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STAFF APPRAISAL REPORT

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

MAY 31, 1994

Population and Human Resources Operations Division
Sahelian Department
Africa Region

CURRENCY EQUIVALENT

Currency unit = CFAF Franc (CFAF) / US$1 = 590 CFAF (February 1994)

ABBREVIATIONS AND ACRONYMS

ABBEF	Association Burkinabé du Bien-Etre Familial
ABSF	Association Burkinabé des Sages-Femmes
AIDS	Acquired Immune-Defiency Syndrome
AGSECAL	Agricultural Sector Adjustment Loan
AITB	Association Islamic Tidiana du Burkina
AVOB	Association of Widows and Orphans (*Association des Veuves et des Orphelins Burkinabé*)
CAMEG	Procurement Center for Essential Generic Drugs (*Centrale d'Achat des Médicaments Essentiels et Génériques*)
CBD	Community-based Distribution
CIDA	Canadian Agency for International Development
CM	Medical Center (*Centre Médical*)
CMA	Medical Center with Surgical Unit (*Centre Médical avec Antenne Chirurgicale*)
CNIEC/Santé	National Committee for IEC Activities in Health (*Comité National pour les Activités en IEC en matière de Santé*)
CNLS	National AIDS Committee (*Centre National pour la Lutte contre le SIDA*)
CONAPO	Interministerial Population Committee (*Comité National de Population*)
CP	Contraceptive Prevalence
CRESA	Regional Center of Education in Health and Hygiene (*Centre Régional d'Education en Santé et Hygiène*)
CSPS	Health and Social Development Center (*Centre de Santé et de Promotion Sociale*)
DEP	Planning and Studies Directorate (*Direction des Etudes de la Planification*)
DESA	Directorate of Education in Health and Hygiene (*Direction Education en Santé et Hygiène*)
DHS	Demographic and Health Survey (*Enquête Démographie et Santé*)
DMP	Department of Preventive Medicine (*Département de la Médecine Préventive*)
DPF	Directorate of Family Promotion (*Direction de la Promotion de la Famille*)
DSF	Family Health Directorate (*Direction de la Santé Familiale*)
ELISA	Enzyme-Linked Immunosorbent Assay
ENFS	National School of Social Services (*Ecole Nationale des Services Sociaux*)
ENSP	National School of Public Health (*Ecole Nationale de Santé Publique*)
FP	Family Planning (*Planification Familiale*)
GTZ	German Agency for Technical Coorporation (*Deutsche Gesellschaft für Technische Zusammenarbeit*)
GUD	Genital Ulcer Disease
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IEC	Information Education and Communication
IHW	Itinerant Health Workers (*Agents de Santé Itinérants*)
INSD	Institute of Statistics and Demographic Studies (*Institut des Satistiques et des Etudes Démographiques*)
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KAP	Knowledge, Attitude and Practices
KfW	Bank for Reconstruction (*Kreditanstalt für Wiedraufbrau*)
LNR	National Reference Laboratory (*Laboratoire National de Référence*)
MS	Ministry of Health (*Ministère de la Santé*)
MSAF	Ministry of Social Affairs and Family (*Ministère de l'Action Sociale et de la Famille*)
MCH	Maternal and Child Health (*Santé Maternelle et Infantile*)
MEFP	Ministry of Economy, Finance and Plan (*Ministère de l'Economie, des Finances et du Plan*)
MIS	Management Information System
MTP	Medium-term Plan (*Plan à Moyen Terme*)
NGO	Non-governmental Organization (*Organisation Non-Gouvernementale*)
OFNACER	National Cereal Office (*Office Nationale des Céréales*)
O&M	Operation and Maintenance
OST	Workers Health Office (*Office de Santé des Travailleurs*)
PASE	Epidemiological Surveillance Project (*Programme d'Appui à la Surveillance Epidémiologique*)
PCS	Population Communication Service
PHC	Primary Health Care
PSI	Population Services International
PROMACO	Social Marketing of Condoms Project (*Projet Marketing Social des Condoms*)
SDR	Special Drawing Rights
SSA	Sub-Saharan Africa
STD/STI	Sexually Transmitted Disease/Infections (*Maladies/Infections Sexuellement Transmises*)
TBA	Traditional Birth Attendant (*Sages-Femmes Traditionnelles*)
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VHW	Village Health Worker (*Agent de Santé Villageois*)
WDR	World Development Report
WHO	World Health Organization
WID	Women-in-Development

Fiscal Year January 1 - December 31

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POPULATION AND AIDS CONTROL PROJECT

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This report is based on the findings of an appraisal mission which visited Burkina Faso in November-December 1993, comprising Ms. B. Vitagliano (Mission Leader) and Messrs./Mmes. A. Kenney, J-G. Dehasse, L. Brenzel, C. Kamenga, A. Drabo, P. Ciardi, and G. Rooz. Mr. C. Bado of the Resident Mission participated in several aspects of preparation of the project. Mr. S. Ben-Halima was the procurement reviewer. Mr. T. Merrick was the Lead Advisor. Dr. S. Habayeb and Ms. M. Mac Donald were the peer reviewers. Mr. B. Fredriksen and Ms. K. Marshall are the managing Division Chief and Department Director, respectively.

