization. However, most of the other public enterprises suffer from lax financial accounting and reporting to the central Government, which makes it difficult to assess the impact of their operations on the consolidated public financial situation. The increasing financial troubles of the public enterprise sector in recent years are rooted partly in the liquidity problems of the Treasury and partly in inadequate policies relating to prices and tariffs, employment and internal management. To improve the financial performance of the public enterprise sector, the newly created Ministry of State Enterprises will need to take prompt action to ensure realistic pricing, curtail excess employment, and strengthen public enterprise finances.

Long-Term Development Prospects

17. Barring the discovery of major economically exploitable mineral deposits, Burkina must continue to rely for its growth on the development of its agricultural and human resource endowments. Therefore the development of these two assets should constitute the focal point of any long-term strategy to extricate the country from its present conditions of extreme poverty.

18. In agriculture, top priority should be given to reversing the deterioration of renewable resources - ground water, topsoil and forest cover - which has resulted from the pressure of growing human and livestock populations. The abandonment of traditional shifting cultivation, overcutting of forests and brush to meet fuelwood demand, and uncontrolled grazing have combined to create nearly irreversible damage to the carrying capacity of parts of the central plateau. To arrest this environmental degradation and eventually raise productivity, requires erosion control and replacement of organic matter in the soil by integrating crop cultivation with reforestation and livestock husbandry. More and better focused research is needed to overcome the technical and economic constraints to the intensification of crop/forest/livestock production systems. Difficult social and political issues as well need to be addressed, particularly concerning land tenure and communal responsibility for management of forests and grazing areas.

19. A second major challenge for the country is to accelerate the development of its human resources. Increasing access to primary education and improving health through better primary health services, water supply and sanitation, and nutrition will be critical to expanding the application

of new agricultural technologies and to raising productivity levels. Progress in these areas will require policy reforms aimed at reducing unit costs, redirecting budgetary resources towards primary services, and increasing cost recovery. Improved education and health services are also important means of changing attitudes regarding fertility and reducing the rate of population growth, which currently outpaces the expansion of agricultural output and makes it difficult to adopt measures to preserve the embattled agricultural resource base.

20. Other elements of a long-term strategy must include exploration and, where economically feasible, development of the country's mineral potential to generate public revenues, diversify exports, and reduce the country's vulnerability to its uncertain climate. Finally, development of transport infrastructure - with an emphasis on ensuring adequate maintenance and rehabilitation of existing assets - is needed to complement actions in the directly productive sectors.

Foreign Assistance and Aid Coordination

21. Burkina has received, and continues to receive, a considerable volume of external assistance. The bulk of this assistance is on highly concessional terms. However, the increasing constraints on counterpart contributions and recurrent expenditures due to the tight budgetary situation call for a more selective and coordinated approach in planning foreign assistance, on the part of the Government and the donor community alike. The country's ability to finance recurrent costs will remain very restricted for some years to come, especially as it undertakes the expansion of agricultural and social services which will inevitably increase demands on the domestic recurrent budget. Accordingly, local cost financing, recurrent cost financing, and high cost-sharing ratios will continue to be necessary features of external assistance to the country.

PART II - WORLD BANK GROUP OPERATIONS IN BURKINA

22. The Bank Group's commitments in Burkina, as of March 31, 1985, amounted to US$250 million for twenty-eight IDA credits. IFC has made one investment. About US$150 million have been disbursed. The IDA credits comprise fourteen projects in agriculture (including one supplementary credit), six projects in transportation (including one supplementary credit), two projects in education, three projects in telecommunications and one project each in industry, mining exploration, and urban development. The IFC investment was made for the production of plastic products destined for the local market. Burkina is also one of the major beneficiaries of the Onchocerciasis Control Programme financed by IDA and other donors. Annex II contains a summary statement of IDA credits and IFC commitments.

23. Project implementation has generally been satisfactory over the past fifteen years. However, the recent political turmoil and resulting administrative and personnel changes have slowed the implementation or start-up of many projects, in some cases necessitating the extension of closing or effectiveness dates. Also, project implementation has been hampered by the Government's fiscal management problems which have made it difficult to meet promptly counterpart funding obligations. Burkina's disbursement rate, which historically has compared favorably with that of other countries in the region, has deteriorated in recent months. Disbursements are expected to return to normal levels, however, as the political and administrative environment stabilizes.

24. In the face of uneven progress in different areas of the economic dialogue, Bank lending is being directed towards operations in sectors of certain priority where the dialogue is advancing the best. Also, operations with heavy policy orientation, designed to improve overall sectoral environments, have been given priority over exclusively "hardware" projects. Thus, recent lending operations in mining and rural development have addressed sectoral policy issues such as sector investment priorities, institution-building and financial policies. The Fertilizer Credit, the first project in the fiscal year, seeked to reform the fertilizer subsector by removing subsidies and other distortions. The present Health Services Development Project, the third to be presented this fiscal year, and the Primary Education Project, submitted earlier this year, will substantially improve the efficiency of the respective sectors, thus permitting expansion of rural health care services and primary school enrollment, without excessive strain on the public finances. Other projects under active preparation are aimed at improving the delivery of agricultural research and extension services and expanding livestock production.

25. On the other hand, operations in sectors bogged down by major issues, which can only be solved in the context of substantial progress in the economic dialogue, are being held in abeyance. Cases in point are the RAN Rehabilitation and the Ouaga-Kaya-Dori Road Projects, which must await the resolution of policy issues in the transport sector concerning the economic feasibility of the Tambao project (para. 12) and the currently inadequate maintenance of existing infrastructure.

PART III - POPULATION, HEALTH AND NUTRITION SECTORS

Background

26. Health Status. Burkina's underdevelopment is aggravated by its people's poor health and nutritional status combined with rapid population growth. The following parameters give a measure of the magnitude of the problem: life expectancy at birth varies from 32 to 45 years between rural and urban areas (compared with 47 years in Ethiopia and 48 years in Bangladesh on average); 38 percent of children do not live beyond 5 years of age; 30 to 50 percent of preschool children suffer from various degrees

of malnutrition; and, depending upon the assumptions, population is expected to reach between 8 and 10 million by the year 2000 from 6.7 million in mid-1982. Recurring droughts and food shortages are key factors, outside the control of the Burkinabè health system, which contribute to the poor health status of the country's rural areas.

27. Health System. Between independence and the 1970's, Burkina maintained a health delivery system based on a network of curative facilities in urban areas and major population centers and on mobile teams for the control of major endemic and epidemic diseases. This dual system achieved major success in eliminating smallpox, in reducing sleeping sickness and yellow fever to sporadic cases, and in decreasing leprosy levels faster than elsewhere in Africa.

28. As a result of these successes, new diseases emerged as health priorities (i.e., tuberculosis, diarrheal diseases, malaria). At the same time, improved medical technology, socio-economic changes, and a better awareness of health benefits increased demands for health services beyond that which the health system was designed to meet. In the mid-1970's the urban and rural health services were integrated in an attempt to meet this new demand. This resulted in a larger share of health resources being channelled to curative and mainly urban facilities where expressed demand was greatest, while health services in rural areas were neglected. Mortality of adults (the productive population) did not decrease significantly after integration of the rural and urban health services, indicating that curative services alone had a very limited impact on the health status.

29. The health care system comprises a pyramid of services in each of Burkina's thirty provinces. At its base are village-level primary health care committees, voluntary organizations to improve health and nutrition through village self-help. The activities of several of these committees are supervised by a center for health and social promotion (CSPS), an upgraded form of existing rural maternities and dispensaries established in rural towns. The CSPS is managed by a core team of four (a head nurse, an auxiliary nurse, a midwife and an itinerant health worker), and it is the base from which health education, technical support and key services, such as immunization, move out towards the villages. It is also the first entry point into the health system for villagers and townspeople in need of care. Each province is administered by a provincial Directorate of Public Health (DPSP) headed by a physician who coordinates health activities and supervises CSPS. So far, facilities for DPSP exist only in twenty-four of Burkina's provinces. Surgery can be performed in nine referral centers located in major towns. The Government intends to increase the surgical coverage by building six additional referral centers. This coverage would provide access to emergency care and surgery to over half of Burkina's population through fifteen strategically placed referral centers - (one referral center for two provinces on average). Existing medical centers, regional hospitals and two national hospitals complete the national system of referral services.

Issues and Problems

30. Restructuring the health system is necessary to make it more responsive to present needs of rural populations. Poor performance to date has led to a lack of confidence on the part of the rural population in a system which has not been capable of reaching out to them and which has lacked the drugs to treat them. Alternative approaches must be found to extend health benefits to geographically remote populations, and financial resources need to be reallocated from curative urban-centered activities towards the rural population.

31. Health System Performance. The deterioration of medical health services is due to the poor condition of buildings and technical equipment in existing facilities, the poor quality of medical services, and the unavailability of drugs. Furthermore, easy access to these facilities is limited to about half of the population living within a 10 km radius. Personnel is adequate in number but often dispirited and deprofessionalized and neither supervised nor trained on a regular basis. Drugs are poorly chosen, inadequately distributed, and often prescribed inappropriately. Expensive drug procurement practices and insufficient supply result from the lack of coordination among the principal sources of procurement, i.e., the Ministry of Public Health, the National Office of Pharmaceutical Supplies (ONAP), the private sector, and foreign aid. ONAP, a public commercial agency, with a monopoly in drug supply to the public sector, cannot be relied upon for adequate drug supply: it lacks financial resources to import drugs due to non-payments of ONAP's bills by public agencies and local authorities and due to huge deficits incurred by its sales outlets. This inefficient procurement system, combined with lack of revenue due to free drug distribution practices by the Ministry of Public Health, has severely constrained the distribution of low cost drugs to rural areas where the public health services are the sole distributor of drugs. The private sector, essentially urban, has extended into rural areas, but its coverage is limited to communities large enough to ensure a profitable drug distribution.

32. Alternative Approaches to Rural Health. Since about 50 percent of the population does not have ready access to health centers due to geographical dispersion, approaches which are financially and operationally viable must be found to improve basic health and nutrition self-reliance. Such approaches would emphasize preventive measures, detection of diseases which require the intervention of qualified personnel and simple curative techniques which could be handled by the communities themselves. The design and implementation of such a program requires a better understanding on the part of health officials of the villagers' demand for health services and their acceptance of preventive health measures. It also requires convincing villagers that adequately equipped and staffed health facilities exist to which they can be referred in case of need.

33. Financial Resources. Insufficient financial resources for rural health stemmed from: (i) a reduction of the health share in the national budget; and (ii) allocation of much of the health budget to urban areas and personnel. The share of health in the national operating budget decreased from 12 percent in 1960 to 6 percent in 1978. While its share has picked up over the last few years, it still stood at 9 percent in 1984. Within that share, the two major towns in Burkina, Ouagadougou and Bobo-Dioulasso, received about 50 percent of the recurrent health budget. Salaries represent 80 percent of the budget. Cost recovery has been practically non-existent as Government has been under strong political pressure to provide health services free of charge. If the basic health needs of rural areas are to be met, a continuing effort will be needed to make the most efficient use of available budgetary resources, to channel greater resources to rural areas, and to recover a larger percentage of costs wherever possible.

