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IMPLEMENTATION COMPLETION REPORT

BURKINA FASO

HEALTH SERVICES DEVELOPMENT PROJECT
(CREDIT 1607-BUR)

DECEMBER 27, 1995

Population and Human Resources Operations Division
West Central Africa Department
Africa Region

CURRENCY EQUIVALENTS

(09/30/95)

Currency Unit	=	CFA franc[1]
US$1	=	495 CFA franc
SDR 1	=	US$1.40

WEIGHTS AND MEASURES

Metric System

FISCAL YEAR OF BORROWER

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

CAMEG	Essential Generic Drugs Purchasing Agency
CMA	Medical Center with Surgical Unit
CSPS	Health and Social Development Center
DENW	Directorate for Equipment, Materiel, and Maintenance
DEPSS, later DEP	Health Studies, Planning and Statistics Directorate
DFP	Professional Training Directorate
DGED	General Directorate for Hospitals
DHC	Directorate of Hospitals and Clinics
DSEV	Directorate of Epidemiological Surveillance and Vaccinations
DSPH	Directorate of Pharmaceutical Services
DSPS	Provincial Directorates of Public Health
EPI	Expanded Program of Immunization
FEER	Water and Rural Equipment Fund (*Fonds de l'eau et d'équipement rural*)
GOBF	Government of Burkina Faso
GTZ	German Technical Cooperation Agency (*Deutsche Gesellschaft für Technische Zusammenarbeit*)
MCH	Maternal and Child Health
MOH	Ministry of Health
OCP	Onchocerciasis Control Program
PMU	Project Management Unit
SONAPHARM	National Pharmaceutical Supply Company
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

[1] The exchange rate for the CFA franc is fixed at a ratio of 100:1 with the French franc, which is a free-floating currency.

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PREFACE

This is the Implementation Completion Report (ICR) for the Health Services Development Project in Burkina Faso, for which Credit 1607-BUR was approved on May 20, 1985, in the amount of SDR 26.9 million (US$26.6 million equivalent in 1985) and which became effective on January 16, 1986. The Credit was closed on December 31, 1994, 42 months behind schedule. It was disbursed up to an amount of SDR 26.3 million (US$35.5 million equivalent in 1995). The undisbursed amount of SDR 0.6 million (US$0.8 million equivalent in 1995) was canceled.

The initial ICR was prepared by Jean George Dehasse, consultant under the supervision of Bruna Vitagliano (task manager, AF4PH). It was redrafted and finalized by Bruna Vitagliano and Ross Pfile (AF4PH), reviewed by Whitney Foster (AF4CO), Ian Porter, Division Chief (AF4PH) and Franz Kaps, Operations Adviser (AF4DR). The Borrower submitted its input to the ICR in a report dated December 12, 1994. The Borrower's acceptance of the ICR was provided during a supervision mission of the follow-up Health and Nutrition Project (Cr. 2595-BUR) which took place November 7-19, 1995 and was recorded in the aide-mémoire of this mission.

Preparation of this ICR was begun during the Bank's final supervision/completion mission in April 1995. It is based on the Staff Appraisal Report, the Credit Agreement, supervision reports, correspondence between the Bank and the Borrower, and other relevant records.

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EVALUATION SUMMARY

1. **Bank's Role in the Country and Sector**. Burkina Faso is one of the world's poorest countries, with a GNP per capita estimated at US$185 in 1994, and low social indicators in primary school enrollment, adult literacy, access to health services, and life expectancy (para. 1.1). Faced with growing fiscal and current account deficits, in 1991 the Government adopted a structural adjustment program which was supported by the IMF and the Bank. This program helped the Government manage public resources more effectively and supported critical actions needed to alleviate long-term constraints on economic growth and social development, with a focus on health, population, and education. In January 1994, the Government decided, together with other countries of the CFA franc zone, to devalue its currency by 50 percent in foreign exchange terms. IDA supported this action through an Economic Recovery Credit. Despite the progress made to date, much remains to be done in all sectors to overcome Burkina Faso's very poor national resource endowment, and the legacy of the country's past policies (paras 1.2 and 1.3).

2. The Bank's involvement in Burkina Faso's health sector started with the Regional Onchocerciasis Control Program (OCP), which succeeded in freeing about 17 percent of Burkina Faso's land from the debilitating riverblindness. The Health Services Development Project was the first IDA operation focused on revitalizing Burkina Faso's health services delivery system.

3. **Project Objectives**. The main objectives of the Health Services Development Project were to (a) strengthen basic health and family planning services; (b) help formulate national health and population policies and promote their application; and (c) strengthen the Ministry of Health's (MOH) institutional capacity in planning, evaluation, and project implementation and monitoring.

4. **Project Description and Components**. Under objective (a), the following components were included: (i) extension of the immunization program and establishment of a national malaria treatment program; (ii) development of an in-service training program in primary health care at the provincial level; (iii) construction and upgrading of 142 health centers (CSPS), and six referral centers (surgical antennae); and (iv) feasibility studies to improve the maintenance of health facilities and equipment and to improve hospital sector management. Under objective (b), the national health policy and program development included: (i) testing cost recovery, drug distribution, and extension of village health and nutrition systems; (ii) implementation of the test results, feasibility and pilot studies; and (iii) establishment of a population program and provision of family planning

services through the public and private sectors. Under objective (c) the following components were included: (i) the establishment of eight Provincial Directorates of Public Health, and the provision of two mobile epidemiological surveillance units; and (iii) strengthening of health planning and project implementation services, including preparation of future health projects.

5. **Credit Covenants and Special Arrangements**. During credit negotiations, the following agreements were reached: (a) establish a revolving fund to support primary health care services, including the replenishment of chloroquine for the anti-malaria treatment program; (b) an annual review of all investments in the health sector; (c) by March 31, 1988 present to IDA the results of operational field testing of drug distribution, cost recovery, village health and nutrition activities, and the financial requirements of a primary health care system; and finalize studies to improve MCH and family planning services, maintenance of health facilities and hospital management; and (d) by April 1, 1989 implement the results of above studies for which a fund of US$5 million was earmarked under the Credit. With regard to its drug policy, the Borrower committed itself to present to IDA by December 31, 1985: (a) plans for strengthening national drug procurement and distribution; (b) an official drug distribution list in conformity with WHO's essential drug guidelines; (c) adopt such list and review it annually; and (d) publish a drug formulary based on such list and create a pharmaceutical information service capable of providing information to prescribers and the public on essential generic drugs.

6. In addition to the above, the following conditions of credit effectiveness were agreed upon: (a) establishment of a Project Management Unit, including appointment of staff; (b) establishment of an adequate project accounting system: and (c) the opening of a special account. These conditions were complied with by the Government to the satisfaction of IDA and the Credit was declared effective on January 16, 1986.

7. **Evaluation of Project Objectives**. The project's objectives were clear and consistent with the Government's primary health care strategy and the sector's needs. Yet, in the absence of an implementation plan and a strong Government commitment, a number of these objectives turned out to be ambitious and difficult to implement. The 1988 project mid-term review (MTR) showed achievements in the immunization, malaria, in-service training, and construction programs, but little or no progress in the area of policy reforms. Inadequate supervision by IDA in the first years of project implementation, poor policy dialogue, and the Government's reluctance to use IDA funds for the social sector are largely responsible for the uneven project success prior to the MTR. Budgetary constraints and concerns about the increasing cost of providing health care services, as well as awareness of the macroeconomic consequences of a rapid population growth led to, at the end of the 1980s, a change in Government's attitude toward policy reforms and encouraged a more intensified policy dialogue with IDA and other donors. This dialogue led to a 1990 decision by the Government to decentralize the health system at the district level, launch a more effective essential drug program and a well-targeted family planning program. The project was restructured to assist the Government in implementing these reforms. Project performance improved considerably as a result of the restructuring,

particularly in the areas of essential drugs and decentralization of the health system. At the time of its closing the project's impact on the development of the health sector in Burkina Faso was quite substantial.

IMPLEMENTATION EXPERIENCE, SUSTAINABILITY, AND RESULTS

8. **Assessment of Project's Success and Sustainability**. The main objectives of the projects were met: (a) basic health services and family planning programs were strengthened through (i) the decentralization of the health system at the district level, the elimination of vertical programs, and the integration of services at the various levels of the health care system; and (ii) the expansion of the malaria treatment and immunization programs; (b) important health and population policies were formulated and implemented during the life of the project; and (c) the MOH's capability in planning, evaluation, and project implementation was strengthened through technical assistance and training.

9. The following factors are likely to sustain the project's outcome: (a) streamlining and rationalization of the health system; elimination of expensive vertical programs and integration of services at the various levels of the health care system; (b) greater national participation in the design of project activities following its restructuring; (c) introduction of more affordable essential generic drugs; and (d) more emphasis on community participation in the management of health facilities.

10. **Financing Arrangements and Costs**. Project financing arrangements included an IDA credit of SDR 26.9 million (US$26.6 million), and a Government contribution for local costs of US$1.4 million equivalent. Because the construction program became considerably larger than envisaged at appraisal as a result of project restructuring, costs increased from US$28.0 million to US$36.8 million. This amount could be accommodated under the original credit amount due to a substantial appreciation of the SDR vis-à-vis the US dollar during the life of the project.

11. **Project Timetable**. The credit was approved by the Board on June 11, 1985, signed on June 17, 1985, and became effective on January 3, 1986. The project closing date, initially scheduled for July 31, 1991, was extended four times to December 31, 1994. The project was executed over a nine year period compared to a projected five and a half year period. Final disbursements took place on April 30, 1995, and an amount of US$800,000 was canceled.

12. **Analysis of Key Factors Affecting Major Objectives**. The reorientation of the project after the MTR was key in helping the project achieve its objectives. The intense policy dialogue established between the Government and the donor community on major health sector policy issues and the participation of the Burkinabè in the restructuring of the project contributed to assuring a greater ownership of the revised operation. During the Sankara regime (1983-87), very limited disbursement took place under the Credit, as the Government did not want to use borrowed funds for the social sector. This attitude, however, disappeared over the years, as grants financing from other donors was reduced.