TABLES:

ANNEXES:

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POPULATION AND AIDS CONTROL PROJECT

CREDIT AND PROJECT SUMMARY

Borrower:	Republic of Burkina Faso
Implementing Agencies:	Ministry of the Economy, Finance and Plan, Ministry of Health, and Ministry of Social Action and Family
Beneficiaries:	Men and women at risk in reproductive age groups, and their dependents
Credit Amount:	SDR 19.0 million (US$26.3 million equivalent)
Terms:	Standard, with 40 years maturity, including 10 years of grace
Project Description:	The overall objectives of the project are to (a) enhance the onset of fertility decline by increasing the prevalence of modern methods of contraception, and (b) slow the spread of HIV infections by promoting behavioral change and treating Sexually Transmitted Diseases (STDs). To this end, the project would support policies and investments designed to: 1. Support the Implementation of the Government's Population Policy by: (i) improving quality of, and access to, family planning (FP) and maternal and child health care (MCH) services nationwide; (ii) promoting information, education, and communication (IEC) programs in the areas of population, FP, and women's rights; and (iii) strengthening institutions in charge of implementing the national population policy and of planning, managing and evaluating FP programs; 2. Strengthen the National Capacity to Contain the Spread of HIV/AIDS/STDs by: (i) strengthening the institution in charge of implementing the national AIDS program and the health system's capacity to deal with AIDS needs; (ii) promoting safer health practices and behavioral change through information, education, and communications campaigns; (iii) promoting the use of condoms; (iv) treating STDs; and (v) strengthening clinical management and community care; and 3. Encourage Private Sector and NGO Participation in Population, FP and HIV/AIDS/STD Programs by establishing a Fund to provide grant financing for projects in those areas.
Benefits and Risks:	The project's interventions would help increase by 1999 the prevalence of modern methods of contraception in rural areas from 1.5% to 9% and in urban areas from 17% to 32%. The number of FP users would grow from an estimated 80,000 to about 350,000 in 1999. The wider practice of FP would have a particularly beneficial impact on the health of women and children. The project would help slow the spread of the HIV infection and alleviate the burden of HIV/AIDS on individuals, families and the nation.

The project would have significant returns in terms of years of healthy life saved and would hold down the indirect economic cost of AIDS - the losses of productivity and human capital, which threaten the long term economic development of Burkina Faso. Most importantly, the cost of dealing with the disease now would be small in comparison to the cost if the disease were allowed to become more widespread. The project would help combat STDs, which is one of the most effective strategies to inhibiting the spread of HIV. By 1999, reliable supplies of condoms would provide protection from HIV/AIDS/STD, to about 570,000 sexually active adult males (about 20% of the estimated sexually active male population) who are expected to be persuaded by the public information campaigns to use condoms. Distribution of condoms targeted to high-risk populations, supported by an intensive IEC effort, is expected to cover a much higher percentage of these populations. Protective supplies would safeguard an estimated 4,500 health personnel. By integrating HIV/AIDS/STD prevention in FP/MCH activities, the project would contribute to alleviating the number of infections transmitted to women. Neonatal infection would be reduced.

The project faces two major risks. First, attainment of project goals may be hampered by the fact that changing reproductive and health behavior is a difficult and time-consuming undertaking. To mitigate this risk, the project would provide heavy support to IEC activities and would use NGOs and other private sector organizations to reach those at risk. To mobilize continued, strong support for FP as well as for HIV/AIDS/STD prevention and control among political, traditional and religious leaders, the project would support (i) actions to increase the awareness of these leaders to the urgency of addressing these issues, and (ii) extensive information campaigns to which national leaders are expected to contribute actively. Second, Government's weak capacity may result in poor project implementation. This risk would be addressed through the strengthening of the institutions involved in the implementation of the project, and through heavy reliance on the private sector and NGOs. Activities in this area would complement those undertaken under other Bank Group operations to strengthen the health services delivery system.

Environmental Risks: No environmental risks are foreseen.

Economic Rate of Return: Not applicable.

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Estimated Project Costs and Financing Plan
(Net of Taxes and Duties)

	Local	Foreign	Total /a
	----------(US$ million)----------		
A. Support the Implementation of the Government's Population Policy	**4.2**	**8.8**	**13.0**
1. Improving the quality of, and access to, MCH/FP services	0.5	4.6	5.1
2. Promoting information, education, and communications programs	1.5	1.7	3.2
3. Institutional strengthening	2.2	2.5	4.7
B. Strengthen the National Capacity to Contain the Spread of HIV/AIDS/STDs	**2.1**	**10.6**	**12.7**
1. Institutional strengthening and capacity-building	0.6	3.1	3.7
2. Promoting safer health practices and behavioral changes	1.5	0.6	2.1
3. Promoting condom use	-	3.0	3.0
4. The STDs program	-	3.1	3.1
5. Strengthening clinical management and community care	0.0	0.8	0.8
C. Encourage Private Sector and NGO Participation			
Fund for population and AIDS control projects	**2.0**	**2.0**	**4.0**
Total BASE COSTS	**8.3**	**21.4**	**29.7**
Physical contingencies	0.1	0.8	0.9
Price contingencies	1.9	2.0	3.9
Total PROJECT COSTS	**10.3**	**24.2**	**34.5**

Financing Plan /a
(in US$ million)

IDA	26.3
Norway	3.0
Denmark	3.0
Government	2.2
TOTAL	**34.5**

/a Totals may not add up due to rounding.

Estimated Credit Disbursements

(in US$ million)	1995	1995	1997	1998	1999	2000
Annual	1.0	3.0	5.5	8.0	7.2	1.6
Cumulative	1.0	4.0	9.5	17.5	24.7	26.3

REPUBLIC OF BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

I. INTRODUCTION

1.1 The Government of Burkina Faso has requested IDA's assistance in financing a project to assist in the implementation of its population program and in the development and implementation of an aggressive program to slow the spread of HIV infection. Total project cost has been estimated at about US$34.5 million equivalent, net of taxes and duties, with a foreign exchange component of US$24.2 million. IDA would finance US$26.3 million of project costs. The Government of Burkina Faso would contribute about US$2.2 million equivalent. The Governments of Norway and Denmark have expressed interest in cofinancing the project and may jointly contribute US$6 million.