Health Program Implications

34. Whatever health policy measures are designed for the medium and long term to address the above issues, current rural health services must and can be rehabilitated immediately. Without increasing the number of facilities, existing buildings need to be renovated and properly equipped. CSPS (para. 29) staff need to be trained in the areas of: (i) organization and management of primary health care; (ii) immunization; (iii) maternal child health and family planning; (iv) sanitation; (v) detection and treatment of malnutrition and control of infections and parasitic diseases; and (vi) prescription of essential drugs. Training programs need to be developed to retrain existing staff, and immunization programs need to be extended immediately to cover the entire target population, using amended immunization schedules and complementing services delivered in fixed facilities with those of mobile teams. Furthermore, malaria can be easily controlled by supplying chloroquine to village communities for treating outbreaks of fever. Public opinion can be sensitized on population issues; and family planning services can be introduced into maternal and child health clinics.

35. Although the foregoing immediate measures alone cannot be expected to solve all health problems, they are essential to a viable rural health system and would restore the system's credibility with the rural population. Further improvements will be needed to complement immediate actions. For example new strategies need to be developed for communicable diseases to prevent the recurrence of major endemic diseases successfully controlled in the past and to control new priority diseases (e.g., tuberculosis, diarrheal diseases). Simple preventive and curative measures for common diseases should be introduced to rural communities through village health workers. Drugs should be made available to the rural population. This will require giving priority to essential drugs, reforming procurement, and finding efficient and cost effective distribution channels. New sources of revenues for the health sector must be identified since budgetary allocations are unlikely to increase. All consumers of health services must share a greater portion of recurrent health costs with

Government. Finally, strengthening the planning and evaluation capacity of the Ministry of Public Health is required to implement measures derived from these policies and to coordinate future investments in the health sector.

Recent Government and Donor Actions

36. Over the past few years, successive Governments have again begun to emphasize rural health. A series of policies have been adopted that aim at rehabilitating health services in rural areas, improving the procurement and distribution of drugs, enforcing existing and introducing new cost recovery measures, and starting family planning activities. Increased donor coordination is being pursued by the Government, and foreign assistance totalling US$20 million (1982) has been channelled into the health sector. (Major donors include the African Development Bank, Canada, People's Republic of China, EEC, France, Federal Republic of Germany, Italy, Netherlands, UNICEF, USAID and various NGO's). With donors' support, Government has begun the rehabilitation of health facilities and the expansion of vaccination campaigns.

37. The Government has begun a national program to upgrade about 400 existing maternity and dispensary facilities to CSPS (para. 29) by 1995. About 200 facilities already have been renovated or reconstructed with assistance from the African Development Bank, the EEC and the Federal Republic of Germany. Medical staff has already been redeployed from urban to rural facilities. The Government administered about 5 million doses of vaccines against measles, yellow fever, and meningitis during a "commando operation" at the end of 1984 -- a unique feat in Africa. A comprehensive immunization campaign in the Kaya region, supported by the Netherlands, has resulted in a 90 percent coverage of the target child population and will soon be extended to two new provinces. Italy is supporting research necessary for anti-malaria programs.

38. The Government has decided to give priority to increasing the availability and affordability of essential drugs, i.e. drugs recommended by WHO, and now adopted by the Ministry of Public Health. Only essential drugs would be authorized for distribution in Burkina to ensure that only effective quality medications are provided to consumers. To reduce costs, essential drugs would be procured in bulk quantities at reduced import prices by only one importer of drugs, the SONAPHARM, created recently by the Government with the support of the private sector to replace the debt-ridden ONAP (para. 31). SONAPHARM, a mixed corporation (51% State, 49% private), will supply drugs to both private and public distributors on a strictly commercial basis. In order to gain the confidence of international pharmaceutical suppliers, the Government has already begun to reimburse most of ONAP's debt through the sale of drug stocks and retail sales outlets. To reduce risks of conflicts with the private sector and to make it financially viable, the Ministry of Public Health would limit the new entity to wholesale of drugs and keep it out of the retail drug distribution business. With lower importation costs, the private sector is expected to earn adequate profit margins on sales. The Government will

also rely on private shareholding and management practices to ensure efficiency. The Government has requested Bank technical assistance in the launching of SONAPHARM. The new entity, if successful, could simplify drug procurement and ensure an adequate supply of essential drugs needed for rural health. However, its de facto monopoly might detract from the enterprise's economic and management performance in the long term. The Government is aware of that risk, and in order to safeguard efficiency in the long run, will assess jointly with IDA on an annual basis its operations, its impact on drug supply and the opportuneness of allowing competition in procurement (Supplemental letter in Annex IV).

39. The Ministry of Public Health has recently undertaken a series of cost recovery measures. Evacuees are now asked to share the cost of medical evacuation abroad. Better enforcement of medical fees for services is being introduced in the two national hospitals. With Italian assistance, the Government is seeking means to extend user fees to lower levels of the health system. Employers are now required to use public health facilities in the provision of medical benefits which are mandatory in Burkina (Workman's compensation). These measures will yield an annual increment of US$0.6 million equivalent, representing an annual increase of about 8 percent over the 1985 budgetary resources. However, these cost recovery measures alone will have only a limited impact on the channelling of resources into the health sector. Better availability of drugs, improved medical services, and better coverage of health services will offer opportunities to increase revenues which will need to be fully exploited. Finally, the Government is considering creating a Health Services Equipment Fund (FEFS), financed by 75 percent of all fees collected through cost recovery measures at health facilities as well as from proceeds from the sale of vaccination cards.

40. The Government, becoming aware of the consequences of rapid population growth, has introduced family planning services in urban areas which, in turn, could have a demonstration effect on rural provincial capitals. Birth spacing is promoted by the media. Recently, the Government repealed the ban on artificial contraception, a colonial law dating back to 1920. There is not yet a national population program, but the Government, with the assistance of USAID, has prepared a population planning assistance project, which in three years, through demographic analysis, information and training, and improvement of family planning services, would lay the groundwork for a population program.

41. The Ministry of Public Health established in 1982 a Directorate of Health Studies, Planning and Statistics which was responsible for preparing the proposed project. The Directorate also prepared the 1986-87 biennial investment program and is involved in the preparation of the 1986-1990 Health Sector Plan. The Directorate receives the technical assistance of a five-member team of USAID to strengthen the planning function in the Ministry. However, in addition to planning, the Ministry still needs to strengthen its epidemiological surveillance capability to avoid the spread of communicable diseases, to complete its network of

Provincial Directorates of Public Health (8 provinces out of 30 still need to be covered) and to strengthen the staff of these Directorates.

Bank's Role in the Health Sector

42. Through its 10-year involvement in Burkina with the Riverblindness Program, the Bank has become increasingly aware of the importance of developing primary health care systems for the rural areas. The Bank's strategy for Burkina emphasizes development of human resources. Economic and health sector missions in 1981 (Health Sector Report No. 3926-UV, November 12, 1982) initiated a dialogue with the Government on health policies, emphasizing priority on rural health, and were the origin of the Bank's direct involvement in the Health Sector. The policy framework recommended by IDA was subsequently approved by the Government in October 1982 and was not modified later despite changes in the Government. The preparation of the proposed project has given momentum to the dialogue with the new Government. The project itself would provide the framework for continuing the policy dialogue on major sector issues and on the financial and budgetary implications of improving Burkina's health system.

43. The first IDA-assisted project in the health sector would complement activities already undertaken by other donors to rehabilitate the existing system. In addition, it would address policy issues, for which detailed measures still need to be found, before these policies can be implemented to improve Burkina's health system. Preparation of the proposed project had a catalytic effect on donor coordination in the health sector and resulted in common objectives for action, sharing and adoption of design standards for construction, immunization programs and measures to be taken in pharmaceuticals. There is an increased common understanding on policy issues among donors, particularly UNICEF, Italy and the World Bank.

PART IV - THE PROJECT

Project Preparation

44. The proposed project preparation followed adoption by the Government in 1982 of policies and approaches recommended by the 1981 economic and health sector missions. Two advances under the Project Preparation Facility (approved in November 1982 and November 1984) totalling US$820,0000 equivalent helped establish a Directorate of Health Studies, Planning and Statistics in the Ministry of Public Health. The proposed project was appraised in May 1984; negotiations were held in Washington in April 1985 and the Burkinabè delegation was led by Mr. André Fayama, Directeur de Cabinet in the Ministry of Financial Resources. The Staff Appraisal Report (No. 5352-BUR) is being distributed separately to the Executive Directors. A Supplementary Project Data Sheet is given in Annex III.

Project Objectives

45. The project is designed as the first in a series of interventions in the health sector by IDA and other donors in support of the Government's strategy in health and population. It plans to rehabilitate and increase the efficiency of the existing rural health infrastructure and institutions, while simultaneously devising cost recovery and budgetary policies that will enable Government in the long run to finance a broad-based rural health care system. It supports the Government's efforts to reorder priorities within the existing health care system from the urban to the rural population through efficiency improvements and the reallocation of financial and human resources. Moreover, the project provides the framework for a continuing dialogue with the Government on the development of the sector.

46. The proposed project would: (a) strengthen existing basic health and family planning services, with initial emphasis on the control of communicable diseases and the treatment of malaria; (b) further formulate national health and population policies; and (c) strengthen the MOPH's institutional capability in planning, evaluation, and project implementation and monitoring.

Detailed Features

A. Strengthening of Basic Health

47. The project would upgrade 142 existing health dispensaries into CSPS (para. 29) in 15 provinces, following a low cost approach. To complete the coverage of surgical care foreseen by the Government and to ensure adequate referral of emergency cases requiring surgery, the project would upgrade six existing medical centers to serve as surgical referral centers (para. 29). Cost estimates of civil works for health facilities are based on simple but functionally appropriate design standards developed by the Ministry of Public Health and successfully being used elsewhere in the CSPS program in Burkina. The average building cost per square meter compares favorably with costs for similar facilities in the region. Moreover, the project foresees mobilizing rural communities to manufacture bricks and to provide unskilled labor during the construction period. Each CSPS would be provided with year-round water supply, and equipped with a refrigerator, motorbicycle or bicycle.

48. Through the project, each CSPS staff, either already in place or to be made available through reallocation of the existing pool of health providers, would receive training and supervision provided by the Provincial Directorate of Public Health in each of the 30 provinces. A minimum of two training cycles would be completed in each province.