In recent years, IDA has become Burkina Faso's main donor in the health sector. The health reform program introduced in the early 1990s received the support of the 1991 First Structural Adjustment Credit (SAC I) and of the 1994 Economic Recovery Program (ERAC), which helped accelerate it. A more explicit linking of health with the budgetary projections contained in the Policy Framework Paper (PFP) also contributed to ensuring better budgetary allocation to the sector.

13. **Assessment of the Bank's and the Borrower's Performance**. The Health Services Development Project was the first comprehensive intervention of the Bank in the health sector in Burkina Faso. Both the Bank's and the Borrower's attitude evolved during the long period of project implementation adjusting to experience and reflecting (in the case of the Bank) the increased emphasis being given to thorough supervision of operations. The much stronger policy dialogue in which the Bank and the Borrower engaged in the early 1990s brought many new ideas and concepts into play and generated a debate which led to a complete overhaul of the existing health system. IDA showed flexibility by adapting the project design to Burkina Faso's changed circumstances and needs.

14. Despite early delays in project implementation, the Borrower's performance was satisfactory, particularly in the areas of essential generic drugs and the restructuring of the health system. While the Project Management Unit (PMU) appeared to fulfill its responsibilities, the lack of a monitoring system and of monitorable indicators makes it particularly difficult to measure project impact.

15. **Assessment of Project's Outcome**. As a result of the restructuring that followed the MTR, the project was able to make considerable progress in helping the Borrower improve the effectiveness of the health care delivery system. The project also contributed in making essential drugs more accessible and affordable in Burkina Faso. By introducing cost recovery and promoting the financial autonomy of peripheral health facilities it has ensured that these facilities have the means to cover some of their operating expenses. In view of above achievements the project's outcome can be rated as satisfactory.

16. **Important Findings of Project Implementation Experience**. The improved relationship between the Government and the Bank midway through the project, greater Burkinabé involvement in the restructuring of the project, the more intensive policy dialogue between the Government, IDA, and other donors on reforms for the health and population sectors, had a major beneficial effect on project implementation.

17. The introduction of some important, politically sensitive reforms, such as the adoption of the district approach, would have benefited from a national debate early in the process, to build consensus. Donors also underestimated the limited capacities of the local authorities to carry out the reform program, which took longer to implement than expected.

18. With the Bank assuming a leadership role in the health sector, it would have been advisable to strengthen the capacity of the Resident Mission to deal with the many policy

issues addressed under the project and ensure a continuous dialogue on them with the Borrower and the donor community.

19. **Future Operations and Sustainability**. IDA's operations in the sector continue to place emphasis on improving quality, coverage, and affordability of health services to increase their utilization and enhance the health status of the population. With regard to population policies, IDA's current operation in this sector emphasizes improving the demand and the supply of family planning services integrated into maternal and child health care.

20. The two new operations currently being implemented in the population and health sectors support private sector and NGO participation in these sectors as well as mobilization of grassroots participation in the management of health and population services.

21. **Lessons for Future projects in the Population and Health Sectors in Burkina Faso**. A **first** important lesson is that policy reforms should be in place prior to starting project investments. A **second** lesson is that a detailed implementation plan, which also incorporates a monitoring system and appropriate monitorable indicators, is absolutely essential to keep track of project progress. A **third** lesson is that stakeholder participation throughout the project cycle is essential to ensure a better sense of ownership and build commitment. A **fourth** lesson is that future projects would need to dramatically expand public education programs on health and population issues, in order to increase acceptance rates. A **fifth** lesson is that adequate emphasis needs to be given to institution strengthening and human resource development. A **sixth** lesson is that projects in the health and population sectors cannot be solely supervised by Headquarters. It is important to have the Resident Mission actively involved in the policy dialogue and in project supervision.

IMPLEMENTATION COMPLETION REPORT
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PART I: PROJECT IMPLEMENTATION ASSESSMENT

I. INTRODUCTION

A. Macroeconomic Setting

1.1 Burkina Faso is a resource-poor, landlocked country in a transitional zone between the Sudano-Guinean regions and the Sahel. Although fragile, soils are comparatively fertile. The majority of Burkina Faso's population of roughly 10 million (nearly 90 percent rural), depends mainly on agriculture and livestock raising. Population growth, at about 3 percent per annum, is creating severe pressure on arable land. Burkina Faso remains one of the world's poorest countries, with a GNP per capita estimated at US$185 in 1994, and with low social indicators in primary school enrollment (estimated at 36 percent in 1994), adult literacy (13 percent in 1993), access to health services, and life expectancy (43 years).

1.2 In spite of the handicaps constraining its economic performance, in the 1980s Burkina Faso recorded a growth rate that was sufficient to slightly raise per capita income and consumption, as real GDP grew by 3.5 percent per year between 1980 and 1993. Year-to-year variations in growth were significant and depended mostly on the weather and related agricultural and livestock production developments. Because 1991 was a good agricultural year and the private sector started to respond to reforms in the incentive framework, the expansion of GDP in real terms reached 6 percent. In contrast, economic developments in 1992 and 1993 were, on the whole, disappointing, as external factors and weak external demand combined with uneven rainfall slowed the growth of domestic output and income, worsened the public finance situation, and weakened the external position.

1.3 The Government adopted a Structural Adjustment Program in 1991 (Cr. 2281-BUR) supported by IDA and the IMF. The corrective measures implemented under the program, which initially focused on internal adjustment policies, have contributed to a narrowing of the overall fiscal deficit and to the containment of the current account deficit. Taking into account changes in the external environment, as well as economic and financial development in Burkina Faso, the Government recognized both the limitations of the purely internal adjustment strategy to achieve the necessary depreciation of the real effective exchange rate and the need to strengthen the ongoing structural reform program. Thus, the Government decided, together with the other countries of the CFA franc zone, to devalue the CFA franc by 50 percent in foreign currency terms effective January 12, 1994, and it adopted an updated medium-term structural adjustment program (supported by the IMF and IDA). Developments since the devaluation are broadly satisfactory.

Inflation appears to have been contained within the projected range, and, as expected, the Government was able to lift the price controls that had been reimposed after the devaluation. There is also strong evidence of a rebound in export and import substitution sectors, such as textiles, soap, and cycles. Despite the progress made to date, much remains to be done to overcome the severe structural and institutional problems left as a legacy of the country's past policies.

B. Bank's Role in the Sector

1.4 Following the 1978 Alma Ata Conference on Health for All by Year 2000, the Government of Burkina Faso adopted a health strategy that emphasized primary health care, prevention, and greater accessibility of services to the population. Primary health care was to be provided by a network of health services consisting of several clusters of village health posts, each of these clusters supervised by a health center (*Centre de Santé et Promotion Social* - CSPS). Run by local volunteers (the village community health workers and the traditional birth attendants), village health posts had the important task of stimulating grass-roots efforts for improving health conditions through village self-help. The public health system, in particular the health post as the first echelon of this system, was to provide the backing the village health post network needed to operate effectively. To carry out this strategy, in the 1980s the Government embarked on a massive program of setting up health posts in most of the country's villages and of upgrading rural dispensaries to become health centers.

1.5 The Health Services Development Project (Cr. 1607-BUR), IDA's second intervention in the health sector after the successful Regional Onchocerciasis Control Program (OCP), was designed to help the Government carry out its primary health care strategy. The project was meant to be dynamic in its approach and keep health and population policy dialogue alive throughout the project's life. It intended to provide, through operational research and testing, the opportunity to improve upon health and family planning policies and practices.

II. PROJECT OBJECTIVES

A. Project Objectives

2.1 The main objectives of the project were to:

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

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

(c) strengthen the Ministry of Health's (MOH) institutional capability in planning, evaluation, and project implementation and monitoring.

B. Project Description and Components

2.2 The project consisted of the following components: **(a) strengthening basic health and family planning services** including: (i) extension of the immunization program to 15 provinces, rehabilitation of 20 mobile teams and 30 urban vaccination centers, and construction of a national malaria treatment program; (ii) development of an in-service training program in primary health care at the provincial level; (iii) construction and upgrading of about 142 Centers for Health and Social Promotion (CSPS) and establishment of six referral centers (surgical antennae); and (iv) execution of feasibility studies to improve maintenance of health facilities and equipment at the provincial level and to improve management of the hospital network; **(b) development of National Health and Population Policies and Program** including: (i) testing cost recovery, drug distribution and extension of village health and nutrition systems; (ii) implementation of the results of tests, feasibility and pilot studies related to objectives (a) (iv) and (b) (i) above; and (iii) establishment of a Population program, including demographic analysis and population policy development, information, training, and the provision of family planning services through the public and private sectors and voluntary associations; **(c) strengthening of the Ministry of Health** including: (i) the establishment of about eight Provincial Directorates of Public Health (DSPS), and provision of two mobile epidemiological surveillance units; and (ii) strengthening health planning and project implementation services, including preparation of future health projects.

2.3 Implementation was carried out by the various directorates of the Ministry of Health which were to incorporate the inputs of the project into their regular flow of activities. MOH directorates involved in project implementation included, in particular:

(a) the Health Studies, Planning and Statistics Directorate (DEPSS, later DEP) charged with undertaking special studies in the province of Boulgou, including drug distribution and cost recovery;

(b) the Professional Training Directorate (DFP), in charge of planning and coordinating the in-service training to be carried out at the provincial level by a team of national trainers. Under the project, the unit was responsible for preparing training modules on six subject matters: organization and management of primary health care; expanded program of immunization (EPI); maternal and child health (MCH) and family planning; detection and treatment of malnutrition; sanitation and the control of parasitic diseases; and prescription and use of essential drugs.

(c) the Epidemiological Surveillance and Vaccinations Directorate (DSEV) charged with carrying out and supervising the cold chain, training and the immunization and malaria components of the project; and

(d) the Pharmaceutical Services Directorate (DSPH), in charge of developing the national pharmaceutical policy, preparing the drug formulary in

conformity with the policy, planning of procurement, and educating the prescribers and the public about the Government's essential drug policy.