1.2 The proposed project would be the fourth World Bank operation in Burkina Faso in the health and population sectors. The first involvement in the sector was through the successful regional Onchocerciasis Control Program (OCP), launched in 1974, of which Burkina Faso is one of the principal beneficiaries. This operation was followed in 1985 by the Health Services Development Project (Cr.1607-BUR), expected to be completed by July 31, 1994. This project focuses on maximizing access and quality of health services and has helped implement important policy reforms in the areas of essential drugs, decentralization of the health system, and cost recovery. Achievements in the health sector would be consolidated and expanded under the new Health and Nutrition Project (approved by the Board in March 1994), which would also improve the poor nutritional status of women and children and enhance national capacity for sustained control of selected endemic parasitic diseases. Although the issues addressed by that project and the present operation are closely interlinked, separating them has helped keep each project simple and tightly focused. It has also reduced the risk of overloading the Ministry of Health's limited institutional capacity. Preparation of the two operations has been closely coordinated. The successive preparation of two IDA projects in the health and population sectors reflects the priority given by the Bank to human resources development in Burkina Faso.

II. SECTORAL CONTEXT

A. Background

2.1 With a gross domestic product per capita of US$304 in 1992, Burkina Faso is among the world's poorest nations. Agricultural production accounts for 44% of GDP, generates over 60% of export earnings, and employs almost 90% of the economically active population. The agro-climatic conditions are poor, with over 50% of the country covered with poor soils and low and irregular rainfall.

2.2 In 1990, an estimated 18% of adults were literate--27% of men and 9% of women--compared with the average for Sub-Saharan Africa (SSA) of about 60% for men and 40% for women. In primary education, only 45% of school age boys and 28% of girls are enrolled (corresponding SSA averages are 82% for boys and 72% for girls). A deprived economic situation, combined with low literacy, is largely responsible for the country's high morbidity and mortality rates, which, in turn, hamper productivity and growth. Leading causes of morbidity and mortality are malaria, diarrhea, tuberculosis, measles, and acute respiratory infections. AIDS is rapidly becoming a major threat to the population's health status and places previous and ongoing investments in jeopardy.

2.3 Despite the fairly rapid growth in food production (about 6% per year over the past ten years), the overall nutritional situation in the country is grim. Farm households sell most of their crop for cash (in part to repay their debts) and keep insufficient stocks for family consumption. At the start of the rainy (hungry) season household food stores are mostly depleted. The situation is aggravated by

the existing restrictions in the interregional movement of food. The AGSECAL and the Food Security and Nutrition Project, both approved in 1992, are supporting a number of reforms aimed at improving the country's food and nutrition situation at the national and household levels. It is estimated that 30% to 50% of pre-school children suffer from chronic malnutrition, with about 5% of them affected by severe malnutrition. About 40% of pregnant and lactating mothers are estimated to be malnourished, and maternal malnutrition accounts for 18% of children with birth weight of less than 2.5 kg, as well as for delayed child development, and high child mortality. The deficiency is not merely one of calories and proteins, but also of specific nutrients such as iron, iodine and vitamin A, leading to serious disabilities.

2.4 The infant and child mortality rates are 134 and 199, respectively per 1,000 live births. These rates frustrate efforts to reduce fertility: parents may want many children to ensure that some survive, inter alia to provide support in old age.

2.5 The low health status of women is especially concerning. A 1991 UNFPA study shows that, over the past 20 years, female mortality has been consistently higher than male mortality in the 0 to 5 and 20 to 49 age groups. The official maternal mortality rate of 810 per 100,000 live births is in all likelihood underestimated, because it is based on deaths which have occurred in public health facilities and does not take into account the many women in rural areas who never make it to a health facility. Major causes of maternal mortality are hemorrhage, eclampsia, toxemia, infections and induced abortion. Women's higher mortality rates and lower literacy level provide an indication of the unfavorable situation of women which remains a key element in the demographic and health situation of Burkina Faso (Burkina's main social indicators are listed in Annex 1).

B. The Population Sector

2.6 Population Dynamics. During the 10-year period between the first (1975) and the second (1985) population censuses, total population increased from 5.6 million to 8 million, an increase of 43%. With 48% of the population below age 15 there is built-in momentum for high growth rates for several decades as larger cohorts of women enter childbearing age. The population growth rate, until recently estimated at 2.7%, is believed to have accelerated to 3% in recent years. At this rate, Burkina's population will double in 23 years. Bank projections based on recent fertility trends and assumption about future changes suggest that the population may stabilize at 50 million in 2045. In the past, the high rate of natural increase was in part offset by an important migration to neighboring countries (in particular the Côte d'Ivoire, where there were, until recently, about 2 million Burkinabé) and Europe. Migration appears to have decreased lately due to the economic difficulties faced by most of Burkina's neighbors. In 1992 the population was estimated at about 10 million, 86% of which is rural. With about one hectare of arable land per capita, Burkina Faso already has one of the highest population densities in the Sahel, resulting in degradation of its fragile soil, biomass and water resources. Recently published findings of a 1992 UNFPA-funded demographic survey show that migration to urban areas has increased at a rate of 9% annually since 1985. The crude mortality rate has decreased from 26 per 1,000 in 1960 to 18 per 1,000 in 1990 (SSA average of 16), while the crude birth rate has remained practically stable, moving only slightly from 48 per 1,000 in 1960 to 47 per 1,000 in 1990 (SSA 46). The fertility rate dropped slightly from 7.2 in 1985 to 6.9 in 1993, according to the 1993 Demographic and Health Survey-DHS (SSA 6.5). Infant mortality decreased from the 1960 level (190 per 1,000) but remains very high (134 per 1,000) (SSA 107). Life expectancy is estimated at 48 years (SSA 51).

2.7 The above figures demonstrate the importance for Burkina to lower its fertility rates and bring about the needed demographic transition. The rapid population growth seriously undermines efforts to bring about poverty reduction, improvements in health, education, employment, and environmental protection.