49. For about 50 percent of the rural population who, largely due to geographic dispersion, do not have ready access to a CSPS, the project would finance tests and studies to find appropriate village-level

approaches that would be operational and financially viable on a national scale. Limited tests have already started with assistance from a variety of sources including the British "Save the Children Fund", the Federal Republic of Germany and the United Nations Fund for Population Activities.

50. The project would provide vaccination coverage in 15 provinces and major urban centers to children under age four against measles, pertussis, poliomyelitis, diptheria, tetanus and tuberculosis. The 1-15 age group would also be inoculated against yellow fever and meningitis. Chloroquine would be provided and sold throughout the country in support of a national malaria program. The credit would finance adequate amounts of chloroquine for an initial two-year period. Replenishment of chloroquine stocks would be secured through a revolving fund financed by the sale of the initial stock. The proceeds from the sale of chloroquine would be placed in an account in its Treasury which would operate as a revolving fund on conditions satisfactory to the Association, to support primary health care services, including the replenishment of chloroquine for the anti-malarial program (Section 3.06 of DCA). In addition, as a condition of disbursement, no credit withdrawals would be authorized for chloroquine until the Association is satisfied that adequate arrangements have been made for bulk procurement, packaging, distribution and recovering costs through sales (Schedule 1, para. 3 (c) of DCA).

B. Development of National Health and Population Policies and Programs

51. Health Policies. To ensure that the Government, the Association and other donors are coordinating efforts around a commonly understood sector policy, the Government has submitted an updated statement of its health policy (included in Annex IV). This policy may be modified as a result of further studies, including inter alia, the studies and experiments to be carried out under the Project. However, if these studies and analyses would indicate the need for a reorientation of the national health policy, the Government would consult about it with IDA as is reflected in a supplemental letter attached in Annex IV. Furthermore, to maintain an effective policy dialogue, the Government will: (i) organize annually a meeting of all aid agencies participating in the financing of the Primary Health Care Program in order to review progress made in its execution and to coordinate further assistance; and (ii) review in detail annually with the Association all expenditures made in the health sector during the previous year and proposed to be made during the upcoming year, regardless of the source of financing of such investments. (Section 3.03 of DCA).

52. The proposed project provides for studies aimed at determining detailed measures needed to implement effectively health and population programs and at adjusting national policies accordingly. These studies would cover the following four areas: (i) users' fees for health services, (ii) drug distribution, (iii) extension of basic health services to villagers, and (iv) development of a population program. All these studies require operational field testing, most of which would be undertaken in one specifically designated province. The Government would present the results of the studies to the Association by March 31, 1988,

for its review and comment; present specific proposals for sub-projects in application of measures emanating from these studies, by September 30, 1988; and start implementation of an agreed program by April 1, 1989, (Schedule 3, para. 14 of DCA). Funds would be provided under the project to finance these sub-projects. The Government will follow agreed criteria and procedures for the use of funds for the implementation of such sub-project proposals (Schedule 3, para. 16 of DCA).

53. Users' fees. To strengthen the system of fees for services (para. 39), the project would finance studies and tests to extend cost recovery from the national hospitals to the provincial hospitals (para. 29) and to the CSPS with a view to determining how various payment schemes affect the quality of services and people's willingness to make use of such services. Parts of these studies will be undertaken by experts provided by the Government of Italy, following terms of reference which have been found satisfactory to the Association.

54. Drug distribution. The project would provide about 24 man-months of technical assistance to strengthen central drug procurement, to improve prescription practices and to launch a public information campaign on the benefits of generic drugs. To improve drug distribution from the provincial capitals to the village level, the project would include a field research component to test how the private and public sectors and village pharmacies could function most efficiently. The Government will: (i) by December 31, 1985, present to the Association for its review and comments: (a) a plan for strengthening national drug procurement and distribution; and (b) an official list of pharmaceutical products authorized for importation and distribution, in conformity with the World Health Organization's essential drug guidelines; (ii) subsequently adopt, and periodically review, such a list; (iii) by June 30, 1986, publish a national drug formulary based on this list, and create a pharmaceutical information service; (iv) carry out a program to inform the public about its essential drug policy (Schedule 3, para. 15 of DCA); and (v) carry out, jointly with IDA, an annual assessment of the performance of SONAPHARM (Supplemental letter in Annex IV).

55. Extension of Basic Health Services to Villagers. For outlying villages, the project would study and test the kinds of health and nutrition services that could appropriately be provided by villagers themselves with the support of CSPS. Simultaneously, it would test the organizational and managerial requirements of the CSPS with regard to out-reach, supervision and referral.

56. To support current efforts to establish a national Population Program, the project would provide technical assistance for the preparation of a feasibility study to upgrade 8 of 15 maternal and child health and maternity facilities in Burkina's two major cities. Funds are also provided under the IDA credit to implement the recommended improvements in these facilities. In addition, the project would be co-ordinated with a national Population Assistance Program which has been identified and prepared with assistance from USAID. This program would strengthen the Government's

capabilities to undertake demographic analysis and surveys related to family planning attitudes and practices. It would develop and diffuse messages on family planning; train doctors, nurses and midwives in contraceptive technology; and test various avenues, including the private sector, for providing family planning services. USAID is currently funding some priority activities under this program; USAID approval of funds for the entire program is expected in mid-1986.

C. Strengthening the Ministry of Public Health

57. At the national level, the project would, through participation of MOPH staff in managing its implementation, continue to support the strengthening of the MOPH's health planning and coordinating capability begun during project preparation. It would complement a separate USAID project providing 5 years of technical assistance in health planning, economics, epidemiology and data collection. To support efforts to monitor communicable diseases, to limit chances of epidemics, and to screen and treat sleeping sickness, the project would provide two mobile epidemiological surveillance units. The project would also provide office facilities for eight Provincial Directorates of Public Health (para. 29).

Project Costs and Financing

58. Total project costs are estimated at US$28 million equivalent. Foreign exchange costs are estimated at US$17 million equivalent (about 60 percent). Base costs are in April 1985 prices. Price contingencies have been applied as follows: inflation rates for foreign costs have been estimated at 5 percent for 1985; 7.5 percent for 1986; and 8 percent for 1987-90. An annual inflation rate of 10 percent has been estimated for all local costs during the period 1985-90. Physical contingencies of 10 percent have been added to the base cost for civil works, equipment and architectural services. Cost estimates of civil works for health facilities are based upon simple but functional designs prepared by the MOPH and used on ongoing health programs in Burkina.

59. The proposed IDA Credit of SDR 26.9 million (US$26.6 million equivalent) would finance the foreign exchange component and about 87 percent of local costs, representing about 95 percent of total project costs net of taxes. The Government and beneficiaries would meet the remaining local costs of US$1.4 million equivalent.

Affordability and Cost Recovery

60. The project is expected to generate an increment in annual operating costs of US$0.9 million equivalent. Vaccination campaign would amount to about US$0.4 million equivalent and chloroquine needed for the anti-malaria campaign to about US$0.2 million equivalent. The remaining US$0.3 million equivalent include vehicle and equipment maintenance for health facilities (para.47) and training (para. 48). At the end of the project, it is assumed that the donor community would continue to finance

US$0.4 million equivalent in support of vaccination campaigns. Domestic resources would be required to finance about US$0.5 million equivalent, all of which would readily be met if cost recovery measures discussed in para. 39 above are implemented.

61. Studies and tests to be financed under the project are expected to identify additional cost recovery schemes which could increase substantially the financial resources available for rural health care. Cost requirements and financing of this and other donor-financed program activities would be closely monitored through annual consultations with the Government (Section 3.03 of DCA). During project implementation, incremental recurrent costs would be met by IDA on a declining scale (para. 67).

62. Coverage and Replicability. The project would complete a nationwide health facilities network in rural areas and strengthen the health delivery system which will serve about 50 percent of the rural population. Extending the health facilities network to provide health coverage to the remaining 50 percent population is not feasible due to the geographical dispersion of this population in outlying villages; and so a different approach is needed to serve these areas. The project's operational research component would seek viable, low-cost approaches to promoting self- help in nutritional improvement, simple preventive measures, health education and first-aid in outlying villages. If the project does not prove successful in identifying such measures, these villages would have to continue to rely on traditional healers and midwives and a distant CSPS for health care until a way could be found to provide them with improved health services at an affordable cost.

Procurement and Disbursements

63. Procurement arrangements are summarized in the table below, with the figures in parentheses showing amounts financed by IDA:

Project Element	Procurement Method				
	ICB	LCB	Other	N/A [a]	Total Cost
	US$ Million				
Civil Works	-	7.7 (7.7)	3.4 [b] (3.4)	-	11.1 11.1
Furniture, Office Equipment, Material, Supplies	0.6 (0.6)	0.2 (0.2)	0.1 (0.1)	-	0.9 (0.9)
Medical Equipment, Drugs	4.6 (4.6)	-	-	-	4.6 (4.6)
Vehicles	0.8 (0.8)	0.2 (0.2)	-	-	1.0 (1.0)
Technical Assistance	-	-	1.3 (1.3)	-	1.3 (1.3)
Professional Fees	-	0.2 (0.2)	-	-	0.2 (0.2)
Training	-	-	0.1 (0.1)	-	0.1 (0.1)
Project Preparation Facility	-	-	-	0.8 (0.8)	0.8 (0.8)
Preinvestment Studies	-	-	-	0.3 (0.3)	0.3 (0.3)
Funds for Implementation of Studies	-	-	-	5.0 (5.0)	5.0 (5.0)
Recurrent Costs	-	-	-	2.7 (1.3)	2.7 (1.3)
TOTAL	6.0 (6.0)	8.3 (8.3)	4.9 (4.9)	8.8 (7.4)	28.0 (26.6)

a/ Not applicable
b/ Fonds de l'Eau et de l'Equipement Rural.

64. Contracts for equipment, furniture, vehicles, materials and drugs amounting to US$5.3 million equivalent, including contingencies, would be procured in accordance with IDA's procurement guidelines for international competitive bidding procedures (ICB). Exceptions to ICB include: (i) contracts with a value of less than US$75,000 equivalent each (for a total of US$400,000 equivalent) which would be awarded through locally advertised competitive bidding procedures acceptable to the Association; and (ii) small value items costing less than US$10,000 equivalent per contract (for a total of US$100,000 equivalent) which would follow prudent local shopping procedures acceptable to the Association (Schedule 4 (C) of draft DCA). Purchases of medical equipment and drugs using UNICEF's international procurement procedures would be permitted where feasible as a recognized means of limiting costs.

65. Civil works contracts for the Provincial Directorates of Public Health (DPSP) (US$0.9 million equivalent including contingencies), referral centers (US$2.2 million equivalent), and for the supply of construction materials for about 142 CSPS (US$4.6 million equivalent), which are unlikely to interest foreign contractors (due to size and dispersion), would be awarded following locally advertised competitive bidding acceptable to the Association. CSPS construction materials costing less than US$10,000 equivalent per contract may be procured on the basis of prudent local shopping procedures acceptable to the Association. Architectural designs, draft tender documents and master lists of furniture, equipment and vehicles would be reviewed by IDA.