2.4 A small Project Management Unit (PMU) was attached to the Office of the General Secretary to coordinate all parties involved in project implementation at central and provincial levels. The PMU was also given the role of scheduling and monitoring program activities

C. Credit Covenants and Special Agreement

2.5 During credit negotiations, the following agreements were reached, namely, that the Borrower will: (a) establish an account as a revolving fund to support primary health care services, including the replenishment of chloroquine for the anti-malaria program. Chloroquine will be sold at prices that will allow the program to be self-supporting as of the third year of project implementation; (b) consult with IDA if further studies indicate the need for reorientation of the national health policy; (c) hold annual meetings of donor agencies to monitor progress in program implementation; (d) annually review all investments made in the health sector in the previous year and which are expected to be made during the upcoming year, including recurrent cost implications; (e) by March 31, 1988, present to IDA the results of operational field testing of drug distribution, cost recovery, village health and nutrition activities, and the financial requirements of a national primary health care system; and finalize feasibility studies to improve MCH and family planning services, maintenance of health facilities and hospital management; and (f) by April 1, 1989, implement the results of above studies, for which a fund of US$5 million had been earmarked under the credit. With regard to its drug policy, the Borrower committed itself to taking the following actions: (a) by December 31, 1985, present to IDA: (i) a plan for strengthening national drug procurement and distribution; and (ii) an official list of pharmaceutical products authorized for importation, such list being presented by the generic and specialty brand names equivalent in conformity with WHO's essential drug guidelines; (b) adopt such list and review it annually; (c) by June 30, 1986, publish a new drug formulary based on said list and create in the MOH a pharmaceutical information service capable of providing information to prescribers and the public on essential drugs; and (d) carry out a program to inform the public about essential drugs. Finally, the Borrower and IDA agreed that they will jointly assess, on an annual basis, the performance of SONAPHARM, a newly created drug importation agency with mixed capital (51 percent Government, 49 percent private pharmacies) and determine the need for allowing greater competition in drug procurement.

2.6 In addition to the above, the following conditions of credit effectiveness were also agreed upon: (a) the establishment of an appropriate project accounting system; (b) establishment of a Project Management Unit, including appointment of staff, and (c) the opening of the project special account. Furthermore, the Borrower agreed not to make withdrawals for: (a) the purchase of chloroquine, until IDA has satisfied itself that adequate arrangements have been made for the procurement, distribution and cost recovery of chloroquine; and (b) the CSPS construction component, prior to (i) the adoption of an agreement between the MOH, the Ministry of Finance on the one hand,

and the *Fonds de l'Eau et d'Equipement Rural* (FEER), on the other; and (ii) the appointment of an engineer, an accountant and two initial site supervisors to the FEER.

D. Evaluation of Project Objectives

2.7 Project's objectives were clear and consistent with both the Government declared primary health care strategy and the sector's needs. However, in the absence of an implementation plan and a strong Government commitment, a number of these objectives turned out to be too ambitious and difficult to implement. Because of the Government preference to use grant funds for the social sector, very little disbursement took place under the project in the first two years of its implementation. The October 1988 mid-term review showed achievements in some areas, but little or no progress in others. The Government **immunization and chloroquine programs** improved considerably as a result of the project (paras 3.1-3.2). With regard to **in-service training**, about 2,300 health workers had received the first cycle of training in the six selected subject matters and a second cycle was being carried out (para. 3.3). In the area of **construction**, 15 instead of 8 provincial Directorates of Public Health were constructed (para. 3.10). The rehabilitation and construction program of CSPS, managed by the parastatal FEER and expected to be carried out with villagers' participation, was considerably behind schedule in 1988, but improved rapidly when the decision was made to have the program completed by local private construction firms (para. 3.5).

2.8 By the project's mid-term review, the poorest results were achieved in the following areas. (a) **Essential drugs.** Half way through the project, the Government had yet to adopt a list of essential drugs authorized for import and distribution in the country, in conformity with WHO essential drug guidelines. The quantity of generic drugs imported in the country was very small, although these drugs were, on average, about seven times cheaper than their correspondent brand names and SONAPHARM had yet to perform its social role of facilitating the import of more affordable drugs in the country. (b) **Cost recovery**. Progress in this area was hampered by the Government's reluctance to institutionalize cost recovery in the health sector and give financial autonomy to peripheral health facilities. The Boulgou cost recovery pilot operation, designed to test appropriate cost recovery mechanisms at each level of services, was experiencing considerable delays. (c) **Feasibility and pilot studies**, in the areas of family planning, drug distribution, village health and nutrition systems, to test: (i) new innovative approaches to family planning services; (ii) the organizational and management requirements of the CSPS with regard to outreach supervision and referral; and (iii) what kind of health and nutrition services could be provided by the villagers themselves with the support of the CSPS. Only one study on family planning had been undertaken at the time of the mid-term review and no use had been made of the US$5 million fund for new projects in above areas. (d) The **development of a more effective population policy.** Little commitment on the Government's side to embark on a stronger population program, prevented any progress in this area. The project's main contribution in this area consisted of the preparation of a family planning program, which focused on the training of health workers in six provinces that still lacked family planning services.

2.9 Most disappointing of all, however, was the recognition that the project was not contributing to improving the credibility of the health care system vis-à-vis the population, which continued to desert it. Utilization rates of public health services were below 30 percent on average and were decreasing.

2.10 A number of factors contributed to the above poor results. In the absence of an upfront agreement on major policy issues, successful project implementation depended on the maintenance of a continuous strong dialogue as well as a good communications policy on these issues and this did not happen in the early stages of the project. The behavior of the Bank during this period clearly reflects the predominant Bank culture at that time, more interested in preparing new projects than in ensuring the successful implementation of those that had been approved. Supervision missions were less frequent, and often addressed only a portion of the activities the project was intended to support. The Burkinabè Government did not show much enthusiasm about IDA's involvement in the social sector, for which it preferred to obtain financing in grant form. This attitude made it particularly difficult for IDA to impose upfront conditionalities. The Government's reluctance to borrow funds for the social sector was also a major factor in the very slow disbursement rate of this credit, as the Government continued to look for grants also for those activities for which funding was provided by the IDA credit.

2.11 The "one village, one health post" strategy did not work because communities were not adequately mobilized and sensitized. Furthermore, health posts never received the backing of an adequate health care system, an essential element in a strategy that emphasizes village level health care. Of the over 6,000 health posts established in village communities in the 1980s, only about 2,000 are still operational, mainly because they receive the support of NGOs and bilateral donors. CSPS had too limited human and material resources to carry out any meaningful outreach program. The referral system was very ineffective, with medical centers (CM) and hospitals operating more as large dispensaries rather than providers of more specialized care. Urban-based hospitals continued to employ a large majority of the trained health personnel and absorb a disproportionate share of the health budget. Health activities continued to be carried out as separate vertical programs, heavily financed by external donors, each with its own coordinator and logistics and with a highly centralized administration. Overlapping of efforts and waste of human resources were thus very common.

2.12 Faced with increasing budgetary constraints, in 1990 the Government abandoned its reluctance to introduce cost recovery in the health system. It also became increasingly concerned about the macroeconomic consequences of a rapidly growing population. These changes in the policy environment encouraged IDA to undertake an intensive policy dialogue with the Burkinabè authorities on the need to restructure tne health system, introduce a more effective drug policy, and address population issues more aggressively. The dialogue was carried out for over a year during frequent and long supervision missions. It led, in the area of health, to a decision by the Government to decentralize the health system so that services could be brought closer to the rural area where most of the population lives. A national working group formed by the Directors of the most relevant Directorates in the Ministry of Health and their staff worked very closely with IDA's

supervision missions in devising a more effective approach. The Government decided to adopt the health district as the new basic operational unit for health care delivery. The district consists of a CM upgraded to provide emergency operations (*Centre Médical avec Antenne Chirurgicale*-CMA), serving a population of about 180,000, and health centers (CSPS), usually 15-20, within its zone of responsibility. The Government decided to establish 53 districts in the country's 30 provinces, with larger provinces having two or three districts. The new structure allowed for a rationalization of the health system so that services could be improved without imposing a heavy burden on the budget. Training and supervision were to be organized and managed at the district level. Community participation in the management of health centers became a crucial element of the new decentralized policy.

2.13 The project was restructured to assist the Government in putting in place the new health system. By the time the IDA credit closed on December 31, 1994, three and one half years later than the original closing date of July 31, 1991, considerable progress had been made in the areas of both pharmaceutical policy and decentralization of the health system. The pharmaceutical legislation was revised and, following the Government decision to privatize SONAPHARM, a new non-profit institution (CAMEG) was established in 1992 to purchase and supply essential generic drugs to the public health facilities and to the private non-profit sector. The price of brand names has been liberalized, while the retail price of about 120 essential generic drugs is set yearly by the Government and is applied to both the public and the private sector. A growing number of private pharmacists currently sell generic drugs in Burkina Faso. The project also financed training programs for district doctors in emergency surgery and district management. By credit closing date, 14 health districts had been established by the project, while donors established 7 additional ones. The dialogue on policy reforms is now carried on in the context of the follow up Health and Nutrition (Cr. 2592-BUR) and Population and AIDS Projects (Cr. 2619-BUR). The first will complete the establishment of the health district network and will also address issues identified by the Health Services Development Project, such as maintenance of health facilities and the development of an appropriate hospital strategy. The second project is assisting the Government in the implementation of its population policy and in the fight against AIDS. The reform program launched in the context of the Health Services Development Project places Burkina Faso in a much better position to address its numerous health problems. The project development objectives have thus been substantially met.

III. IMPLEMENTATION EXPERIENCE AND RESULTS

A. Assessment of Project's Success and Sustainability

Strengthening of Basic Health and Family Planning Services

3.1 *Expanding the immunization program and establishing a malaria treatment program*: The project originally envisaged to extend the immunization program to 15 provinces. This target was reduced to 9 provinces soon after credit effectiveness because

of an expansion of UNICEF's immunization program in the country. However, when this agency started to experience financial difficulties in 1990 and could no longer maintain its commitments, the project again expanded its support to the program covering three additional provinces. Through the combined IDA/UNICEF operation the immunization coverage of infants increased considerably in the country from 2 percent in the early 1980s to an estimated 50 percent on average in 1994. While in the early stages of the program, the Government relied mainly on vertically managed mass vaccination campaigns, starting 1990 it increasingly integrated immunization activities into the regular services of the health facilities, an essential step to ensure the sustainability of the program. Vaccinations are now offered by all the 600 CSPS. While the 1994 results represent an important achievement, vaccination coverage is still considerably below the 90 percent target set by the Government for 1997. A beneficiary assessment conducted in 1992 on the utilization of health services in Burkina Faso showed that the immunization program is still more supply than demand-driven and that a greater effort needs to be made to sensitize the population and local leaders as to the reasons for and the benefits of vaccination.