2.8 Family Planning (FP). FP services were introduced in Burkina Faso in 1979 by the *Association burkinabé de bien-être familial* (ABBEF), an affiliate of IPPF, through a network of volunteers. In 1985, the Government integrated FP services into general Maternal and Child Health (MCH) Care and Primary Health Care (PHC) services and gave primary responsibility for all FP activities in the country to the Family Health Directorate (DSF) of the Ministry of Health (MS). FP services are currently available only in 250 out of 650 health centers (Centres de santé et de promotion sociale-CSPS), in all the 70 medical centers (CM), 9 regional hospitals and 2 national hospitals. Preliminary results of the 1993 DHS show a considerable gap between contraceptive prevalence (CP) in urban areas (17%) and in rural areas (1.5%). The total number of users is estimated to be about 80,000. The pill is the predominant method of contraception (50% of women surveyed), followed by condoms (19%) and IUD (17%). Condom use appears to have increased considerably in 1992, largely as a result of an effective social marketing program launched in the context of AIDS-control activities, supported by USAID.

2.9 Many donors have been active in the population/FP sector, with USAID, UNFPA, and IDA providing the largest support. IPPF supports the activities of its affiliate, ABBEF. Donors which have, at one time or another, assisted Burkina Faso's population and FP program include: the Netherlands, the Republic of Germany, the Population Council, the Center for Development and Population Activities, FP International Assistance, and Columbia University. Since 1986, **USAID** has provided about US$13 million to Burkina Faso to help develop a strong public foundation from which to expand nationwide and integrated MCH/FP information and service delivery. Its assistance covers about 82 health facilities in 14 provinces. In addition, USAID has started a few FP pilot operations in the private sector. Activities include: a community-based distribution (CBD) project carried out by the *Association burkinabé des sages femmes* (ABSF), and promotion of FP services at private clinics. USAID is expected to drastically reduce its support to Burkina's FP program, following its decision to close the Burkina Faso's office.

2.10 **UNFPA** supports FP activities in 10 provinces, promotes family life education in rural areas and population education in urban secondary schools. In addition, it financed Burkina's first (1975) and second (1985) population censuses and, since 1980, it has supported the preparation and implementation of a comprehensive population program, which includes demographic research, population policy formulation and implementation, Information, Education and Communication (IEC), and women's issues. UNFPA's total assistance has amounted to US$25 million. Present commitments are expected to continue until 1995. **IDA**'s support to FP has been provided in the context of the ongoing health project. Started in 1989, IDA-financed FP activities cover the remaining 6 provinces not covered by the other two major donors. Activities are similar to the ones conducted by USAID and UNFPA, focusing on rehabilitation of health facilities, training, provision of MCH/FP equipment and IEC. Total outlay for the FP component is about US$1.2 million. Contraceptive needs have so far been covered exclusively by UNFPA, IPPF and USAID on a grant basis.

2.11 Institutional Arrangements. Responsibilities for population-related activities is shared between the Ministry of the Economy, Finance and Plan (MEFP) and the MS. The MEFP analyzes the effects of demographic factors on development, while the MS promotes family planning mainly as a health intervention, with a goal to lower maternal and infant mortality and malnutrition. The MFFP chairs the interministerial population committee (CONAPO), which in 1991 prepared the national population policy, and is responsible for overseeing its execution through the Permanent Secretariat of CONAPO, placed directly under the Delegate Minister of Plan. Also under MEFP is the National Institute of Statistics and Demographic Studies (INSD), which is responsible for studying the interaction between demographic variables and economic development. Under the MEFP directives, other Ministries, such as the Ministry of Basic Education and Literacy, the Ministry of Secondary Education

and Scientific Research, the Ministry of Communications and Culture, are also involved in population IEC activities. The MS has primary responsibility for FP policy-making and programming, and for coordinating, supervising and evaluating all FP activities. It conducts these activities through the DSF. The Directorate of Family Promotion (DPF) of the Ministry of Social Action and Family (MASF) collaborates with the DSF in carrying out FP IEC activities.

Population Sector Development Issues

2.12 Need to Mobilize Stronger Political Support. Government support to population and FP programs has been growing in recent years. The national population policy, adopted in 1991, sets specific targets and describes the strategies to achieve them. In December 1993, the Government passed legislation defining CONAPO's and it Permanent Secretariat's role and functions in the context of the implementation of the new population policy. It also adopted a National Family Planning Strategy for the 1993-1998 period, which introduces a number of reforms essential for the expansion of the FP program.

2.13 The targets set in the 1991 Population Policy Statement are very ambitious, calling for an increase in the contraceptive prevalence (CP) from 4% (nationwide) to 60% in 2005; and a 10% decrease in the fertility rate every 5 years starting in 2005. Achieving these targets would require a radical change in behavior that can only occur over time and with a considerable effort on the part of the Government to increase public awareness of the issues at stake, build a consensus on objectives and strategies, implement well-designed action programs, and provide universal coverage of MCH services. While the Government would need considerable donor support in its effort to disseminate and operationalize the population policy, the success of the latter will ultimately depend on the continued presence of a strong political commitment, and on Government's ability to provide the leadership required to mobilize all the country's forces (political, religious and traditional) in support of the required reforms.

2.14 Limited Availability of FP Services. As indicated earlier, FP services are currently provided by DSF in less than half of the existing public health facilities. While in the urban areas, NGO-run FP clinics and the FP operations of other private sector organizations provide an additional important source of contraceptives, in rural areas there is no outreach program and the public sector is virtually the only provider of FP services. Factors that have contributed to the limited availability of contraceptives, particularly in rural areas, include: regulations (lifted in December 1993), allowing doctors, nurses and midwives, but not obstetrical assistants to prescribe contraceptives (the last group is considerably more numerous than midwives in rural areas); and preventing itinerant health workers (IHW), traditional birth attendants (TBA) and village health workers (VHW) to resupply contraceptives on the basis of a prescription provided by a public health officer; the narrow range of methods provided, focusing on the pill and, to a lesser degree, on the condom and IUD; the limited quantity of contraceptives provided to the users in the course of a visit to a health facility, making repeated visits to the facility necessary (an important reason for the high drop-out rate); and, finally, the practice of requesting the husband's consent before prescribing contraceptives. Because of the above constraints on the availability of FP services, the number of women who resort to abortion is estimated to be quite high. Since abortion is illegal, it is often performed under hazardous conditions, with considerable risks for the life of the pregnant woman.