66. Because the Government is unable to pre-finance expenditures to be reimbursed under the IDA Credit, an IDA-financed Special Account of US$1 million equivalent would be established (Section 2.02 (b) of DCA). The Government would also establish a Local Advance Account for its own local revolving fund for counterpart financing. The opening of this account and the initial deposit of CFAF 25 million would a condition of effectiveness (Section 5.01 (b) of DCA).

67. Proceeds from the proposed Credit would be disbursed as follows:

(i) 100 percent of total expenditures for civil works (US$9.6 million equivalent); equipment, furniture, vehicles, materials and drugs except chloroquine (US$5.6 million equivalent); chloroquine (US$0.2 million equivalent); technical assistance and training (US$1.8 million equivalent); implementation of sub-projects (US$5.0 million equivalent); refunding of project preparation advance (US$0.8 million equivalent);

(ii) 95 percent of operating costs (US$0.9 million equivalent), excluding salaries except for Project Management Unit staff, until disbursement reaches US$0.48 million equivalent, 60 percent thereafter until aggregate disbursement reaches US$0.7 million equivalent and 30 percent thereafter; and

(iii) an amount of US$2.7 million equivalent would be unallocated.

Accounts and Audits

68. The project provides for services of independent accountants to audit the Special Account, the Local Advance Account and all other accounts in respect of the Project for each fiscal year; audited statements would be submitted to IDA no later than six months after the end of each fiscal year (Section 4.01 (b) of DCA).

Organization and Management

69. The office of the Secretary General of Health in the Ministry of Public Health will be strengthened by the creation of a Project Management Unit (PMU) which would coordinate project implementation. It would monitor project costs, keep project accounts, and authorize all project expenditures. The setting up of an appropriate PMU project accounting system would be a condition of Credit effectiveness (Section 5.01 (a) of DCA). Key staff of the PMU include a director, an administrator and an accountant. The establishment and staffing of the PMU would be a condition of Credit effectiveness (Section 5.01 (a) of DCA).

70. Construction Program. Construction of the referral centers and DPSP would be undertaken by the private contractors under the supervision of the Ministry of Equipment. Rehabilitation of the CSPS would be undertaken through village self-help by concerned villagers themselves, under the supervision of the Rural Water and Equipment Fund (FEER), an independent public body under the Ministry of Water, which has a proven capability in coordinating rural small works such as CSPS construction. The conclusion of an agreement between the Ministry of Public Health and the Ministry of Financial Resources, on the one hand, and the FEER on the other would be a condition of disbursement of the civil works component of the project (Schedule 1, para. 3 of DCA). The appointment of an engineer, accountant and site supervisors to the FEER, to assist in coordinating the CSPS building program, would also be a condition of disbursement on the civil works component (Schedule 1, para. 3 of DCA).

71. Technical Assistance. In addition to available Burkinabè expertise, the project would provide 100 man-months (m/m) for technical assistance to be utilized as follows: in-service training, 21 m/m; economist, 24 m/m; drug specialists, 30 m/m; maintenance specialist, 4 m/m; maternal and child health and family planning specialist, 4 m/m; financial specialist, 3 m/m; auditors, 14 m/m.

Project Benefits and Risks

72. The project will yield the following benefits: First, it would principally improve the quality and accessibility of health services available to more than half the total population of Burkina. Second, it would improve the quality of preventive and curative services by increasing the skills and performance capability of rural health staff, by improving the supply of essential drugs, and by promoting village-level health and

nutrition programs. Third, due to improved procurement and distribution practices, essential drugs would be available to the population at reduced costs. In addition, the gradual introduction of cost recovery measures would provide additional revenue required for more efficient functioning of health services at all levels of the system. Fourth, the project would help lay the basis for a national integrated program of maternal and child health and family planning services in both urban and rural areas. Fifth, the project would help strengthen institutional mechanisms thus allowing for improved health sector planning, policy implementation and donor coordination.

73. There are two primary risks. The first risk is that institutions and measures needed to mobilize resources for the health sector and to enforce cost recovery may not meet expectations. This risk would be mitigated by an ongoing consultative process in the form of regular supervision missions, quarterly reports and annual meetings among Government, IDA and other donors. A second risk stems from the Government's lack of experience in implementing projects on a national scale in the population and health sectors in Burkina. It is already implementing localized projects in the primary health care sector with the help of other donors and seems to be capable of mobilizing the limited resources necessary to carry out the projects. Moreover, the project would strengthen institutions, create a strong Project Management Unit, and draw on the support and experience of other donors through the consultative process indicated in para. 51, above. The largest and most costly component (infrastructure) is entrusted to an experienced organization, the FEER, with demonstrated achievements in rural areas of Burkina. The strengthening of the MOPH's Secretary General's office and the Directorate of Studies and Planning will contribute to a better coordination of the various inputs required to improve health services through the project.

PART V - LEGAL INSTRUMENTS AND AUTHORITY

74. The draft Development Credit Agreement between Burkina Faso and the Association and the Recommendation of the Committee provided for in Article V, Section 1 (d) of the Articles of Agreement of the Association are being distributed to the Executive Directors separately.

75. Annex IV contains a Health Policy Statement prepared by the Government and a Supplemental Letter reflecting agreement to: (i) consult with IDA prior to modifying the policy; and (ii) assess annually with IDA the performance of the newly created drug importation enterprise. Special conditions of the project are listed in Section III of Annex III. Conditions of effectiveness would be the establishment of: (i) a Local Advance Account (para. 66); and (ii) the Project Management Unit (including appointment of the required full-time staff and establishment of its accounting system).

76. I am satisfied that the proposed Credit would comply with the Articles of Agreement of the Association.

PART VI - RECOMMENDATION

77. I recommend that the Executive Directors approve the proposed Credit.

A.W. Clausen
President

Attachments

Washington, D.C.
May 14, 1985

TABLE 3A

UPPER VOLTA - SOCIAL INDICATORS DATA SHEET

	UPPER VOLTA			REFERENCE GROUPS (WEIGHTED AVERAGES) /a	
				(MOST RECENT ESTIMATE) /b	
	1960/b	1970/b	MOST RECENT ESTIMATE/b	LOW INCOME AFRICA SOUTH OF SAHARA	MIDDLE INCOME AFRICA S. OF SAHARA
AREA (THOUSAND SQ. KM)					
TOTAL	274.2	274.2	274.2	.	.
AGRICULTURAL	119.9	122.4	126.3	.	.
GNP PER CAPITA (US$)	60.0	80.0	210.0	249.1	1112.9
ENERGY CONSUMPTION PER CAPITA					
(KILOGRAMS OF OIL EQUIVALENT)	3.0	9.0	22.0	62.8	529.0
POPULATION AND VITAL STATISTICS					
POPULATION,MID-YEAR (THOUSANDS)	4164.0	5071.0	6493.0	.	.
URBAN POPULATION (% OF TOTAL)	4.7	6.8	10.9	19.2	29.7
POPULATION PROJECTIONS					
POPULATION IN YEAR 2000 (MILL)			10.0	.	.
STATIONARY POPULATION (MILL)			34.7	.	.
POPULATION MOMENTUM			1.7	.	.
POPULATION DENSITY					
PER SQ. KM.	15.2	18.5	23.1	32.5	55.8
PER SQ. KM. AGRI. LAND	34.7	41.4	50.1	119.2	111.5
POPULATION AGE STRUCTURE (%)					
0-14 YRS	42.8	43.9	44.7	45.6	45.4
15-64 YRS	54.3	53.2	51.9	51.5	51.7
65 AND ABOVE	2.9	2.9	2.8	2.9	2.9
POPULATION GROWTH RATE (%)					
TOTAL	1.9 /c	2.0 /c	2.1 /c	2.8	2.8
URBAN	5.7	5.7	6.0	6.2	5.2
CRUDE BIRTH RATE (PER THOUS)	48.6	48.0	47.9	48.6	47.0
CRUDE DEATH RATE (PER THOUS)	26.8	23.8	21.3	17.7	15.2
GROSS REPRODUCTION RATE	3.2	3.2	3.2	3.2	3.2
FAMILY PLANNING					
ACCEPTORS, ANNUAL (THOUS)	..	..	..	.	.
USERS (% OF MARRIED WOMEN)	..	..	..	..	..
FOOD AND NUTRITION					
INDEX OF FOOD PROD. PER CAPITA (1969-71=100)	101.0	102.0	95.0	85.4	91.6
PER CAPITA SUPPLY OF					
CALORIES (% OF REQUIREMENTS)	92.0	89.0	95.0	86.4	98.2
PROTEINS (GRAMS PER DAY)	71.0	69.0	72.0	49.9	56.7
OF WHICH ANIMAL AND PULSE	19.0	19.0	19.0 /d	18.3	17.0
CHILD (AGES 1-4) DEATH RATE	71.0	49.0	36.0	23.8	18.7
HEALTH					
LIFE EXPECT. AT BIRTH (YEARS)	37.5	42.0	44.3	48.4	51.7
INFANT MORT. RATE (PER THOUS)	234.0	188.0	157.0	117.5	102.7
ACCESS TO SAFE WATER (ZPOP)					
TOTAL	..	12.0	25.0 /e	21.8	35.6
URBAN	..	35.0	50.0 /e	61.5	54.1
RURAL	..	10.0	23.0 /e	14.2	27.3
ACCESS TO EXCRETA DISPOSAL (% OF POPULATION)					
TOTAL	..	4.0	4.0 /e	32.0	..
URBAN	..	49.0	47.0 /e	69.2	..
RURAL	..	..	..	24.8	..
POPULATION PER PHYSICIAN	81650.0	87430.0	48510.0	27477.8	11948.3
POP. PER NURSING PERSON	3980.0 /f	3980.0	4950.0	3396.2	2248.9
POP. PER HOSPITAL BED					
TOTAL	1720.0	1580.0	1600.0 /d	1089.0	986.9
URBAN	210.0 /g	270.0	370.0 /d	395.2	368.7
RURAL	3090.0 /g	2440.0	2470.0 /d	3094.0	4012.1
ADMISSIONS PER HOSPITAL BED	..	..	..	..	..
HOUSING					
AVERAGE SIZE OF HOUSEHOLD					
TOTAL	7.5 /h	..	..	..	..
URBAN	..	..	..	..	..
RURAL	..	..	..	..	..
AVERAGE NO. OF PERSONS/ROOM					
TOTAL	..	..	..	..	..
URBAN	..	..	..	..	..
RURAL	..	..	..	..	..
ACCESS TO ELECT. (% OF DWELLINGS)					
TOTAL	..	..	..	..	..
URBAN	..	..	..	..	..
RURAL	..	..	..	..	..