3.2 *Malaria:* The MOH decided to abandon its earlier emphasis on malaria prevention, promoting instead treatment of malaria with chloroquine. The project supported this approach by making chloroquine available in sufficient quantity to all levels of the health care system. Chloroquine tablets were to be sold at prices that would have allowed the program to become self-supporting as of the third year of its implementation. This result was achieved. Chloroquine is now available in most of the 600 CSPS at prices varying between 200 and 250 CFA franc for a normal dose and the program is self supporting as planned. The chloroquine revolving fund, originally managed by the PMU, has now been taken over by CAMEG. However, in spite of greater chloroquine availability, malaria continues to be a major source of morbidity and mortality in the country. In 1992, it accounted for 23 percent of all cases of disease, 17 percent of all cases of hospitalization, and for about 50 percent of the mortality cases. To encourage a greater use of chloroquine, the Center for Malaria Control, established by the Italian Cooperation, is now selling chloroquine tablets at a subsidized price. Cost is not, however, the only factor preventing a greater consumption of chloroquine. Studies on the health behavior of the population have shown that the causes of malaria are not well understood by the population and that there is a need to conduct intensive education campaigns.

3.3 *Development of an in-service training program in primary health care at the provincial level.* The objective of the project was to provide, by September 1988, two cycles of practical in-service training to all CSPS and CM health workers. Training was to be provided by training units established at the provincial level. By mid-1988, 128 provincial trainers had been trained and 2,367 health workers had completed the first cycle of training and were undergoing the second one. The impact of this training is, however, very difficult to assess because of infrequent follow-up supervisions and the high turnover of health personnel. The in-service training program of the project was interrupted in 1990 to be replaced by the training program in health district management for district doctors. Under the new decentralized health system, district doctors will be responsible

for training and supervising the staff operating in their districts. This measure should improve both training and supervision and make these activities more sustainable.

3.4 Beginning in 1990, the project also financed unplanned long-term training for about 20 doctors in public health and surgery.

3.5 *Construction and upgrading of about 142 centers for health and social promotion (CSPS) and establishment of 6 new referral centers.* The project financed the construction of 158 CSPS, 16 more than originally planned. By the end of the project, the total number of CSPS was 600, each covering, on average, about 13,000 people (down from an average coverage of about 19,000 people in 1982). The project also upgraded 14 medical centers (CM) by adding a unit for emergency surgery. Originally, only 6 surgical antennae had been planned. Other donors upgraded additional 7 CM bringing the total number of CMA to 21. The CSPS construction program experienced considerable delays in the beginning of the project because of poor management by the FEER and the project's inability to mobilize villagers to participate in the construction program. The latter improved rapidly when the decision was made to have it carried out by local private entrepreneurs.

3.6 *Execution of feasibility studies to improve maintenance of health facilities and equipment at the provincial level and to improve management of the hospital network.* The study on maintenance of health facilities was carried out through a joint effort of the German GTZ and the project and its recommendations will be implemented under the follow up Health and Nutrition Project. The French Cooperation became involved in the maintenance of the two national hospitals but in the end did not carry out any comprehensive study of the hospital sector. Such a study was recently completed as part of the activities of the ongoing project with financing provided under the Danish Trust Fund. Its recommendations will be implemented under the new project. To underline its growing interest in these two issues, the MOH has recently created a new General Directorate for Hospitals (DGES divided into two directorates: the Directorate of Hospitals and Clinics (DHC) and the Directorate for equipment materiel and maintenance (DEMM).

Development of National Health and Population Policies and Programs

3.7 *Testing cost recovery, drug distribution and extension of village health and nutrition systems.* The purpose of these tests was to assist the Government in further refining its national health policies and making them more explicit particularly with respect to drug distribution, cost recovery (and associated affordability and replicability issues), and the extension of basic health services to villages. The Government had also agreed to organize annual meetings with donors to review the experience in the above areas. Although in the area of drugs, only the Boulgou cost recovery pilot operation was carried out, considerable progress was made under the project with respect to the formulation and implementation of national policies for cost recovery, drug distribution, and financial autonomy of peripheral health facilities. This was largely the result of the more active policy dialogue established between IDA and the Government in 1990. Other donors

increasingly participated in this dialogue and collaboration among them became very close on these issues. The dialogue with IDA was conducted both in the context of the supervision of the Health Services Development Project and of the preparation of the follow up project. The two operations became closely intertwined in 1993-1994 and a number of policy issues raised under the first project became conditionalities for the processing of the new operation.

3.8 *Village-level Health and Nutrition Activities.* Field tests conducted in this area were expected to help develop better outreach services and a supervision system linked to the promotion of village-level health and nutrition activities. Only one pilot operation was conducted in 1993 with respect to village nutrition services. The operation was carried out in a number of villages in four provinces of the country and involved nutrition activities for weaning-age children and pregnant and lactating mothers. Carried out under the supervision of health center personnel, this operation was generally well received but remained isolated and did not have an immediate follow-up. The Government did not have, at that time, a comprehensive national nutrition strategy, which it elaborated only one year later as part of the preparation of the new project. Lately, the Government also established a national nutrition center (CNN) entrusted with carrying out the strategy and coordinating all nutrition interventions in the country. It is expected that the results of the 1993 pilot nutrition operation will be reexamined in the context of the implementation of the national nutrition strategy and action plan.

3.9 *Establishment of a fund of US$5 million to finance the implementation of the results of tests, feasibility and pilot studies.* Inactive for a long time, the Fund was, in the last four years of project implementation, utilized to finance, in addition to family planning and village nutrition extension programs, new activities that originated from the reorientation of the project, namely: the first year of CAMEG's operating expenses, the technical assistance for the district doctors' training program, and the preparation of the new Health and Nutrition and Population and AIDS Control Projects

3.10 *Establishment of a Population program.* This program included demographic analysis and population policy development, information, training, and the provision of family planning services through the public and private sectors and voluntary associations. The Government's reluctance to address population issues during the first years of the project prevented the execution of any meaningful dialogue in this area and the implementation of population-related activities. Family planning programs were also very low key during those years. The Government's attitude vis-à-vis population issues changed in 1990 when it became more concerned about the macroeconomic consequences of a rapid population growth. The project's family planning program implemented in six provinces of the country (para. 2.8) was successfully completed in 1993. IDA initiated an important policy dialogue on population issues, which was mostly carried out in the context of the preparation of the new Population and AIDS Control project. Important population activities are being carried out under the new project, including a family planning program that envisages increasing the contraceptive prevalence rate from 17 percent to 32 percent in urban areas and from 1.5 percent to 9 percent in rural areas by

year 1999. The project is also supporting the involvement of NGOs and private sector organizations in the implementation of family planning programs particularly in urban areas.

Strengthening of the Ministry of Public Health

3.11 *Establishment of about 8 Provincial Directorates of Public Health (DPS); and provision of 2 mobile epidemiological units.* These targets were exceeded by the project as 16 DPS were established. The two epidemiological units have carried out epidemiological surveillance in the areas of onchocerciasis, trypanosomiasis, schistosomiasis, and meningitis, all diseases which posed a considerable threat in numerous provinces. Lessons learned from these units are being used for expanding the surveillance network to other diseases, including AIDS.

3.12 *Strengthening health planning and project implementation services, including preparation of future health projects.* The Government reduced the project's intervention in this area because it preferred to use USAID's assistance under a grant fund. The project's assistance mostly consisted of the financing of long- and short-term training for the staff of the Planning and Studies Directorate (DEP), while USAID financed long-term technical assistance. Largely as a result of the joint USAID/IDA support, the DEP has become the nursing ground of MOH's cadres and leaders. The DEP played an important role in the preparation of the Government's decentralized health strategy, which is now being carried out by the new decentralization unit of the Directorate of Public Health (CADSS). Strengthening of the DEP will continue under the new Health and Nutrition Project.

B. Summary of Financing Arrangements and Costs

3.13 **Financing Arrangements and Costs**. Project financing arrangements included an IDA credit of SDR 26.9 million (US$26.6 million) and a Government contribution for local costs of US$1.4 million equivalent. Because the construction program was considerably expanded as a result of project restructuring, costs increased from US$28.0 million to US$31.6 million. This amount could be accommodated under the original credit amount due to a substantial appreciation of the SDR vis-à-vis the US dollar during the life of the project.

3.14 **Project Timetable:** The credit was approved by the Board on May 20, 1985, was signed on June 17, 1985, and became effective on January 16, 1986. The project closing date, initially scheduled for July 31, 1991, was extended four times to December 31, 1994. The project was executed over a nine year period compared to a projected five and a half year period. An amount of US$800,000 was canceled. Final disbursements took place on April 30, 1995.

C. Analysis of Key Factors Affecting Major Objectives

3.15 The reorientation of the project after the MTR was key in helping the project achieve its objectives. The intense policy dialogue established between the Government and the donor community on major health sector policy issues and the participation of the Burkinabè in the design of the project's new interventions contributed to assuring a greater ownership of the revised operation. The Government's preference for grant funds to finance activities in the social sector, a major cause for the very slow implementation at the beginning of the project, gave way over the years to a greater reliance on IDA financing mainly because of a reduction in grant financing from other donors.

D. Assessment of the Bank's and the Borrower's Performance

3.17 Through the Health Services Development Project, the Bank has made a positive contribution to the development of the primary health care system in Burkina Faso. Both the Government's and the Bank's attitude evolved through the implementation of the project as more experience was acquired and the Bank, which originally had not sufficiently focused on project implementation, started to address more vigoroulsy crucial policy issues and pay more attention to obtaining results. The implementation period was very long. However, one has to take into account that very little activity was carried out under the project in the first two years of its implementation. Also, credit disbursements were slowed considerably in 1991 as the health system was being overhauled and new activities put in place. Following the overhaul, Credit disbursements resumed strongly and the project remained very active until its closure.