2.15 The limited availability of FP services is one important reason for the current low CP, particularly in rural areas. Preliminary data of the 1992 DHS reveal the existence of a considerable unmet demand for FP: about 19% of interviewed women nationwide stated that they do not want more children, and about 50% would like to space childbirth for periods longer than two years. In light of the DHS results, providing good access to FP services and to appropriate contraceptive methods, using a variety of delivery systems, becomes an important priority. The private sector (NGOs, private clinics and

pharmacies) which currently covers about 20% of FP users in Burkina (1992 DHS), has the potential for reaching a considerably larger share of the population, particularly in urban areas. In rural areas, however, without the back up provided by a good public health care system, it will be difficult to develop an outreach program. Thus, the public health system will remain, for the near future, the major provider of FP services in rural areas.

2.16 Limited FP Promotion. In addition to limited availability of FP services, the Burkinabé FP program has been hampered by rather low key promotional activities which have mostly focused on raising public awareness of FP services, particularly in terms of birth spacing, leaving, however, the public with limited knowledge about the different methods available and where to obtain contraceptives. Major responsibility for planning and implementing FP IEC activities rests with the IEC Unit of the DSF, which started this activity in 1987 with the assistance of the Population Communication Services (PCS) of Johns Hopkins University under a USAID-financed project. Activities supported by PCS included: training, research, print and media-related output. The project trained eight social workers in FP communication and conducted six IEC workshops for 140 health and social workers. It also: (i) helped develop a trainers' handbook in FP communication and designed a FP/IEC curriculum for the National School of Social Services (ENFS); (ii) instituted a monitoring system for FP/IEC activities of the Ministry of Health's extension agents; and (iii) carried out IEC campaigns and FP awareness programs for opinion leaders. PCS conducted in 1992 an evaluation of its program which revealed the above mentioned limitations. The DHS provided similar findings: while over 60% of those interviewed knew of at least one modern method of contraception, only 28.4% knew where to obtain it.

2.17 Burkina's FP/IEC program has so far placed insufficient emphasis on interpersonal communication. To date, only about 50% of FP providers have received training in IEC, and those that have received this training spend very little time promoting FP activities. Because of a lack of transportation, the majority of social workers trained in FP/IEC has not had the opportunity to conduct extensive outreach activities.

2.18 Successful FP programs in other countries have relied on a mix of mass media and interpersonal communication. These two channels are complementary: mass media provides information quickly and repeatedly to a very large audience, while interpersonal communication leads to a more in-depth understanding, addresses individual concerns, and gives immediate feedback. Interpersonal communication plays a particularly important role in FP acceptance and continuation.

2.19 An immediate priority for an FP/IEC campaign in Burkina Faso is to design aggressive promotion campaigns that direct people to FP delivery points and provide specific, reassuring information about different modern contraceptive methods. The 1994-1998 FP/IEC program which PCS has designed for the DSF, places considerable emphasis on mass media and would need to be complemented with a face-to-face outreach and counseling program. Although past programs have made a good start on covering the training needs of health and social workers, much work remains to be done in the area of interpersonal communication in the public and private sectors. Another important issue in FP/IEC is the lack of coordination among the various agencies carrying out FP/IEC population activities (DSF, DPF, ABBEF, ABSF, the Ministry of Higher Education, the Ministry of Agriculture, etc.). Concerned that this lack of coordination could create duplication of efforts and inconsistency in the messages delivered, the Government organized, in November 1992, an interagency workshop to discuss this and other issues related to IEC activities for population. The workshop recommended the establishment within CONAPO of an IEC commission to coordinate all IEC/population activities undertaken in the country. DPF was given a leadership role in the commission.

2.20 Weak Institutional Capacity. The DSF is currently affected by a number of organizational problems. These include: poor supervision of staff, an information system that does not allow for proper monitoring of the results of FP activities and feedback; and an unreliable supply system for contraceptives. Supervision of staff is poor both in quality and in frequency, affecting field workers motivation and performance. Regarding FP monitoring, evaluation and research, infrastructure for these activities consists of the Management Information System (MIS) of the Planning and Studies Directorate (DEP) of the MS, set up in 1985 with USAID assistance, and the INSD. A situation analysis conducted in 1992 revealed serious problems in the quality of record collection and keeping, making it practically impossible to draw any conclusions about the performance of provincial health facilities and progress in the FP/health program. Flow of data is affected by logistic and geographic constraints, limited resources, insufficient supervision visits, providers workload or lack of competency, and the multiplicity of channels. At the central level, the DSF receives field reports directly from the CMs and the CSPS, thus bypassing the DEP and has established its own system for analyzing the data. A number of donors recently expressed interest in helping improve Burkina's health information system.

2.21 Considerable effort has been made in the past eight years to provide the necessary skills in FP to health personnel. Between 1987 and 1989, with the assistance of INTRAH (University of North Carolina), Johns Hopkins University, and the Free University of Brussels, the DSF has trained about 487 agents: 367 health agents and 120 social workers. About 127 social and health agents have also received training in supervisory techniques. Since 1990, FP training is included in the basic preparation of all paramedical personnel, provided at the School of Public Health (ENSP) and, since 1991, it has been introduced at the faculty of medicine. About 24 health personnel have received training in Tunisia, Zimbabwe and Mauritius, countries which have implemented successful FP programs. Under the FP component of the ongoing project, 295 health agents received training and refresher courses in FP between 1989 and 1992. These efforts notwithstanding, training of new staff and continual training and motivation of existing staff remains a major task, particularly in view of the expansion of FP services called for under the project.