TABLE 3A

UPPER VOLTA - SOCIAL INDICATORS DATA SHEET

	UPPER VOLTA			REFERENCE GROUPS (WEIGHTED AVERAGES) /a (MOST RECENT ESTIMATE) /b	
	1960/b	1970/b	MOST RECENT ESTIMATE/b	LOW INCOME AFRICA SOUTH OF SAHARA	MIDDLE INCOME AFRICA S. OF SAHARA
EDUCATION					
ADJUSTED ENROLLMENT RATIOS					
PRIMARY: TOTAL	8.0	12.0	20.0	69.2	91.0
MALE	12.0	16.0	26.0	78.8	90.5
FEMALE	5.0	9.0	15.0	57.6	73.6
SECONDARY: TOTAL	1.0	1.0	3.0	13.1	17.4
MALE	1.0	2.0	4.0	17.6	23.7
FEMALE	..	1.0	2.0	8.3	14.8
VOCATIONAL (% OF SECONDARY)	21.2	14.7	18.7	7.2	5.3
PUPIL-TEACHER RATIO					
PRIMARY	47.0	44.0	54.0	46.1	38.6
SECONDARY	20.0	23.0	20.0 /e	25.9	24.3
ADULT LITERACY RATE (%)	1.5 /g	5.0 /i	8.8 /e	44.3	35.6
CONSUMPTION					
PASSENGER CARS/THOUSAND POP	0.4	1.3	2.0 /j	3.8	20.7
RADIO RECEIVERS/THOUSAND POP	0.7	17.2	17.9	41.9	100.8
TV RECEIVERS/THOUSAND POP	0.1	1.2	1.6	2.0	18.5
NEWSPAPER ("DAILY GENERAL INTEREST") CIRCULATION PER THOUSAND POPULATION	..	0.3	0.2 /k	5.4	17.2
CINEMA ANNUAL ATTENDANCE/CAPITA	..	0.2	0.7 /k	1.4	0.3
LABOR FORCE					
TOTAL LABOR FORCE (THOUS)	2380.0	2779.0	3320.0	.	.
FEMALE (PERCENT)	47.1	46.8	46.1	36.5	33.8
AGRICULTURE (PERCENT)	92.0	87.0	82.0	77.4	57.1
INDUSTRY (PERCENT)	5.0	8.0	13.0	9.8	17.4
PARTICIPATION RATE (PERCENT)					
TOTAL	57.2	54.8	51.1	41.0	36.3
MALE	60.8	58.8	55.3	52.1	47.6
FEMALE	53.5	50.9	47.0	30.2	25.1
ECONOMIC DEPENDENCY RATIO	0.8	0.9	0.9	1.2	1.4
INCOME DISTRIBUTION					
PERCENT OF PRIVATE INCOME RECEIVED BY					
HIGHEST 5% OF HOUSEHOLDS	..	..	..	..	..
HIGHEST 20% OF HOUSEHOLDS	..	..	..	..	..
LOWEST 20% OF HOUSEHOLDS	..	..	..	..	..
LOWEST 40% OF HOUSEHOLDS	..	..	..	..	..
POVERTY TARGET GROUPS					
ESTIMATED ABSOLUTE POVERTY INCOME LEVEL (US$ PER CAPITA)					
URBAN	..	..	164.0 /k	168.3	525.3
RURAL	..	..	105.0 /k	90.8	249.0
ESTIMATED RELATIVE POVERTY INCOME LEVEL (US$ PER CAPITA)					
URBAN	..	..	..	107.7	477.4
RURAL	..	..	53.0 /k	65.0	186.0
ESTIMATED POP. BELOW ABSOLUTE POVERTY INCOME LEVEL (%)					
URBAN	..	..	..	34.7	..
RURAL	..	..	..	65.4	..

.. NOT AVAILABLE
. NOT APPLICABLE

NOTES

/a The group averages for each indicator are population-weighted arithmetic means. Coverage of countries among the indicators depends on availability of data and is not uniform.

/b Unless otherwise noted, "Data for 1960" refer to any year between 1959 and 1961; "Data for 1970" between 1969 and 1971; and data for "Most Recent Estimate" between 1980 and 1982.

/c Due to emigration population growth rate is lower than rate of natural increase; /d 1977; /e 1975; /f 1963; /g 1962; /h 1964; /i 1972; /j 1978; /k 1979.

DEFINITIONS OF SOCIAL INDICATORS

Notes: Although the data are drawn from sources generally judged the most authoritative and reliable, it should also be noted that they may not be internationally comparable because of the lack of standardized definitions and concepts used by different countries in collecting the data. The data are, nonetheless, useful to describe orders of magnitude, indicate trends, and characterize certain major differences between countries.

The reference groups are (1) the same country group of the subject country and (2) a country group with somewhat higher average income than the country group of the subject country (except for "High Income Oil Exporters" group; where "Middle Income South African and Middle East" is chosen because of stronger socio-cultural affinities). In the reference group data the averages are population weighted arithmetic means for each indicator and shown only when majority of the countries in a group has data for that indicator. Since the coverage of countries among the indicators depends on the availability of data and is not uniform, caution must be exercised in relating averages of one indicator to another. These averages are only useful in comparing the value of one indicator at a time against the country and

AREA (thousand sq.km.)
Total - Total surface area comprising land area and inland waters; 1960, 1970 and 1981 data.
Agricultural - Estimate of agricultural area used temporarily or permanently for crops, pastures, market and kitchen gardens or to lie fallow; 1960, 1970 and 1981 data.

GNP PER CAPITA (1981) - GNP per capita estimates at current market prices, calculated by same conversion method as World Bank Atlas (1980-82 basis); 1960, 1970, and 1982 data.

ENERGY CONSUMPTION PER CAPITA - Annual apparent consumption of commercial primary energy (coal and lignite, petroleum, natural gas and hydro-, nuclear and geothermal electricity) in kilograms of oil equivalent per capita; 1960, 1970, and 1981 data.

POPULATION AND VITAL STATISTICS
Total Population, Mid-year (Thousands) - As of July 1; 1960, 1970, and 1982 data.
Urban Population (percent of total) - Ratio of urban to total population; different definitions of urban areas may affect comparability of data among countries; 1960, 1970, and 1982 data.
Population Projections
Population in year 2000 - Current population projections are based on 1980 total population by age and sex and their mortality and fertility rates. Projection parameters for mortality rates comprise of three levels assuming life expectancy at birth increasing with country's per capita income level, and female life expectancy stabilizing at 77.5 years. The parameters for fertility rates also have three levels assuming decline in fertility according to income level and past family planning performance. Each country is then assigned one of these nine combinations of mortality and fertility trends for projection purposes.
Stationary population - Is one in which age- and sex-specific mortality rates have not changed over a long period, while age-specific fertility rates have simultaneously remained at replacement level (net reproduction rate=1). In such a population, the birth rate is constant and equal to the death rate, the age structure is also constant, and the growth rate is zero. The stationary population size was estimated on the basis of the projected characteristics of the population in the year 2000, and the rate of decline of fertility rate to replacement level.
Population Momentum - Is the tendency for population growth to continue beyond the time that replacement-level fertility has been achieved; that is, even after the net reproduction rate has reached unity. The momentum of a population in the year x is measured as a ratio of the ultimate stationary population to the population in the year x, given the assumption that fertility remains at replacement level from year x onward, 1980 data.
Population Density
Per sq. km. - Mid-year population per square kilometer (100 hectares) of total area; 1960, 1970, and 1981 data.
Per sq. km. agricultural land - Computed as above for agricultural land only; 1960, 1970 and 1981 data.
Population Age Structure (percent) - Children (0-14 years), working-age (15-64 years), and retired (65 years and over) as percentage of mid-year population; 1960, 1970, and 1982 data.
Population Growth Rate (percent) - Annual growth rates of total mid-year population for 1950-60, 1960-70, and 1970-82.
Population Growth Rate (percent) - urban - Annual growth rates of urban populations for 1950-60, 1960-70, and 1970-82.
Crude Birth Rate (per thousand) - Annual live births per thousand of mid-year populations; 1960, 1970, and 1982 data.
Crude Death Rate (per thousand) - Annual deaths per thousand of mid-year population; 1960, 1970, and 1982 data.
Gross Reproduction Rate - Average number of daughters a woman will bear in her normal reproductive period if she experiences present age-specific fertility rates; usually five-year averages ending in 1960, 1970, and 1982.
Family Planning - Acceptors, Annual (thousands) - Annual number of acceptors of birth-control devices under auspices of national family planning program.
Family Planning - Users (percent of married women) - Percentage of married women of child-bearing age who are practicing or whose husbands are practicing any form of contraception to all married women. Women of child-bearing age are generally women aged 15-49, although for some countries contraceptive usage is measured for other age groups.

FOOD AND NUTRITION
Index of Food Production per Capita (1969-71=100) - Index of per capita annual production of all food commodities. Production excludes seed and feed and is on calendar year basis. Commodities cover primary goods (e.g. sugarcane instead of sugar) which are edible and contain nutrients (e.g. coffee and tea are excluded). Aggregate production of each country is based on national average producer price weights; 1961-65, 1970, and 1982 data.
Per capita supply of calories (percent of requirements) - Computed from energy equivalent of net food supplies available in country per capita per day. Available supplies comprise domestic production, imports less exports, and changes in stock. Net supplies exclude animal feed, seeds, quantities used in food processing, and losses in distribution. Requirements were estimated by FAO based on physiological needs for normal activity and health considering environmental temperature, body weights, age and sex distribution of population, and allowing 10 percent for waste at household level; 1961-65, 1970 and 1980 data.
Per capita supply of protein (grams per day) - Protein content of per capita net supply of food per day. Net supply of food is defined as above. Requirements for all countries established by USDA provide for minimum allowance of 60 grams of total protein per day and 20 grams of animal and pulse protein, of which 10 grams should be animal protein. These standards are lower than those of 75 grams of total protein and 23 grams of animal protein as an average for the world, proposed by FAO in the Third World Food Supply; 1961-65, 1970 and 1980 data.
Per Capita protein supply from animal and pulse - Protein supply of food derived from animals and pulses in grams per day; 1961-65, 1970 and 1977 data.
Child (ages 1-4) Death Rate (per thousand) - Annual deaths per thousand in age group 1-4 years, to children in this age group; for most developing countries data derived from life tables; 1960, 1970 and 1981 data.

HEALTH
Life Expectancy at Birth (years) - Average number of years of life remaining at birth; 1960, 1970 and 1982 data.
Infant Mortality Rate (per thousand) - Annual deaths of infants under one year of age per thousand live births; 1960, 1970 and 1981 data.
Access of Safe Water (percent of population) - total, urban, and rural - Number of people (total, urban, and rural) with reasonable access to safe water supply (includes treated surface waters or untreated but uncontaminated water such as that from protected boreholes, springs, and sanitary wells) as percentages of their respective populations. In an urban area a public fountain or standpost located not more than 200 meters from a house may be considered as being within reasonable access of that house. In rural areas reasonable access would imply that the households or members of the household do not have to spend a disproportionate part of the day in fetching the family's water needs.