3.18 Despite early delays in project implementation, the Borrower's performance was satisfactory, particularly in the areas of essential generic drugs and the restructuring of the health system. The PMU appeared to generally fulfill its responsibilities. However, in the absence of a monitoring system under the project (there are no indicators for measuring project performance), it is difficult to estimate the adequacy of PMU's project monitoring activities as well as to measure the project's impact.

E. Assessment of Project's Outcome

3.19 As a result of the restructuring that followed the MTR, the project made considerable progress in helping the Borrower in rationalizing and improving the effectiveness of the health care delivery system. The project also contributed to making drugs more accessible and affordable in Burkina Faso. By promoting the financial autonomy of peripheral health facilities it has ensured that these facilities have the means to cover some of their operating expenses. The Health Services Development Project can thus be classified as satisfactory in its effort to make health services more accessible to the population.

IV. SUMMARY OF FINDINGS, FUTURE OPERATIONS AND KEY LESSONS LEARNED

A. Important Findings of Project Implementation Experience

4.1 The Government's increased experience in the health and population sectors and a more intensified policy dialogue with IDA and other donors on major reforms for these sectors had a major effect on the implementation of the project. The Government became very concerned about the cost and the sustainability of the vertical programs supported by its donors. It realized that it needed to depart from the existing highly centralized structure and vertically run health programs, and to rationalize its health system both to reduce costs and improve the quality of health services and make them more responsive to the health needs of the population.

4.2 The introduction of some important, politically sensitive reforms (such as the adoption of the district approach) would have benefited from a national debate in the early stages of the process, which would have facilitated consensus building. The donors also underestimated the limited implementation capacities of the local authorities and the need to pace the reform process to take into account these constraints. The two units entrusted with carrying out the decentralization process, MOH's Planning and Studies Directorate and Decentralization Unit, were too poorly staffed to properly handle such a huge job. Strengthening of the two units is now a priority of the Ministry and is supported by IDA through the follow up Health and Nutrition Project.

4.3. MOH's considerable human resources constraints prevented much quicker project implementation. The many health sector reforms introduced in Burkina Faso in recent years, in particular the pace of these reforms, have pushed MOH's absorptive capacity to its limits. Considerable efforts are now being made under the new operations to strengthen institutional capacity and the development of human resources.

4.4 With the Bank assuming a leadership role in the health sector, it would have been advisable to strengthen the capacity of the Resident Mission to deal with the many health sector issues and to ensure a continuous dialogue on them with the Borrower and the donor community. While donor coordination was in general good, it experienced, at times, some damaging breakdowns which should be avoided in the future.

B. Future Operations and Sustainability

4.5 The Health Services Development Project supported the Government's Primary Health Care Strategy aimed at improving the quality and accessibility of health services particularly to the rural and urban poor. Because the disease burden is still high and a large percentage of the Burkinabè population still has no access to modern health services, IDA's operations in the sector continue to place emphasis on improving quality, coverage, and affordability of health services to increase their utilization and enhance the health status of the population. In the area of population, IDA's operations will emphasize

improving the quality of, and access to, family planning services integrated into maternal and child health care, promoting IEC campaigns in health and family planning, and encouraging private sector and NGO participation in population, family planning, and health programs.

4.6 The new operations are also supporting increased efforts to mobilize grassroots participation in the management of the health care system. They are encouraging the Government to work with NGOs to increase civic consciousness and popular participation. The community co-management system would need to be assessed periodically to determine the impact of the approach in improving the quality of services and whether beneficiaries have gained a sense of ownership of the projects.

C. Lessons for Future projects in the Population and Health Sectors in Burkina Faso

4.7 A **first** important lesson is that policy reforms should be in place prior to starting project investments. A **second** lesson is that a detailed implementation plan, which also incorporates a monitoring system and appropriate monitorable indicators, is absolutely essential to keep track of project progress. A **third** lesson is that stakeholder participation throughout the project cycle is essential to ensure a better sense of ownership and build commitment. A **fourth** lesson is that future projects would need to dramatically expand public education programs on health and population issues, in order to increase acceptance rates. A **fifth** lesson is that adequate emphasis needs to be given to institution strengthening and human resource development. A **sixth** lesson is that projects in the health and population sectors cannot be solely supervised by Headquarters. It is important to have the Resident Mission actively involved in the policy dialogue and in project supervision.

PART II: STATISTICAL ANNEXES

Table 1: Summary of Assessments

A. Achievement of Objectives	Substantial	Partial	Negligible	Not applicable
Macro Policies	☐	☑	☐	☐
Sector Policies	☑	☐	☐	☐
Financial Objectives	☑	☐	☐	☐
Institutional Development	☐	☑	☐	☐
Physical Objectives	☑	☐	☐	☐
Poverty Reduction	☑	☐	☐	☐
Gender Issues	☐	☑	☐	☐
Other Social Objectives	☐	☐	☐	☑
Environmental Objectives	☐	☐	☐	☑
Public Sector Management	☐	☑	☐	☐
Private Sector Development	☐	☑	☐	☐
Other (specify)	☐	☐	☐	☑

B. Project Sustainability	Likely	Unlikely	Uncertain
	☑	☐	☐

C. Bank Performance	Highly Satisfactory	Satisfactory	Deficient
Identification	☐	☑	☐
Preparation Assistance	☐	☑	☐
Appraisal	☐	☑	☐
Supervision	☐	☑	☐

D. Borrower Performance	Highly Satisfactory	Satisfactory	Deficient
Identification	☐	☑	☐
Preparation Assistance	☐	☑	☐
Appraisal	☐	☑	☐
Supervision	☐	☑	☐

Table 2: Related Bank Credits

Credit	Purpose	Year of Approval	Status
	Preceding Operations		
Cr. 1482-BUR	Perkoa Mining Exploration & Tech. Asst.	1984	Closed
Cr. 1293-UV	Koudougou Agriculture Development	1982	Closed
Cr. 1285-UV	Haut-Bassins Agriculture Development	1982	Closed
	Following Operations		
Cr. 2728-BUR	Urban III	1995	Ongoing
Cr. 20671-BUR	Urban II (Supplemental)	1994	Ongoing
Cr. 2619-BUR	Population/AIDS	1994	Ongoing
Cr. 2592-BUR	Health & Nutrition	1994	Ongoing
Cr. 2590-BUR	Economic Recovery Credit	1994	Ongoing
Cr. 2519-BUR	Engineering Credit	1993	Ongoing
Cr. 2472-BUR	Private Sector Assistance	1993	Ongoing
Cr. 2414-BUR	Food Security	1993	Ongoing
Cr. 2381-BUR	Agriculture SECAL	1992	Ongoing
Cr. 2378-BUR	Public Institution	1992	Ongoing
Cr. 2332-BUR	Transport SECAL	1992	Ongoing

Table 3: Project Timetable

Steps in Project Cycle	Date Planned	Actual Date
Identification (Executive Project Summary)		August 1982
Preparation		August 1982-May 1984
Appraisal		May 1984
Negotiations		March 1985
Board Presentation		June 11, 1985
Signing		June 17, 1985
Effectiveness	October 1985	January 3, 1986
Credit Closing	July 31, 1991	December 31, 1994

Table 4: Credit Disbursements: Estimated and Actual
(US$ million)

	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95
Appraisal estimate	2.39	3.73	5.32	5.85	5.59	3.72				
Actual	1.61	0.78	3.44	3.36	6.66	1.97	5.65	2.35	5.54	4.12
Actual as % of estimated	67.4	20.9	64.7	57.4	117.4	50.3				
Date of final disbursement	April 30, 1995									

TABLE 5: KEY INDICATORS FOR PROJECT IMPLEMENTATION AND OPERATION

SUBJECT	PROGRAM	ACHIEVEMENTS
A. Strengthening Basic Health and FP services	(a) Rehabilitation of 20 mobile teams;	(a) Implemented
	(b) Rehabilitation of 30 Urban Vaccination Centers	(b) Implemented
A.1. Immunization and Malaria Programs	(c) Provide vaccines, cold chain equipment and storage facilities and operating cost in 15 provinces	(c) Implemented
1. Immunization	(a) provide adequate amount of chloroquine for two year period. Tablets to be sold at a price sufficient to establish a self supporting program	(a) Implemented, self supporting program now taken over by CAMEG
2. Malaria programs		
A.2 In-service Training	(a) establishing a core unit responsible for planning and coordinating and to train 30 teams of provincial trainers;	(a) Core unit installed, provincial trainers trained
	(b) TA to assist the core unit in hand-out materials and develop six courses (organization and management of primary health care, EPI, maternal and child health and FP; sanitation; detection and treatment of malnutrition/ control of infectious and parasitic diseases; prescription and use of essential drugs);	(b) Materials developed by DFP
	(c) 1000 paramedicals to be trained over the life of the project, i.e. 2 complete cycle in each province;	(c) 2367 workers trained by 1990 Program interrupted in 1990 because of restructuring or training program at the district level.
A.3. Upgrading of Dispensaries to CSPS Facilities	(a) Renovate 54 health facilities and replace or enlarge 88 facilities, all provided with year round water facilities (boring of wells of boreholes) equipped with a refrigerator and a motorbike for supervision, plus housing for the head nurse;	(a) 158 CSPS build or restored and equipped Total was of 602 in 1992
	(b) Build 6 referral centers (antennae with emergency surgery capabilities)	(b) 14 referral centers build and fully equipped

SUBJECT	PROGRAM	ACHIEVEMENTS
A.4. Feasibility studies	(a) 4 PM of TA to conduct feasibility study and proposals to improve the management of the hospital network; (b) 4 PM of TA to conduct feasibility study to improve maintenance of health facilities	(a) Implemented under follow-up project. (b) Implemented under follow-up project.
B. Development of National Health and Population Policies and Programs **B.1. Operational Field Research**	(a) 24 PM of TA needs assessments, and policy formulation, procurement planning, training in stock management, preparation of a drug formulary, study the role of the private sector, test alternative mechanisms for improved delivery, etc..	(a) Implemented
1. Drug Distribution	(b) 6 PM of TA for a program to inform the public about the Government essential drug policy; and (c) TA to provide to the DEP to help them undertake special studies in drug distribution in Boulgou	(b) Implemented (c) Implemented
2. Cost Recovery	(a) Tests appropriate costs recovery mechanisms at each level; (b) Assess the organizational and management requirements of partial cost-recovery; (c) Determine the cost of providing adequate primary health care at CSPS ands referral levels, and; (d) Provide scenarios of the share of the state budget, provincial budget and the financial contribution of beneficiaries	(a) Implemented (b) Implemented under the follow up project. (c) Implemented under the follow up project. (d) Not implemented.
3. Village Level Health and Nutritic n Activities	(a) Tests the organizational and managerial requirements of the CSPS with regard to outreach and supervision and referral; (b) Promote what kinds of health and nutrition services could appropriately be provided by villagers, setting up Health Committees, improving preventive activities in the catchment area. Studies to be completed by Year 2	(a) Proposal of a nutrition survey by Prof Hayward (1989). (b) Four small nutrition programs in 4 provinces conducted between 1993 and 1995.