2.22 The DSF is responsible for the procurement, storage and distribution of contraceptives and other FP supplies in the country. The system is affected by a number of deficiencies, including poor forecasting, and transportation; and the weak information system. Supply break downs contribute to contraception discontinuation and user dissatisfaction, damage morale among staff, and contribute to poor program image.

2.23 Weak Collaboration with NGOs and Other Private Sector Organizations. NGOs have played an important role in introducing and expanding FP services in Burkina Faso. ABBEF, in particular, has been a pioneer in the area. This NGO currently operates through a network of 2,600 volunteers, mostly engaged in FP/IEC, and 6 FP clinics--two in Ouagadougou, two in Bobo-Dioulasso, one in Koupea and one in Koudougou/Yako. Other NGOs involved in the provision of FP services are: the ABSF, which has two FP clinics in Ouagadougou; the Association of Widows and Orphans (AVOB), which recently opened a FP clinic in Ouagadougou; and the APAF, a Catholic association, which promotes natural FP methods. The Workers' Health Office (OST), which provides health services to formal sector employees, introduced FP services in 1992 and supplies contraceptives in about half of its 50 health facilities, located in major urban areas. An increasing number of NGOs have included FP promotion and service delivery in their activities.

2.24 An important issue in Burkina Faso is the weak Government/NGO collaboration in the health sector in general, and FP in particular. As indicated in para. 2.15, with a 20% share of the contraceptive market, NGOs still play a modest role in Burkina's FP program. This role could be expanded particularly in urban areas where NGOs have helped achieve current encouraging CP prevalence

rates. NGOs have, in particular, demonstrated a comparative advantage in the area of FP promotion, as they are more effective than the public sector in reaching target groups, largely due to their flexibility and community presence. NGOs and other private sector organizations have a limited capacity to expand, mostly due to lack of capital and expertise. The Government can help NGOs overcome these limitations, through financial and technical support, provision of clinic and office space, loaned personnel, and goods.

2.25 Private practitioners (doctors, pharmacists, village health workers, traditional practitioners) could considerably extend the public contraceptive distribution network. The Government could encourage these providers by making contraceptives available at a subsidized price, promoting their sales through mass media, training traditional practitioners, and allowing them to refill contraceptive prescriptions and make referrals to public health facilities.

C. The HIV/AIDS Situation

2.26 Following recognition of the first 10 cases of AIDS in 1986, surveillance activities have expanded in Burkina Faso to include a variety of population groups. Studies on HIV prevalence have been conducted all over the country. Although they are based on small samples of a mostly urban population, the data they provide clearly indicate that the HIV infection is rapidly expanding. Table 1 below shows HIV prevalence resulting from these studies.

2.27 The highest seropositive rates are reported among people age 20 to 39 (over 50% of the reported cases), men (over 60%), migrant workers (36%) and prostitutes. There are no data for HIV prevalence among the gold miners, another important risk groups, and data collected on seroprevalence among the military is not being released. Increases in the infection rates among pregnant women are of particular concern as this is supposedly a low-risk group. These women are considered the sample group most representative of the general adult population. The MS recently revised its estimates of the seroprevalence in the country, from 4% of the adult population to 7%. Taking into account infected newborns, it is estimated that about 450,000 persons are currently HIV positive. This prevalence rate places Burkina third, after Côte d'Ivoire and Ghana, among the Western Africa countries most affected by the infection. Reported AIDS cases increased from 10 in 1986 to 776 in 1989. As of December 31, 1992, a total of 2,886 AIDS cases had been reported, of which 1073 were reported in 1992 alone.

2.28 It is, however, estimated that underreporting is considerable and that actual cases are 3 to 4 times larger than the reported ones. The most common symptoms of HIV/AIDS patients presenting to hospitals are similar to those of other endemic diseases in Burkina Faso (chronic diarrhea, tuberculosis and other pulmonary infections). This, together with limited availability of diagnostic tests, has lead to misdiagnosis of AIDS. A rapid assessment conducted during appraisal suggests that nearly 50% of hospital beds in the gastro-intestinal and pneumophysiology wards of the national hospitals are occupied by HIV patients. Similar patterns are evident at the regional level. The mission also found that in one private clinic in Ouagadougou, 26% of first-time visits, within a two-week period, tested positive for HIV. Heterosexual transmission is predominant (85% of the cases), followed by blood transfusion and perinatal transmission. A high prevalence of sexually transmitted diseases (STDs), particularly among prostitutes and their clients, considerably increases the risk of transmission of HIV. While the probability of being infected with HIV during sexual intercourse with a seropositive person is between 1 and 5 per thousand, this probability increases to 50 per thousand in the presence of an STD.

2.29 Public recognition of the importance of the AIDS epidemic in the country is recent and so are programs to control the spread of the disease. Surveillance and IEC activities were started in 1987 with WHO and other donors' support. In 1989, the first Medium Term Program (MTP) for AIDS control was launched; and in 1990 the Government established, within the MS, the National AIDS

Table 1: Studies of HIV Prevalence in Burkina Faso

Population Group	Prevalence (%)	Sample Size	Date of Study
1. STD Patients			
Ouagadougou	23.0	200	1987
Bobo Dioulasso	18.2	192	1991
2. Commercial Sex Workers			
Ouagadougou	64.0	185	1989
Bobo Dioulasso	43.0	182	1992
3. Hospital Patients			
Ouagadougou	19.0	200	1987
Ouagadougou TB Patients	29.0	200	1987
Boulgou	34.9	292	1989
Bobo Dioulasso	22.7	573	1990
Bobo Dioulasso Children	5.3	679	1991
Gaoua	9.1	174	1991
4. Pregnant Women			
Ouagadougou	7.5	200	1987
Gaoua	5.8	147	1987
Gaoua	14.0	250	1991
Gaoua	15.0	267	1993
Bobo Dioulasso	7.8	267	1991
5. Truck Drivers	13.1	196	1993
6. Blood Donors			
Ouagadougou	11.0	200	1987

Committee (CNLS) with the mandate of "preparing, executing, coordinating and evaluating all strategies aimed at controlling the spread of AIDS in the country." The CNLS is a multisectoral body co-chaired by the Ministers of Health and Communications and comprises about 60 members. Day-to-day implementation of AIDS activities is entrusted to a Permanent Secretariat headed by the Secretary General (SG) of the MS and comprising a Deputy Secretary General, two administrators (one representing WHO) and a Permanent Secretary, with mere administrative functions. The CNLS also includes five technical sub-committees (IEC, laboratory, epidemiological surveillance, research, and case management) and program monitoring sub-committee. Members of the sub-committees include representatives of various agencies (ministerial units and NGOs).