Access to Excreta Disposal (percent of population) - total, urban, and rural - Number of people (total, urban, and rural) served by excreta disposal as percentages of their respective populations. Excreta disposal may include the collection and disposal, with or without treatment, of human excreta and wastewater by water-borne systems or the use of pit privies and similar installations.

Population per Physician - Population divided by number of practicing physicians qualified from a medical school at university level.
Population per Nursing Person - Population divided by number of practicing male and female graduate nurses, assistant nurses, practical nurses and nursing auxiliaries.
Population per Hospital Bed - total, urban, and rural - Population (total, urban, and rural) divided by their respective number of hospital beds available in public and private general and specialized hospital and rehabilitation centers. Hospitals are establishments permanently staffed by at least one physician. Establishments providing principally custodial care are not included. Rural hospitals, however, include health and medical centers not permanently staffed by a physician (but by a medical assistant, nurse, midwife, etc.) which offer in-patient accommodation and provide a limited range of medical facilities.
Admissions per Hospital Bed - Total number of admissions to or discharges from hospitals divided by the number of beds.

HOUSING
Average Size of Household (persons per household) - total, urban, and rural - A household consists of a group of individuals who share living quarters and their main meals. A boarder or lodger may or may not be included in the household for statistical purposes.
Average Number of persons per room - total, urban, and rural average number of persons per room in all urban, and rural occupied conventional dwellings, respectively. Dwellings exclude non-permanent structures and unoccupied parts.
Access to Electricity (percent of dwellings) - total, urban, and rural - Conventional dwellings with electricity in living quarters as percentage of total, urban, and rural dwellings respectively.

EDUCATION
Adjusted Enrollment Ratios
Primary school - total, male and female - Gross total, male and female enrollment of all ages at the primary level as percentages of respective primary school-age populations; normally includes children aged 6-11 years but adjusted for different lengths of primary education; for countries with universal education enrollment may exceed 100 percent since some pupils are below or above the official school age.
Secondary school - total, male and female - Computed as above; secondary education requires at least four years of approved primary instruction; provides general, vocational, or teacher training instructions for pupils usually of 12 to 17 years of age; correspondence courses are generally excluded.
Vocational enrollment (percent of secondary) - Vocational institutions include technical, industrial, or other programs which operate independently or as departments of secondary institutions.
Pupil-teacher Ratio - primary, and secondary - Total students enrolled in primary and secondary levels divided by teachers in the corresponding levels.
Adult literacy rate (percent) - Literate adults (able to read and write) as a percentage of total adult population aged 15 years and over.

COMMUNICATION
Passenger Cars (per thousand population) - Passenger cars comprise motor cars seating less than eight persons; excludes ambulances, hearses, and military vehicles.
Radio Receivers (per thousand population) - All types of receivers for radio broadcasts to general public per thousand of population; excludes unlicensed receivers in countries and in years when registration of radio sets was in effect; data for recent years may not be comparable since most countries abolished licensing.
TV Receivers (per thousand population) - TV receivers for broadcast to general public per thousand population; excludes unlicensed TV receivers in countries and in years when registration of TV sets was in effect.
Newspaper Circulation (per thousand population) - Shows the average circulation of "daily general interest newspaper," defined as a periodical publication devoted primarily to recording general news. It is considered to be "daily" if it appears at least four times a week.
Cinema Annual Attendance per Capita per Year - Based on the number of tickets sold during the year, including admissions to drive-in cinemas as counts unite.

LABOR FORCE
Total Labor Force (thousands) - Economically active persons, including armed forces and unemployed but excluding housewives, students, etc., covering population of all ages. Definitions in various countries are not comparable; 1960, 1970 and 1982 data.
Female (percent) - Female labor force as percentage of total labor force.
Agriculture (percent) - Labor force in farming, forestry, hunting and fishing as percentage of total labor force; 1960, 1970 and 1981 data
Industry (percent) - Labor force in mining, construction, manufacturing and electricity, water and gas as percentage of total labor force; 1960, 1970 and 1981 data.
Participation Rate (percent) - total, male, and female - Participation or activity rates are computed as total, male, and female labor force as percentages of total, male and female population of all ages respectively; 1960, 1970, and 1981 data. These are based on ILO's participation rates reflecting age-sex structure of the population, and long time trend. A few estimates are from national sources.
Economic Dependency Ratio - Ratio of population under 15 and 65 and over to the working age population (those aged 15-64).

INCOME DISTRIBUTION
Percentage of Private Income (both in cash and kind) - Received by richest 5 percent, richest 20 percent, poorest 20 percent, and poorest 40 percent of households.

POVERTY TARGET GROUPS
The following estimates are very approximate measures of poverty levels, and should be interpreted with considerable caution.
Estimated Absolute Poverty Income Level (US$ per capita) - urban and rural - Absolute poverty income level is that income level below which a minimal nutritionally adequate diet plus essential non-food requirements is not affordable.
Estimated Relative Poverty Income Level (US$ per capita) - urban and rural - Rural relative poverty income level is one-third of average per capita personal income of the country. Urban level is derived from the rural level with adjustment for higher cost of living in urban areas.
Estimated Population Below Absolute Poverty Income Level (percent) - urban and rural - Percent of population (urban and rural) who are "absolute poor."

Comparative Analysis and Data Division
Economic Analysis and Projections Department
June 1984

ECONOMIC INDICATORS

GROSS NATIONAL PRODUCT IN 1984 /a

	US$ Mln.	%	Annual compound rate of growth (%, constant 1980 prices) 1970-82	1970-76	1977-82	1979-84
GNP AT MARKET PRICES	1012.1	100.0	3.5	3.5	3.1	1.9
GROSS DOMESTIC INVESTMENT	139.5	13.8	2.9	13.5	-3.6	-2.4
GROSS NATIONAL SAVINGS	-26.3	-2.6	-1.4	12.1	19.2	11.3
CURRENT ACCOUNT BALANCE	-67.4	-6.7	4.5	15.1	-16.5	-15.5
EXPORTS OF GOODS, NFS	151.0	14.9	4.7	3.9	2.4	3.4
IMPORTS OF GOODS, NFS	381.4	37.7	3.6	6.5	-5.3	1.2

OUTPUT, LABOR FORCE AND PRODUCTIVITY

	VALUE ADDED IN 1984 /a US$ Mln.	%	LABOR FORCE IN 1982 /b Mln.	%	V.A. PER WORKER IN 1982 /b US$	%
AGRICULTURE	368.6	41.0	2.7	81.8	152.7	50.6
INDUSTRY, MINING, UTILITIES, CONSTRUCTION	156.5	17.4	0.4	12.1	379.3	125.8
SERVICES	373.1	41.5	0.2	6.1	2470.2	819.0
TOTAL/AVERAGE	898.2	100.0	3.3	100.0	301.6	100.0

GOVERNMENT FINANCE /c — CENTRAL GOVERNMENT

	CFAF billion 1980	1981	1982	1983	1984 /e	% of GDP 1980	1981	1982	1983	1984 /e
CURRENT RECEIPTS	41.2	44.9	50.2	52.2	57.4	14.5	13.8	13.9	13.9	13.8
CURRENT EXPENDITURES	33.4	36.7	56.8	64.7	51.4	11.7	11.2	15.7	17.2	12.4
CURRENT SURPLUS	7.8	8.2	-6.6	-12.5	6.0	2.7	2.5	-1.8	-3.3	1.4
CAPITAL EXPENDITURES /d	5.2	7.3	3.7	3.3	3.6	1.8	2.2	1.3	0.9	0.9
OVERALL BALANCE	2.6	0.9	-11.3	-15.8	2.4	0.9	0.3	-3.1	-4.2	0.6

MONEY, CREDIT AND PRICES /f

	1980	1981	1982	1983	1984 g/
	(Billion CFAF Outstanding End Period)				
MONEY AND QUASI-MONEY	53.2	63.7	71.4	80.1	85.9
BANK CREDIT TO PUBLIC SECTOR	-3.4	1.6	0.6	-6.9	-9.4
BANK CREDIT TO PRIVATE SECTOR	59.0	62.0	71.0	73.7	71.9
	(Percentages or Index Numbers)				
MONEY AND QUASI-MONEY (% GDP)	18.7	19.5	19.8	21.3	20.7
IMPLICIT GDP DEFLATOR (1980=100) /h	100.0	110.0	121.2	130.9	138.5
Annual Percentage Changes in:					
GDP DEFLATOR /h	10.0	10.0	10.2	8.0	5.8
BANK CREDIT TO PUBLIC SECTOR	-47.8	147.1	-62.5	-1250.0	-244.4
BANK CREDIT TO PRIVATE SECTOR	7.2	5.1	14.5	3.8	-10.1

/a/ From "Recent Economic Developments", August 1984. IMF staff estimates for 1984 figures; 1983 data are provisional.
/b/ Last census was in 1975; latest available estimates only for 1982.
/c/ 1980 and 1981 figures from the CEN, September 1983; for later years, see /a/ above.
/d/ Excluding externally financed investment expenditure.
/e/ 1984 budget.
/f/ From International Financial Statistics, January 1984.
/g/ 1984 figures as of the end of March.
/h/ For 1980-82 from the CEN; for later years see /a/ above.