SUBJECT	PROGRAM	ACHIEVEMENTS
B.2. FUND to implement the results of feasibility and operational field research, including in Population and FP studies		
B.3. Establishment of a Population Program	(a) 6 PM TA feasibility study to upgrade 8 maternity facilities in Ouaga and Bobo	(a) Study implemented but construction not carried out following restructuring.
	(b) TA to training to the National Institute of Statistics and Demographics to analyze national census data, disseminate demographic information and do a survey of contraceptive practices	(b) Not implemented
	(c) I.E.C. component to test, evaluate and disseminate population related messages in local languages	(c) Not implemented
	(d) Training component training of trainers in MCH and FP and 15 in-country seminars for nurses, midwives on FP methods/short-term training of 15 physicians in fertility management/in-country training in contraceptive commodities management and logistics;	(d) Implemented in the follow up project.
	(e) strengthening the 2 national hospitals to become FP referral centers/assistance to the development of a FP clinic at ABBEF/provision of FP commodities (all this complementary to the USAID program)	(c) Implemented
Strengthening the Ministry of Health C.1. Construction	(a) provide facilities to house the staff and in-service training in 8 provinces	(a) Implemented
	(b) provide two mobile units for epidemiological surveillance in the Comoe and Bulkiemde provinces	(b) Implemented
C.2. Strengthening the DEPSS (complementary to USAID project)	(a) entrusting the DEPSS with start-up activities and with organizing and evaluating pilot studies	(c) Partially implemented

Table 6: Studies Included in the Project

Study	Purpose as defined at Appraisal/Redefined	Status	Impact of Study
Cost Recovery	Test the possibility of introducing cost recovery and willingness of the population to pay.	Completed	Study reinforced need to introduce lower cost drugs in the market.
Village Nutrition Activities	Test village level appropriateness.	Completed	Impact not great because at that time there was no national nutritional strategy.

Table 7A: Project Costs

	Appraisal Estimate (US$M)				Actual/ Latest Estimate (US$M)	
	Local Costs	Foreign Costs	Total	Local Costs	Foreign Costs	Total
Civil Works		9.6	9.6		16.3	16.3
Furniture/ Equipment		5.6	5.6		13.5	13.5
Chloroquine		0.2	0.2		0.5	0.5
Operating Costs	1.34	0.9	2.24	1.34	1.8	3.2
Technical Assistance		1.8	1.8		2.5	2.5
PPF		.82	0.82		0.3	0.3
Sub-projects		5.0	5.0		0.5	0.5
Unallocated		2.68	2.68		0	0

Table 7B: Project Financing

	Appraisal Estimate (US$M)			Actual/Latest Estimate (US$M)		
Source	**Local Costs**	**Foreign Costs**	**Total**	**Local Costs**	**Foreign Costs**	**Total**
IBRD/IDA	9.6	17.0	26.6	1.0	34.5	35.5
Domestic Contributions	1.4		1.4	1.3		1.3
Total	11.0	17.0	28.0	2.3	34.5	36.8

Table 8: Status of Legal Covenants

SELECTION NO. OF CREDIT/LOAN AGREEMENT	COVENANT	STATUS M=Met NM=Met P=Not Met	COMMENTS	ACTION TAKEN OR REQUIRED
2.02	Open and maintain in CFAF a special account in a commercial bank on terms and conditions stisfactory to IDA	M		
3.03	Annually: (i) organize a meeting of all aid agencies participating in the financing of the Borrower's primary care policy; (ii) review with IDA investments made in the health sector during the previous year and expected to be made during the next year.	M		Review of IDA investments in the health sector carried out in the context of SAL I, the 1993 PER and PFP's
3.05	Furnish quarterly progress reports	M		
3.06	Establish revolving fund to support primary care services, including replenishment of the choroquine for anti-malaria program.	M		
4.01 (b)	Have consolidated accounts of PMU separate accounts of FEER, special account, local advance account, audited each fiscal year by independent auditors acceptable to IDA.	M		
Schedule 3 (9)	FEER will obtain the full-time services of an accountant and initially of 2 qualified site supervisors. The Ministry of Equipment o make the services of a qualified engineer or building technician available to FEER.	M	In spite of the compliance with the Crédit Agreement covenant, FEER's performance was not very satisfactory. Government decided to turn remainder of construction program to private enterprises.	Construction program move on quickly after decision were taken to award contracts to private enterprises.

SELECTION NO. OF CREDIT/LOAN AGREEMENT	COVENANT	STATUS M=Met NM=Met P=Not Met	COMMENTS	ACTION TAKEN OR REQUIRED
Schedule 3 (10)	FEER to prepare an annual work program for IDA's review. Such program will include a report of progress during the previous year, the status of site surveys and community mobilization, updated cost estimates and an account of the relationship of the annual program to the master plan.	M		
Schedule 3 (14)	The Borrower shall present the results of studies, experiments and tests referred to in para. 13 and in part A(4), to IDA by March 31, 1988, for its review and comments; and	M	A cost recovery study was completed in March 1991 and an evaluation report was produced in August 1991. Feasibility study for strengthening delivery of family planning services was completed in 1988. Studies on village-level health and nutrition activities were completed in November 1989.	Implementation of a family planning component based on the recommandations of the feasibility study, started in early 1989. Nutrition Action plans for four provinces were implemented by the Provincial Health Directorates in 1992-94.
Schedule 3 (15)	By Dec. 31, 1985, present (i) a plan for strengthening national drug procurement and distribution; and (ii) an official list of pharmaceutical products in conformity with WHO's essential drug guidelines. By June 30, 1986, (i) publish a new national drug formalary based on such list; (ii) create a pharmaceutical information service in the Ministry of Health; and (iii) carry out a program to inform the public about essential drug policy.	M	Putting in place a more effective pharmaceutical policy started only in 1991.	Since 1991, action taken include: (i) revision of pharmaceutical regulation (1992); (ii) establishment of central buying agency for essential generic drugs (1992); (iii) allowing peripheral health facilities to retain the revenues from the sale of drugs (1993).

Table 9: Bank Resources: Staff Inputs

Stage of Project Cycle	Actual Staff Weeks
Preparation to appraisal	30
Appraisal	4
Negotiation through Board approval	8
Supervision	149
Completion	7
TOTAL	198

Table 10: Bank Resources: Missions

					Performance rating		
Stage of project cycle	Month/ Year	Nmber of persns	Days in field	Spcialized staff skills reprsented	Impl. status	Dev. obj.	Types of Problems
Supervision	11/85	2	5	TM	1	1	
	4/86	2	15	TM	1	1	
	8-9/86	2	16	TM	1	1	
	7/87	1	3	TM		1	Delays in construction works
	9-10/87	1	16	TM	1	1	
	2/88	1	5	TM	1	1	
Mid Term Evaluation	9-10/ 88	4	14	TM; Pub. Hlth. Spec.; Pharm. Spec.			
	11/89	1	5	TM	2	2	High turnover/ Resistance to generic drugs policy
	4-5/90	1	12	TM	2	2	Turover of MSPAS personnel/ Resistance to Generic drugs
	10-11/90	4	20	TM; Consult. (2: Hlth. Spec., Pharm. Spec.): AFTPH (1)	2	2	
	5/91	3	14	TM Consult. (2: Hlth. Spec., Pharm. Spec.)	3	3	Lack of essential drug policy/ lack of training
	11/91	3	14	TM; Consult. (2: Hlth. Spec., Pharm. Spec.)	2	2	Generic drugs, cost recovery
Supervision Preparation of 2 other projects	3-4/92	4	24	TM; Oncho Coordinator Consult. (2: Hlth. Spec., Pharm. Spec.)	2	2	Generic drugs, District health system, Cost recovery
Supervision	5-6/92	4	18	TM; Consult. (3: (2 Hlth. Spec., Pharm. Spec)	2	2	CAMEG, District Health system
Supervision Preparation of 2 other projects	9-10/92	1	12	TM	2	2	Turnover at MS.AS, resistance to generic drugs policy, Decentralization

IMPLEMENTATION COMPLETION REPORT
BURKINA FASO
HEALTH SERVICES DEVELOPMENT PROJECT
(Credit 1607-BUR)

SUMMARY OF THE GOVERNMENT'S REPORT

1. In its report the Government emphasizes its lack of experience in implementing a large-scale project and its concern that the country's financial constraints may hinder its ability to obtain the financial resources needed to cover the recurrent costs of the facilities and services introduced by the project. In the absence of pre-established monitorable indicators, the Government decided to use the expected project outputs, as specified in the Staff Appraisal Report, as proxy for these indicators. The Government estimated that objective No.1, strengthening of the basic health care system, was 95 percent achieved, while objective No. 2, development of policies and programs for health and population, was only 50 percent achieved. Objective No. 3, strengthening of the Ministry of Health, was fully achieved as a result of IDA and USAID intervention. On the whole, the Government feels that the project attained 81 percent of its objectives.

2. The report lists a number of originally unplanned activities, which were executed under the project, including the construction of the training center for district doctors, the extension of the Public Health School; the equipping of four regional hospitals, and the digging of 75 wells in rural health facilities.

3. Among the constraints that have contributed to impeding project implementation, the report mentions cumbersome procurement procedures, the considerable role initially played by the FEER in the project's construction program, cumbersome IDA procedures for financing the project and replenishing the Special Account, delays in the provision of Government counterpart funds, delays by executing agencies in carrying out their activities, and contradictory advice provided by IDA.