2.30 HIV/AIDS programs have received considerable assistance from the international community. The first MTP, 1989-1992, received US$3.6 million equivalent, contributed mainly by WHO, USAID, the EC, and the Republic of Germany. This support focused mostly on improving blood screening capabilities. It helped rehabilitate two blood banks in Ouagadougou and Bobo Dioulasso, train and retrain a number of laboratory technicians, and improve the supply of medical equipment and materials. It also launched a number of sensitization campaigns. However, other important activities in the area of prevention and control such as the provision of essential drugs for the treatment of STDs and opportunistic infections, HIV/AIDS training of doctors and paramedical personnel, preparation of diagnostic and treatment protocols for STDs and launching of counseling and community care activities, have been either neglected or insufficiently carried out. The Second Medium-Term Program 1993-1995 addresses the above constraints. It is also heavily weighted towards prevention activities (75% of the

proposed budget of US$7.1 million). For the 1993 activities the Government requested US$2.5 million. IDA provided US$750,000 under the ongoing First Health Project, while the Republic of Germany, WHO, CIDA, UNICEF, and the EC agreed to provide the balance.

Issues Affecting HIV/AIDS Prevention and Control Activities

2.31 Need to Mobilize Stronger Political Support. Strong support from political, religious and traditional leaders is critical for the success of the HIV/AIDS prevention program. As the number of AIDS cases mounts dramatically in the country, the Government has moved from a stage of reluctant acceptance to one of more constructive engagement and the MS, in particular, recently started responding publicly to the crisis, declaring the fight against AIDS one of its top priority. Political authorities at all levels, including the President, should be encouraged to actively intervene to increase the population's awareness about the threat of AIDS and ensure that every sector of the society is mobilized to combat the infection. Political support would need to be backed by adequate budgetary allocations.

2.32 Insufficient Awareness of Risk Behavior. Data of the DSH survey show that awareness of HIV/AIDS is relatively high in Burkina (over 90% of surveyed persons), but that people's knowledge has yet to be translated into use of safer health practices (only 7% of men said they were using condoms at the time of the interview and only 17% declared that they had used them in the past). Focus group discussions organized during project appraisal in rural areas confirmed a high awareness of AIDS (in all the villages the mission visited there was at least one known case of AIDS), but also considerable ignorance of modes of transmission and preventive measures. People interviewed appeared frightened and asked for guidance. Adolescents, who represent about 50% of Burkina's population, are particularly at risk, as they become sexually active very early but lack the information needed to prevent HIV/AIDS. Information and prevention activities targeted to the youth thus become very urgent.

2.33 The current program of IEC activities addressing HIV/AIDS and STDs in many ways echoes that of IEC for family planning, both in achievements to date and challenges that remain. While the Government and NGO participating agencies have made a good start in implementing the IEC strategies called for in the MTP, much more emphasis would need to be given to: (a) training in interpersonal communication and other IEC techniques; (b) provision of materials for specific target groups; (c) rural community outreach programs; (d) mass media; and (e) promotion of condoms. Implementing these activities would require allocating a much higher level of funding for IEC than has been the case so far. All health units offering FP and MCH services are now charged with integrating information and services pertaining to AIDS and other STDs in their activities; programs and materials to reach high-risk groups (youth, truck drivers, migrants and prostitutes) are being developed and some have been implemented. However, as with FP/IEC, too few health workers have been trained in IEC and there is almost no time for additional IEC activities due to the pressure of other tasks. Funding for IEC activities is currently being provided by a number of donors, mostly for interventions in limited geographical areas.

2.34 Responsibility for coordinating IEC HIV/AIDS activities and refining communication strategies rests with the IEC sub-committee of the CNLS, composed of about 30 people representing twenty governmental and non-governmental agencies involved in HIV/AIDS/STD communication activities. Implementation of IEC activities at the public sector level was, until recently, the responsibility of the Directorate of Education in Health and Hygiene (DESA). This task was, however, not very efficiently undertaken and a few units in MS, such as the DSF and the Preventive Medicine Directorate (DMP) initiated their own IEC program. When the MS was reorganized in December 1992, the Government decided to dismantle the DESA and decentralize IEC activities at the regional level. It established ten regional Health and Hygiene Education Centers (CRESA), which are not yet fully

operational. In January 1994, the Government established under the MS a new Center for IEC activities (CNIEC/Santé) with the role of coordinating and supervising all health IEC activities, including those of the CRESAs. The DPF of the MASF, charged with coordinating IEC population activities, has also begun to incorporate AIDS prevention activities in its social action programs for women and families and anticipates a much larger role in HIV/AIDS IEC activities in the future. To reach the public at large, DESA utilized mass media (radio and television), and organized a few seminars for opinion leaders and workshops for radio and television broadcasters and journalists.