DATE: 1/18/85

TRADE PAYMENTS AND CAPITAL FLOWS

BALANCE OF PAYMENTS /a

	1981	1982	1983	1984/b
	Million US$			
EXPORTS OF GOODS & NFS	173.0	142.1	154.9	151.0
IMPORTS OF GOODS & NFS	483.7	438.1	392.6	381.5
RESOURCE GAP	-310.7	-296.0	-237.7	-230.5
NET FACTOR INCOME /c	-7.6	-10.7	-12.1	-7.4
of which: MLT int. payments /d	6.2	7.6	7.4	10.7
NET TRANSFERS /e	115.2	89.8	81.9	72.1
BALANCE ON CURRENT ACCOUNT	-203.1	-216.9	-167.9	-165.8
OFFICIAL GRANT AID	147.2	124.8	112.8	98.4
NET OFFICIAL MLT BORROWING /d	69.9	78.7	82.7	84.1
Disbursements	78.4	87.8	89.3	109.3
Amortization	8.5	9.1	6.7	25.2
NET CREDIT FROM THE IMF	1.8	0.0	0.0	0.0
OTHER CAPITAL (NET) /f	-17.3	-11.1	-42.3	-25.5
CHANGE IN RESERVES (increase = -)	1.5	24.5	-14.7	-8.8
IMPORTS OF PETROLEUM PRODUCTS /a	50.1	51.7	48.5	52.6
RATE OF EXCHANGE				
US$ 1.00 = CFAF	271.7	328.6	391.1	437.0

MERCHANDISE EXPORTS (Average 1982-84) /a

	US$ Mln.	%
LIVESTOCK PRODUCTS	34.8	29.0
COTTON	34.3	28.5
SHEANUTS	11.8	9.8
OTHER GOODS	39.3	32.7
TOTAL	120.2	100.0

EXTERNAL DEBT (DECEMBER 31, 1983) /d

	US$ Mln.
PUBLIC DEBT, INCL. UNDISBURSED	681.2
NONGUARANTEED PRIVATE DEBT	..
TOTAL OUTSTANDING & DISBURSED	398.4

DEBT SERVICE RATIO FOR 1983 /g

	%
PUBLIC DEBT, INCL. GUARANTEED	9.1

IDA LENDING (DECEMBER 31, 1983) /d

	US$ Mln.
OUTSTANDING & DISBURSED	112.6
UNDISBURSED	121.2
TOTAL	233.8

/a/ Data are from "Recent Economic Developments", August 1984, except as indicated otherwise.
/b/ IMF staff estimates.
/c/ Excluding remittances.
/d/ From IBRD Debt Reporting Service (DRS); projections for 1984.
/e/ Including remittances, pensions, etc.
/f/ Including errors and omissions, direct investment, short-term capital, discrepancy between DRS and Government-reported debt, etc.
/g/ MLT interest payments plus amortization as a proportion of exports of goods and non-factor services.
.. Not available.

DATE: 1/19/85

ANNEX II

STATUS OF BANK GROUP OPERATIONS IN BURKINA

A. Statement of IDA Credits as of March 31, 1985

Borrower: BURKINA FASO

Credit Number	IDA Fiscal Year	Purpose	Amount (less cancellations) IDA	Undisbursed a/
			-----US$ million----	
Fifteen Credits fully disbursed			82.6	
759-UV	1977	Small & Medium Scale Enterprise	3.3	0.50
766-UV	1978	Urban Development	8.2	1.77
956-UV	1979	Education II	14.0	6.62
982-UV	1980	Forestry	14.5	10.01
1013-UV	1980	Niena Dionkele Rice Development	6.5	3.84
1097-UV*	1981	Second Bougouriba Agri. Dev.	16.0 b/	7.72
1164-UV	1981	Fourth Highway	46.0 b/	27.81
1218-UV	1982	Third Rural Development Fund	16.0 b/	10.70
1235-UV	1982	Third Telecommunications	17.0 b/	11.76
1284-UV	1982	Volta Noire Agricultural Dev.	6.8 b/	5.31
1285-UV	1982	Hauts-Bassins Agri. Dev.	4.7 b/	3.54
1293-UV	1982	Koudougou Agri. Dev.	7.0 b/	5.57
1482-BUR	1984	Perkoa Mining Explor. & Tech. Assis.	7.4 b/	6.36
	TOTAL		250.00	
	of which has been repaid		2.04	
	TOTAL now held by IDA a/		247.96	
	TOTAL undisbursed			100.51

B. Statement of IFC Investments (as of March 31, 1985)

Year	Obligator	Type Business	Amount in US$ Millions Loan	Equity	Total
1978	SOVOLPLAS, S.A.	Plastic	.41	.13	.54

a/ Prior to exchange adjustment.
b/ Computed at the rate of the approval dates.
*/ Beginning with Credit 1097-UV, credits have been denominated in Special Drawing Rights. The dollar amounts in these columns represent the dollar equivalents at the time of credit negotiations for the IDA amounts and the dollar equivalents as of March 31, 1985, for the undisbursed amounts.

Supplementary Project Data Sheet

Section I: Timetable of Key Events

1. Identification: In November 1981, a joint health and education sector mission opened the way for extensive health sector discussions with the Government. In February 1982, a country economic mission reviewed the principal issues in the context of Burkina's overall development strategy, and reached agreement with the Government on health sector priorities and possible components of a first health project.

2. Project Preparation: Ministry of Public Health; August 1982 - April 1984

3. Appraisal: May 1984

4. Negotiations: April 1985

5. Target effectiveness: October 1985

Section II: Special Project Implementation Action

None

Section III: Special Conditions

1. Conditions of effectiveness:

   (a) establishment of the Project Management Unit (PMU), including the setting up of an appropriate PMU accounting system (para. 69); and

   (b) opening of a Local Advance Account (para. 66).

2. Conditions of disbursement:

   (a) no withdrawals would be made for the purchase of chloroquine until evidence satisfactory to the Association is provided showing that adequate arrangements have been made for bulk procurement of chloroquine, their packaging, distribution, and for recovering costs through sales (para. 50);

   (b) no withdrawals would be made for the construction of Centers for Health and Social Promotion (CSPS) prior to: (i) the adoption of an agreement between the Ministry of Financial Resources, the Ministry of Public Health (MOPH) and the Rural Water and Equipment Fund (FEER); and (ii) the appointment of an engineer, accountant and two initial site supervisors to the FEER (para. 70);

Other conditions:

(a) the proceeds from the sale of chloroquine would be put in an account in its Treasury which would operate as a revolving fund to support primary health care services including the replenishment of chloroquine for the anti-malarial program (para. 50);

(b) Government would: (i) consult with the Association if further studies and experiments indicate the need for a reorientation of the national health policy; (ii) annually organize a meeting of all aid agencies participating in the financing of the Health policy; and (iii) review in detail annually with the Association all investments made in the health sector during the previous year and expected to be made during the upcoming year, regardless of the sources of financing of such investments (paras. 51 and 61);

(c) by March 31, 1988, Government would present to the Association the results of special studies related to Health and Population activities and included in the project; by September 30, 1988 present proposals to apply the results of these studies to the remainder of the country; and, by April 1, 1989, begin to implement these proposals (para. 52);

(d) Government would follow agreed criteria and procedures for the use of funds provided through the Credit for implementing the results of special studies financed under the project (para. 52);

(e) with respect to the national pharmaceutical policy, Government would: (i) prepare an investment plan for strengthening national drug procurement and distribution; (ii) adopt an official list of pharmaceutical products authorized for importation and distribution; (iii) review this list annually; (iv) publish a new drug formulary; (v) create an MOPH pharmaceutical information service (para. 54); and (vi), jointly with IDA, review annually the performance of the new drug importation and wholesale corporation and the opportuneness of allowing competition in drug procurement (para. 38); and

(f) Government would have the Special Account, the Local Advance Account, the FEER's accounts in respect of this project and all other project accounts for each fiscal year audited by independent auditors; audit reports would be furnished to the Association within six months after the end of the fiscal year (para. 68).

BURKINA FASO

MINISTRY OF PUBLIC HEALTH

, 1985

International Development Association
1818 H Street, N.W.
Washington, D.C. 20433
United States of America

Re: Credit No. BUR
(Health Services Development Project)
Statement of Health Sector Policy

Dear Sirs:

Please refer to the Development Credit Agreement (Health Services Development Project) of even date herewith between Burkina Faso (the Borrower) and the International Development Association (the "Association").

We are pleased to provide you in the Annex to this letter with a statement of the Borrower's policy in the health sector. While this policy may be modified as a result of further studies, including, inter alia, the studies and experiments to be carried out under the Project, the Borrower undertakes that no change in policy shall be adopted without full and prior consultation with the Association.

Paragraph 9 of said statement of policy refers to the creation of a parapublic enterprise for the importation of drugs. The Borrower will provide the Association with the instruments creating the said enterprise, its statutes and a statement of its agreed operating procedures, as soon as possible. The Borrower hereby confirms that the enterprise will operate on, inter alia, the following principles: (i) the enterprise shall be a "Société d'économie mixte" with 51% of its shares held by the Borrower and 49% by the private sector; (ii) drugs shall normally be procured on the basis of international competitive bidding; (iii) the sales prices of drugs shall be set at a reasonable mark-up over cost price and shall be the same for public and private purchasers; and (iv) its assets and staffing shall be appropriate for its purpose.

The Borrower hereby undertakes to carry out an annual assessment of said enterprise, jointly with the Association, in conjunction with the annual reviews referred to in Section 3.03 of the Development Credit Agreement. Said assessment will focus on, inter alia, (i) the organizational structure and operational procedures of the enterprise; (ii) its management, its procurement procedures, and its performance in satisfying the market (drug availability and affordability); and (iii) the opportuneness of allowing other firms to import drugs.

Please confirm your agreement with the above by signing this letter in the space provided.

Very truly yours,

BURKINA FASO

By _____
Authorized Representative

CONFIRMED:

INTERNATIONAL DEVELOPMENT ASSOCIATION

By _____

Enclosure: Statement of Policy
in the Health Sector

TRANSLATION FROM THE
OFFICIAL FRENCH TEXT

May 9, 1985

BURKINA FASO
MINISTRY OF PUBLIC HEALTH
OFFICE OF THE MINISTER

Ouagadougou, April 5, 1985

NATIONAL HEALTH POLICY

A. POLITICAL BASIS

1. As a result of the approval on March 14, 1979 of the National Health Programming Document by the Council of Ministers, Burkina has adopted primary health care as the basis of all its national health policy, in accordance with World Health Organization's Resolution WHA 30.43 and the declaration of Alma-Ata endorsed by the Government. This policy was underlined once more in the Policy Statement Speech of October 2, 1983. In the face of the main health problems confronting Burkina, the President has especially emphasized the development of maternal and child welfare and assistance; an immunization program against communicable diseases by increasing vaccination campaigns; and making the population at large sensitive to good hygiene practice.

Consequently, the Ministry of Public Health is strictly committed, since the advent of the People's Democratic Revolution, to reorganizing and strengthening the fight against diseases.

The main objectives are, inter alia, to develop preventive measures, to increase the number and improve the skills of health workers and to enhance their awareness through an approach to a genuinely popular type of health because health, as a collective consumer item, is the people's major concern.

2. Furthermore, the promotion of maternal and child health has been a matter of constant concern for our government since 1984, and the integration of family planning services has become since that date the cornerstone of a comprehensive child spacing policy. This will help foster social and health development. On the other hand, the faster the development of maternal and child care in the rural areas of the country, the more efficient it will be to disseminate the essential themes of family planning to the targeted population. These two actions are mutually reinforcing.

B. ECONOMIC CONSTRAINTS AND PROGRAM TO CONTROL RECURRENT COSTS

1. While emphasizing the fact that primary health coverage (health facilities, equipment, personnel, drugs, knowledge of the environment) is now to be extended as far as possible, the government is aware that the main constraint to such an expansion does not reside in the lack of investment resources, but rather in the financial operation of the Government health services.