4. The report indicates that IDA provided continuous and satisfactory assistance to the project throughout its implementation. With regard to the Government's performance, the monitoring and coordinating activities of the project's management unit were negatively affected by a lack of coordination among the different executing agencies, poor understanding of expectations placed upon them, FEER's inadequate procurement procedures, and the inadequate amount of subsistence paid to Ministry staff while on training and supervision (a strong disincentive in the report's view).

5. While the report does not discuss the project's restructuring process in order to better achieve project objectives, it mentions as activities for the future: the completion of the ongoing decentralization of the health system, the need to elaborate a hospital sector strategy, and the need to implement population and nutrition interventions integrating the participation of both the public and private sectors. The report emphasizes that all activities are being carried out in the context of the follow up Health and Nutrition Project.

MINISTERE DE LA SANTE

SECRETARIAT GENERAL

PROJET DEVELOPPEMENT DES SERVICES
DE SANTE BP.7062 TEL. 30.86.11

BURKINA FASO

RAPPORT DE FIN DE PROJET

TABLE DES MATIERES

CGP	=	Cellule de Gestion du Projet
CSPS	=	Centre de Santé et de Promotion Sociale
CHR	=	Centre Hospitalier Régional
DAAF	=	Direction des Affaires Administratives et financières .
DEP	=	Direction des Etudes et de la Planification
DFP	=	Direction de la Formation Professionnelle
DGAHC	=	Direction Générale de l'Architecture, de l'Habitat et de la Construction
DMP	=	Direction de la Médecine Préventive
DPS	=	Direction Provinciale de la Santé
DSF	=	Direction de la Santé de la Famille
DSPh	=	Direction des Services pharmaceutiques
ENSP	=	Ecole Nationale de Santé Publique
FEER	=	Fonds de l'Eau et de l'Equipement Rural
IDA	=	Association Internationale de Développement
ONMP	=	Office National des Marchés Publics
PEV	=	Programme Elargi de Vaccination
PDSN	=	Projet de Développement Santé et Nutrition
PDSS	=	Projet Développement des Services de Santé

I. RESUME DU CREDIT ET DU PROJET DEVELOPPEMENT DES SERVICES DE SANTE

Signé le 17 Juin 1985, l'accord de crédit pour le financement du Projet Développement des Services de Santé (PDSS) à été mis en vigueur le 16 Janvier 1986 sous le numéro 1607 BUR.

EMPRUNTEUR : BURKINA FASO
BENEFICIAIRE : Ministère de la Santé
MONTANT : 26,9 Millions de DTS (somme équivalente à 28 Millions de Dollars).

1.1 - OBJECTIFS ET COMPOSANTES DU PROJET : Les principaux objectifs visaient à :

a) renforcer les soins de santé de base et les services de planification familiale, en mettant tout d'abord l'accent sur le contrôle des maladies transmissibles et le traitement du paludisme ;

b) expliciter les politiques nationales en matière de santé et de population et favoriser leur réalisation ;

c) renforcer la capacité institutionnelle du Ministère de la santé en matière de planification et d'évaluation des opérations, la mise en oeuvre et la supervision des projets.

Les composantes du Projet sont :

- travaux de génie-civil
  - Construction et/ou renovation de Cent Quarante Deux (142) CSPS avec leur équipement ;
  - Construction de Huit (8) Directions Provinciales de la Santé
  - Construction de six (6) Centres de référence (Antennes Chirurgicales) ;
- Extension du Programme Elargi de Vaccination dans quinze (15) Provinces ;
- Mise en oeuvre d'un programme national de traitement du Paludisme par la chloroquinothérapie des accès aigus palustres ;
- Développement au niveau provincial d'un programme de recyclage centré sur les soins de santé primaires ;
- Expérimentation des systèmes de recouvrement des coûts et mise en application des résultats découlant des études de faisabilité ;
- Etablissement d'un programme de planification familiale, de santé maternelle et infantile et de nutrition ;

- Mise en place de deux (2) équipes mobiles de lutte et de surveillance de la trypanosomiase ;

- Appui à la nouvelle politique pharmaceutique du Ministère de la Santé.

1.2 - BENEFICES :

Les bénéfices attendus par le projet étaient les suivants:

- amélioration de la qualité et de l'accessibilité des services de santé et de planification familiale destinés à plus de 4 Millions de personnes (soit plus de la moitié de la population totale du pays).

- Protection effective de Soixante pour cent (60%)) des enfants de 0 à 4 ans qui seront effectivement protégés contre les principales maladies transmissibles de l'enfance.

- Amélioration des compétences et des performances d'environ 1 000 agents de santé travaillant en zones rurales.

  Les perspectives du projet impliquent que les médicaments essentiels seront plus largement disponibles et à un moindre coût, dans l'ensemble du pays, tandis qu'un système de recouvrement partiel des coûts sera étendu au secteur de la santé. Le programme de planification familiale qui commence à se développer sera consolidé. Les améliorations en matière de formulation d'une politique de santé, de planification et de coordination des aides faisaient partie des effets bénéfiques qui devaient découler de ce projet.

1.3 - RISQUES :

Les risques identifiés lors de l'élaboration du projet étaient liés en grande partie au fait que le Ministère de la Santé n'avait pas l'expérience de la réalisation d'un projet de cette envergure et en partie au fait que, à la fin du projet, les contraintes économiques du Burkina pourraient mettre le Gouvernement dans l'impossibilité de supporter entièrement la charge des frais récurrents.

Pour minimiser ces risques, des mesures de limitation et de recouvrement des coûts devaient être prises dans le cadre de l'exécution de ce projet. Par ailleurs, des consultations fréquentes entre l'IDA et le Gouvernement devaient déterminer les démarches à entreprendre pour mobiliser des ressources supplémentaires destinées au secteur de la santé, afin d'aider le Gouvernement à faire face aux charges des frais récurrents.

II. ETAT DE REALISATION DES OBJECTIFS

2.1 - CRITERES D'APPRECIATION :

En l'absence de critères d'évaluation pré-établis, l'on peut se référer à certains indicateurs transparaissant dans la description proprement dite du projet.

Les tableaux suivants permettent d'apprécier l'état d'atteinte des objectifs initiaux.

2.2 - ETAT D'ATTEINTE DES OBJECTIFS

Les tableaux N°1 à 4 récapitulent l'état d'atteinte des objectifs.

TABLEAU N°1. ETAT D'ATTEINTE DE L'OBJECTIF N°1

-:-:-:-:-:-:-

Objectif No. : : Renforcer les services de santé de base et de planification familiale

COMPOSANTES DU PROJET	OBJECTIFS SPECIFIQUES	ETAT DES REALISATIONS	TAUX DE REALISATION	COMMENTAIRES
1) Extension du Programme élargi de vaccination	Quinze (15) provinces	Douze (12) provinces	80%	Action menée par d'autres partenaires sur les 3 autres provinces
2) Lancement d'un programme national de traitement du paludisme par la chloroquine	A développer	Programme développé avec système de recouvrement des coûts	100%	Deux appels d'offres ont permis d'acquérir les stocks de chloroquine au profit de la DSPH. Chaque formation sanitaire s'approvisionnait auprès de la DSPh et les recettes générées par la vente leur permettaient de poursuivre l'opération.
3) Recyclage en soins de santé primaires du personnel de santé des provinces	6 thèmes 2 fois par an	6 thèmes développés au moins une fois par an		Une évaluation a été faite par une équipe de l'ancienne Direction de la Formation Professionnelle (DFP). Un fascicule de synthèse de l'évaluation est disponible

COMPOSANTES DU PROJET	OBJECTIFS SPECIFIQUES	ETAT DES REALISATIONS	TAUX DE REALISA-TION	COMMENTAIRES
4) Construire et/ou renover et équiper des CSPS	Cent Quarante Deux (142) CSPS	158 construits et équipés	111%	Confère contraintes
5) Construire et équiper des centres de références	Six (6) Centres de références	14 centres de références développés	116%	réallocation des fonds du crédit restant
6) Etudes de faisabilité sur la gestion, l'installation du matériel et la gestion du réseau hospitalier	exécuter les études	Aucune	0%	aspects reportés à plusieurs reprises car absence de politiques et stratégies nationales en la matière. La non décentralisation de la gestion rendait ces aspects secondaires.

<u>En conclusion</u> : l'atteinte de l'objectif N° 1 est estimé à 95%.

TABLEAU N° 2 : ETAT D'ATTEINTE DE L'OBJECTIF N°2

-:-:-:-:-:-:-

Objectif No. 2 : Développer des politiques et programmes de santé et population.

COMPOSANTES DU PROJET	OBJECTIFS SPECIFIQUES	ETAT DES REALISATIONS	TAUX DE REALISATION	COMMENTAIRES
1) Système de recouvrement des coûts	Expérimenter le système de recouvrement des coûts	Initié et expérimenté au Boulgou	100%	Résultat utilisé dans la mise en oeuvre de l'initiative de Bamako.
2) Système de distribution de médicaments et d'extension des programmes de santé et nutrition	à expérimenter	uniquement pour le système de distribution du médicament dans le Boulgou		Pour le volet nutrition des documents ont été produits par des consultants mais ce volet n'a pas été mis en oeuvre.
3) Résultats des études de faisabilité	à appliquer	Etudes sur le recouvrement des coûts et distribution de médicaments dans l'étude du Boulgou font partie des éléments de références pour la mise en oeuvre de l'I.B.		Les études de faisabilité n'ayant pas été développées dans tous les domaines, leurs résultats ne peuvent être appliqués.
4) Analyse démographique	à mettre en place	Début d'exécution des activités de formation en matière de population		les plans des activités ont été élaborés avec l'appui de consultants

COMPOSANTES DU PROJET	OBJECTIFS SPECIFIQUES	ETAT DES REALISATIONS	TAUX DE REALISATION	COMMENTAIRES
5) services de planification familiale.	à développer	Uniquement au niveau du secteur public		Secteur privé n'a pas été impliqué dans le financement du PDSS.

En conclusion : l'atteinte de l'objectif N°2 est estimé à 50%

TABLEAU N°3 : ETAT D'ATTEINTE DE L'OBJECTIF N°3

-:-:-:-:-:-:-

Objectif No. 3 : Renforcement du Ministère de la Santé.

COMPOSANTES DU PROJET	OBJECTIFS SPECIFIQUES	ETAT DES REALISATIONS	TAUX DE REALISATIONS	COMMENTAIRES
1) Construction des Directions Provinciales de la Santé (DPS)	8 DPS prévues	16 construites	200%	Coût prévu pour 8 DPS a permis finalement d'en réaliser 16
2) Mise en place d'unités épidémiologiques	02 Unités épidémiologiques prescrites	02 mises en place	100%	
3) Renforcement des services de planification sanitaire et d'exécution des projets	DEP/SANTE	DEP équipée en matériel informatique, logistique et frais de supervision de la zone d'étude	100%	En collaboration avec l'USAID (cofinancement)
4) Assistance technique à fournir à la DEP	PDSS doit fournir cette assistance technique	Néant		car Intervention de l'USAID

<u>En conclusion</u> : l'atteinte de l'objectif N°3 est estimé à 100%

TABLEAU N°4 : ACTIVITES NON PREVUES ET REALISEES

COMPOSANTES RAJOUTEES	ETAT DES REALISATIONS	TAUX DE REALISATION	COMMENTAIRES
1) Forages	75 Forages équipés de pompes manuelles		Tous ces forages ont été réalisés dans les Formations Sanitaires afin d'assurer leur approvisionnement en eau potable.
2) Equipement de CHR	4 CHR équipés		Le PDSS a été prorogé à 4 reprises et suite à la réallocation des fonds du crédit restant par la Banque Mondiale, ces nouveaux volets non prévus initialement ont été pris en compte.
3)Construction du centre de formation des médecins de districts	En cours par FASO BAARA		
4) Construction de l'annexe de l'ENSP	achevée		

2.3. COMMENTAIRES

Il ressort des différents tableaux que tous les volets n'ont pas été réalisés en totalité sur fonds PDSS.

Le PDSS a respecté les activités ayant obtenu d'autres financements par l'intermédiaire d'autres partenaires du Ministère de la Santé.

III. MISE EN OEUVRE DU PROJET

3.1. *Cadre Général

Les organes d'exécution du PDSS sont les Directions techniques du Ministère de la Santé sous la coordination de la Cellule de Gestion du Projet (CGP).

La CGP est composée de onze (11) membres ainsi repartis :

- Direction = 2 membres
- Comptabilité = 2 "
- Secrétariat = 2 "
- Chauffeurs = 2 "
- Gardiens = 2 "
- Planton = 1 "

Les organes d'exécution sus-mentionnés sont :

- DSF = Volet SMI/PF/NUTRITION
- Service PEV de la DSF = Volet Vaccination
- DMP = Volet dévolution élargie
- DSPh = Volet appui à la politique pharmaceutique
- DEP = Volet formation longue durée et décentralisation
- DAAF = Volet gestion du personnel, des infrastructures et équipements
- Equipe des Formateurs Centraux = Volet formation des Médecins de districts en gestion
- FEER ET DGAHC = Volet Génie civil
- ONMP = Passation des marchés.

La clôture du PDSS a été reportée à quatre reprises pour voir son nouveau terme fixé au 31 décembre 1994. Ces reports successifs avaient pour but de permettre l'utilisation du montant restant du crédit (1607 BUR).

De nombreux facteurs ont influencé la mise en oeuvre du projet dont nous ne citerons que quelques uns.

3.2. *Facteurs favorisants

- stabilité du personnel de la Cellule de Gestion du Projet (CGP) permettant de mieux comprendre les procédures de la Banque Mondiale.

  Ainsi en Neuf (9) ans, la CGP n'a connu que deux Directeurs
  et deux (2) Administrateurs. Les autres membres n'ont pas changé.

- Existence de manuel de procédures des dossiers de la Banque Mondiale

- Supervisions régulières des activités par les missions de la Banque Mondiale.

- Autonomie de fonctionnement accordée par le Ministère de la Santé à la CGP

3.3. *Les contraintes

- Lourdeurs des procédures de passation des Marchés : Il faut en général douze (12) mois pour acquérir des équipements par appel d'offres international.

- La procédure en régie utilisée au départ par le FEER a occasionné de nombreuses malfaçons ou des retards importants.

- La lourdeur des procédures de financement ou réapprovisionnement du compte spécial.

- Les retards de paiement de la contrepartie Nationale par le trésor public.

- Les réactions tardives ou incomplètes de certains organes d'exécution.

- Les fréquentes contradictions de la Banque Mondiale elle-même sur des dossiers qu'elle a au préalable approuvés.

3.4. *Les performances de la Banque Mondiale :

A compter de la phase initiale de préparation du projet, puis de son évaluation et de la supervision, l'action de la Banque Mondiale a été permanente et satisfaisante.

3.5.*Performances du gouvernement

Les organes d'exécution du PDSS n'ont pas toujours permis d'atteindre les objectifs. Quelques raisons peuvent expliquer cet état de fait :

- insuffisance de concertation à un certain moment entre la CGP et les organes d'exécution
- incompréhension des tâches à accomplir par les organes d'exécution
- méthodes de passation des Marchés du FEER inadaptées
- taux de prise en charge de frais de mission à l'intérieur jugé faible.

VI. CONCLUSION

4.1) EVALUATION DES RESULTATS

En nous référant aux indicateurs établis pour la réalisation des composantes, l'atteinte globale des objectifs du PDSS en fin de projet est estimée à 81% et le taux de décaissement à la même période de 96%

Ces résultats sont très satisfaisants et ont certainement contribué au renforcement du système national de santé.

4.2) PERPECTIVES D'AVENIR

A la lumière des résultats du PDSS, certaines activités doivent être réalisées pour renforcer les acquis du Projet.

Ces activités se regroupent en majeure partie dans les composantes non exécutées qui font que les objectifs ne pourront jamais être atteints à 100%. Ce sont :

- Les études de faisabilité sur la gestion des installations, du matériel et du réseau hospitalier.

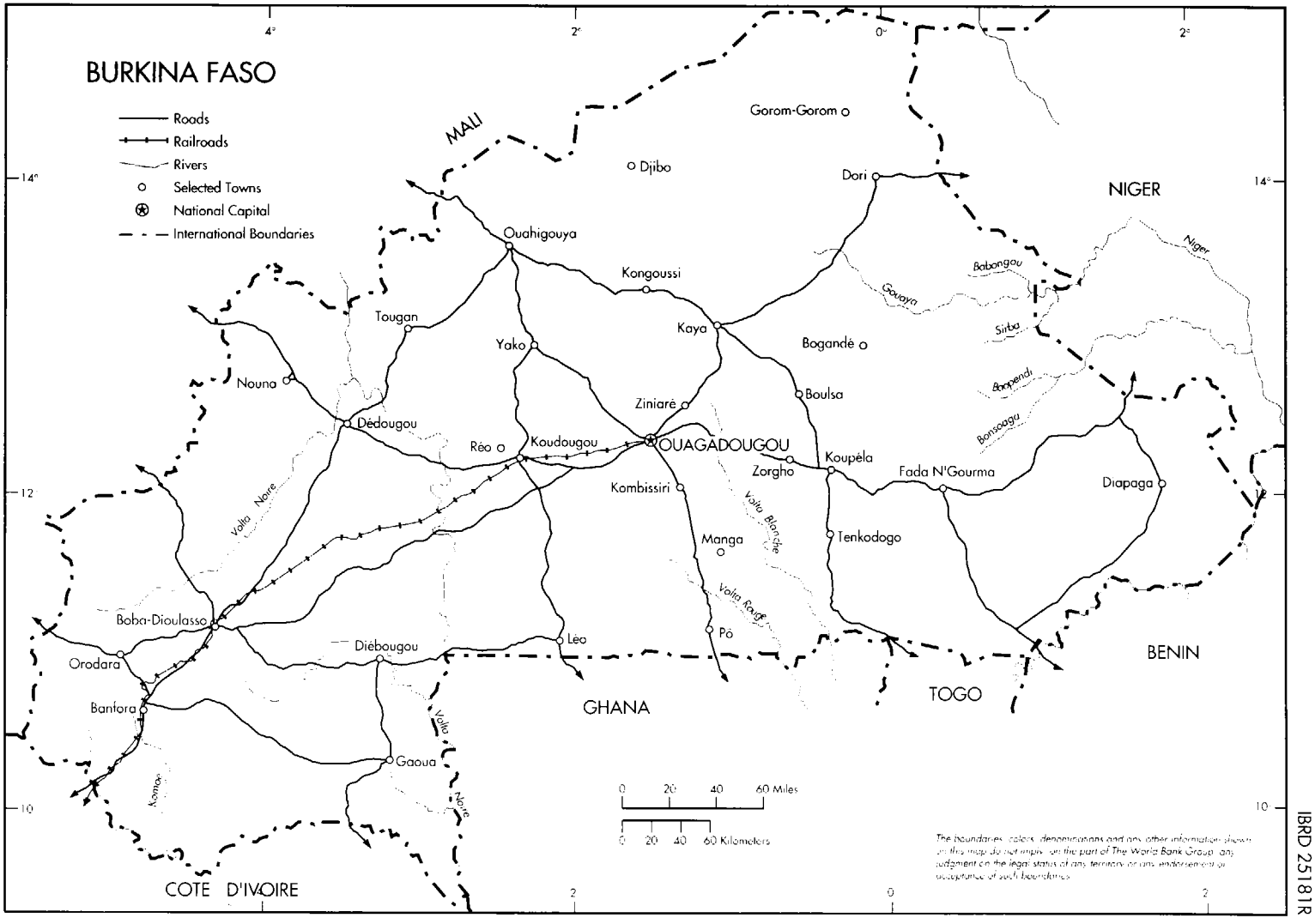
  Ces actions méritent amplement d'être développées dans un second projet.

- La décentralisation de la gestion du système de santé publique au niveau des ressources humaines, financières et matérielles.

- Le développement des politiques de population et de nutrition par l'intermédiaire des structures publiques et privées.

  La réalisation de ces trois grandes actions est indispensable pour compléter l'action du PDSS.

  Un nouveau projet intitulé Projet Développement Santé et Nutrition (PDSN), qui a pris amplement en compte ces aspects sera bientôt mis en vigueur.



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IMAGING

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