2. It is therefore essential to adopt a political program to control recurrent expenditures and to mobilize additional domestic resources in order to avoid that the desired expansion of the system, far from eliminating the financial constraints, may instead reinforce them. This program is summarized as follows:

- to streamline expenditures through a better geographical distribution of equipment, stocks and points of sale and through a relative increase of physical expenditures as compared to salaries.

- to effectively emphasize the primary sub-sector (first of all CSPS) within the overall budget approved for the health sector's operating and capital expenditures, in relation to expenditures on secondary health, especially if the total volume of resources available to the sector does not increase.

- to work at preserving and if possible increasing the portion of the national budget earmarked for the operation of health facilities, especially in the rural areas, in relation to the other sectors, so long as it can be sustained by the overall development of the economy and/or so long as savings may be achieved elsewhere.

- to have the users/beneficiaries pay part of the recurrent costs now borne by the Government by introducing fees for professional health care delivery, by defining the communities' responsibilities in terms of the maintenance of buildings, by making available auxiliary personnel, etc.

3. However, the present knowledge of the financial structure of health services operations, the medicine distribution network now being established, the people's attitudes and receptiveness, and especially the impact of any one system of rates and cost recovery within the available range, is still inadequate for comprehensive and specific measures to be undertaken in all areas. The Government intends therefore to gradually adopt positive measures along those lines of approach, in the light of the important operational research and pilot schemes to be carried out under the health project (World Bank). Some very important measures are described in sections E and F below. Other measures along the same line will follow as soon as operational recommendations are available, always bearing in mind Burkina's strong commitment to control the financial constraints mentioned above.

C. EVOLVING PLANNING PROCESS

1. The national strategy assumes that the provision of services will be both simple and efficient with regard to cost, techniques and organization and that they will be easily accessible to the people concerned.

2. This strategy is subject to an evolving planning process based on the National Health Programming principles (see A.1) whereby the Government undertakes:

a) to determine periodically the demographic and health situation on the basis of relevant statistics, surveys and studies;

b) tc develop every five years on this basis a 5-year indicative plan with the purpose of:

. determining the needs of the population;

. promoting a dialogue among the population and officials on achievements, constraints, availability of resources and the plan's objectives;

. evolving a strategy and proposing a program directed first towards maintaining and developing existing resources and then proposing new investments in the light of demographic projections, staffing, the operating budget and financial participation of the population (five-year plan and census);

c) to program each year the following year's activities to ensure that they are geared to the country's political and administrative developments and concomitant with the actual availability of human and financial resources.

3. Through this process, the Government commits itself to a planning method by successive approximations starting from long term absolute priorities, followed by the isolation of continuing actions deemed necessary to preserve and better utilize existing services and to provide for their financing. This process is accompanied by an iterative method for selecting the most viable and feasible priorities, setting aside those that would require a very large mobilization of domestic resources.

D. PRIORITY OBJECTIVES OF HEALTH PLANNING, 1986-1990

1. The means to be sought will be strictly based on the following priority objectives. These are targets deemed attainable on the basis of current knowledge (1985), but at any rate to be reviewed at least every year in the light of (a) cost, effect and impact indicators that are to be continually updated, (b) changes in available resources.

2. General objective

To extend progressively the national health coverage, on a quantitative and qualitative basis, to provide health services to all the population of Burkina.

3. Intermediate objectives

i) Reorganize and strengthen the existing health infrastructure as well as central structures;

ii) Institutionalize the primary health care system throughout the country;

iii) Strengthen the planning capacity of the Ministry of Health;

iv) Reinforce maternal and child health services, including family planning;

v) Improve feeding and nutrition for the Burkina people;

vi) Ensure the control of endemic diseases;

vii) Establish a system of supply and distribution of pharmaceutical drugs in order to make basic drugs accessible to all the people of Burkina;

viii) Strengthen health education and improve the sanitation and environmental health services;

ix) Improve the organization and coverage of occupational health;

x) Ensure that the training of medical and paramedical personnel is responsive to the needs of health services.

In order to reach these objectives a whole array of strategies and measures has been proposed.

E. MAIN LINES OF ACTION AND STRUCTURES

1. Considering that the country cannot do everything all at once, the national policy aims at (a) reinforcing by 1990 actions already taken that have really demonstrated their efficiency since 1979; (b) improving health coverage and logistical support for a better organization and supervision of services, a more adequate maintenance and supply of equipment and medicines; (c) improving demographic and health data collection, operational research and evaluation; and (d) integrating financial planning in the national health programming process, while mobilizing the financial resources required to take charge of the projects financed with external assistance and to operate the whole health system.

2. In the area of the reinforcement of ongoing actions, the Government aims at:

. maintaining the mobile immunization system to provide an efficient transition for the Expanded Program of Immunization (EPI) on a permanent basis.

. extending gradually EPI to all the cities and throughout the 30 provinces, to achieve complete coverage by 1990.

. extending the malaria and diarrhoeal disease control operations.

. improving childbirth conditions.

. providing integrated family planning services with MCH in the cities and provincial capitals.

. improving educational and nutrition rehabilitation activities, the detection of malnourished people, the provision of food and the extension of truck gardening.

3. In the area of improving health coverage, the Government shall maintain the five-level pyramidal system and will increase its efficiency and

effectiveness, particularly through a better allocation of personnel (in accordance with standards established during the National Health Seminar of January 31 - February 4, 1984); intensified follow-up training on management, standardization, improved diagnostic and better supervision; and the utilization of health personnel, other officials and the media for the education of the public at large.

4. The pyramidal system is based on the following standards:

. at the village level, the establishment of health committees and Primary Health Posts (PHP) that do not entail construction but will be manned by at least one village midwife and one village health worker;

. at the level of village groups consisting of 150,000 to 200,000 inhabitants, Medical Centers (MC) responsible for the supervision of CSPS and PHPs, prevention and promotion activities, maternity and MCH/family planning, leprosy treatment, epidemiological and statistical surveillance, laboratory and pharmacy services, minor surgery and oral-dental care;

. for groupings of 400,000 to 500,000 inhabitants, Regional Hospital Centers (CHR) that serve as referral to MCs and CSPS.

. two national hospitals at Ouagadougou and Bobo-Dioulasso. These density standards are to be considered as the optimal coverage to be reached only in stages: during the first phase 1986-1990 such coverage will not be available for the whole country.

5. Since (a) a look at the allocation of present resources (equipment, personnel, funds) shows a double bias in favor of cities and hospital care, and (b) this inequitable resource allocation runs counter to the objectives of community-based primary health care, the Government will, for the period 1986-1990, direct on a priority basis the new investments towards the PSPs, CSPS and CMs, of which 15 will be equipped with a surgical unit (thus serving the 30 provinces). Without calling into question the standards and uniqueness of the pyramidal system, the Government opts as a matter of priority for a type of facility (CSPS) which should provide all the basic care to a specific population and represent the first level of health service. It will be complemented by a referral level consisting of existing CMs and hospitals that make up the second priority. Their management will be improved through cost recovery and their conversion into genuine referral centers.

6. In the area of medicine supply and distribution, the Government is committed to the policy of essential drugs, as proposed by the World Health Organization, with a view to bringing drug supply into line with the most widespread pathology in Burkina and with the financial resources of the population and Government. The key elements of this policy are: the establishment of a national list of essential drugs; the introduction of a form listing the international non-proprietary names of medicines with the corresponding trade names; the education of prescribers and the public; quality control of medicines; procurement on the basis of international competitive bidding appropriate to the needs, in order to reduce prices; promotion of the traditional pharmacopoeia; local production if economically justified and, in the mean time, local packaging of imported medicines, whenever feasible.

7. With regard to distribution, the Government has decided first to exclude Government pharmacies from ONAP's jurisdiction and to relinquish them by agreement to the provinces and neighborhood districts where they are located. During the period 1986-1990, the Government will promote the establishment of one pharmaceutical products warehouse per CM and per city district, each of which will have to follow the restricted nomenclature. In addition, each province will establish a pharmacy in its capital, for a total of about 80 pharmacies at the CM and city levels. The cost of the manager shall be borne by the province (contractual status); the manager shall be trained and supervised by the DPSP's pharmacist; his salary and other charges will be covered by the sale price of the medicine.

8. The CSPS will serve as depositories for pharmaceuticals and will be supplied by provincial capitals and city district pharmacies. Village pharmacies are to be encouraged, but they will continue as mutual associations managed by health committees. This pharmacy network will be the subject of an operational research exercise under the project financed by the World Bank to better determine the respective activicies of each unit and the relationship between each link.

9. With regard to central supply, the Government proposes to eliminate ONAP and to replace it by a semi-public company with mixed private and public ownership that will not inherit the liabilities of ONAP. ONAP will be liquidated, in agreement with ONAP's suppliers, by the end of June 1985. The parastatal company will be the only wholesaler and will supply the private and public sectors. Orders will be placed on the basis of international competitive bidding. The importing company will not have to support any retail pharmacy. It shall in no case deliver two successive lots of medicines to private pharmacies, provincial pharmacies or government health facilities, until the first delivery has been fully paid.

10. With regard to data collection improvement and operational research, the Directorate for Studies, Planning and Health Statistics will be strengthened. In order to ensure that the primary health care policy continues to be responsive to the country's realities, operational research will be conducted in the areas of family planning, organization and management of health services, village health and nutrition promotion, drug distribution and cost recovery.

F. OTHER FINANCIAL AND FISCAL PROVISIONS

1. In the financial area, economic studies will be conducted during the five-year plan to estimate the capital and operating costs of a national primary health care system based on different assumptions. National health programming and every health project's file will be coupled with a financial study of related recurrent costs. Consultations between the Government and the various foreign donor sources are to take place frequently and at least once a year.

2. To remedy the budget shortcomings in favor of primary health care, the present policy of limiting the number of medical transfers and requesting financial contributions from the transferred patients will be continued.

3. The policy of payment of a hospitalization flat fee shall be extended to all the hospitals and CMs on grounds of social equity and to improve their operations. Similar tariff measures might be considered at the CSPD level in the light of the results from projected operational research.

4. In the case of outpatient care, there will be a charge for medicines. Prices shall not be less than those charged by the provincial and village pharmacy system.

5. The decree establishing the rate of contributions for companies, agencies, public and private enterprises that enjoy benefits from the Directorate of Workers Health Services (DSST) shall be strictly enforced.

6. To remedy the operating budget shortcomings, a special account is open with the Treasury. This account is to be used for the operation of the primary health care national system, including hospitals. Salaries of health personnel are excluded. The account shall be maintained by quotas from occupational health services. In addition, 75% of revenues from health facilities shall be deposited in the special account as well as proceeds from the sale of vaccination cards and chloroquine.

The Minister of Public Health

(signed)
Pharmacist-Major
Abdou Salam Kabore

IBRD 18565
NOVEMBER 1984

BURKINA
HEALTH SERVICES DEVELOPMENT PROJECT
PROJET DE DÉVELOPPEMENT DES SERVICES DE SANTÉ