2.35 Limited Condom Promotion. Condoms are the key component of HIV and other STD control strategies as they are the only proven reliable means of preventing the transmission of STDs and HIV during sexual intercourse. In Burkina, condoms are mostly sold through a social marketing program started in September 1991 by PROMACO (Projet marketing social des condoms), a USAID-funded project, receiving technical assistance from the US-based NGO Population Services International (PSI). Although the program appears to be successful, with current yearly sales estimated at 3 million condoms, current use of condoms, estimated at about 2.5% of the sexually active adult male population (para. 3.59), is too low to have any impact on the growth in new HIV cases (the discrepancy between the 2.5% rate quoted here and the 7% quoted in para. 2.32 is due to the fact that condom users in the DHS do not represent continuous users). PROMACO's sales, which are mostly concentrated in urban areas, seem to have tapered off in the last year of operation. The organization appears to have reached a stage where it has to review its various operational strategies, strengthen planning, programming and supervision capabilities, expand its sales force and invest much more intensively than it has done so far in promotion activities. With financing of US$7 million equivalent to be provided by the German KFW for the period 1994-1997 (USAID financing is expected to end in April 1994), PROMACO intends to consolidate as well as expand its operations and plans to increase sales by one million a year, reaching a yearly sale of 7 million condoms by 1997. This is quite a conservative target, below what is possible to achieve through social marketing of condoms, as demonstrated by the experience of other countries. In addition to PROMACO, condoms are distributed by public health facilities whose distribution has been declining and is currently estimated at about 180,000 condoms a year. Private pharmacists also sell condoms. Major constraints to an expansion of condom sales in Burkina include: low demand, because of cultural barriers and dislike for the device; inadequate promotion of condom use; limited availability and accessibility of condoms; and their price, which in 1993 ranged from US cents 4.36 (PROMACO) to US cents 69-95 (private pharmacists) for a single condom.

2.36 Limited Information on the Development of the HIV/AIDS Epidemic. As in most developing countries, epidemiological surveillance is very limited in Burkina Faso, thus preventing a full appreciation of the gravity of the HIV/AIDS epidemics. The surveillance subcommittee of the CNLS is responsible for HIV/AIDS surveillance. In reality, one member of the sub-committee is in charge of all epidemiological surveillance in the country. The epidemiological surveillance system is poorly organized, AIDS cases are not regularly notified, nor has the Ministry provided a standard definition of AIDS to be used for the notification of AIDS cases and given clear instruction concerning notification. As a result, the HIV/AIDS situation is considerably underreported. Most of the information on AIDS in the country derives from active surveillance activities conducted by the Preventive Medicine Directorate (DMP) through its network of ten regional epidemiological centers (CSE), established in the context of the Canada-supported PASE project (projet d'appui à la surveillance epidemiologique). Sentinel surveillance, started in about 8 sites of the country, could not be continued for lack of medical and laboratory supplies, HIV tests, and limited skills among health staff. Of the eight sites, only three (Gaoua, Bobo Dioulasso, and Ouagadougou) are currently functioning.

2.37. High Level of Sexually Transmitted Diseases (STDs). STDs are associated with the same risk behavior that put a person at risk for HIV infection. In addition to posing a serious public health

threat, because STDs are responsible for considerable morbidity, such as genital ulcer diseases (GUDs), pelvic inflammatory diseases, ectopic pregnancies with consequent surgical emergencies, as well as long-term complications such as infertility, and neonatal infections (e.g., congenital syphilis and blinding eye infection), STDs accelerate the acquisition and transmission of HIV. Burkina Faso does not have a STD control program and data on the prevalence and incidence of these diseases are rather scanty. Most information available on STD prevalence comes from two surveys conducted in Ouagadougou and Bobo-Dioulasso among commercial sex workers in 1987 and 1991, showing a STD prevalence of 23% and 18.2%, respectively. Lack of diagnostic equipment, drugs and appropriate training of health workers are important constraints to proper STD treatment. Yet, the experience of other countries shows that with modest investment in the identification and treatment of STDs those most at risk for HIV could be effectively protected. Treated cases of STD can cost as little as one dollar, especially if the intervention is targeted at a high prevalence group. With financial and technical assistance from IDA, the Government is preparing a STD/HIV rapid risk assessment to identify the more important STD infections in the country and determine their prevalence.

2.38 Weak Institutional Capacity. The CNLS, which has the task to lead Burkina Faso's campaign against AIDS, lacks at present the strength needed to provide the required leadership and support to the different agencies involved in the implementation of AIDS control activities, both in the public and private sector. The present organizational structure of the CNLS is an important constraint to the effectiveness of its operations. As indicated earlier (para. 2.29), the Permanent Secretary of the CNLS (the only permanent staff of the Secretariat) has limited authority and resources. The heads of the five technical sub-committees are all directors of different MS's units, reporting directly to the General Secretary of the MS (who is the effective head of both the Permanent Secretariat and the monitoring subcommittee) and bypassing the Permanent Secretary, a physician and a middle ranking civil servant. The legislation which established the CNLS in 1990 does not specify the roles and relationships of the three main structures of the CNLS, i.e., the interministerial committee, the technical subcommittees and the Permanent Secretariat, in the elaboration and approval of AIDS policies and strategies. The situation resulting from this lack of clarity and from the weakness of the Permanent Secretary's position is one of confusion, dispersion of efforts and relative paralysis. The General Secretary and the heads of the technical subcommittees are overburdened with other tasks and have a very limited time to dedicate to the activities of the CNLS. In fact, most sub-committees have had infrequent meetings since their establishment in 1990.

2.39 A draft decree reorganizing the Permanent Secretariat was recently submitted to the Minister of Health for his approval. While giving the Permanent Secretary more authority and responsibility in the conduct of his activities (the Secretary would become the effective head of the Secretariat), the proposed new legislation does not mention staffing of the Secretariat and it fails to clarify the role of the technical sub-committees and their relationship vis-à-vis the Permanent Secretary. Mobilization of other sectors' agencies (NGOs, sector ministries, other private groups) to reach larger segments of the population with information about the epidemics is still limited to date.

2.40 HIV/AIDS/STD prevention and care activities are integrated into the existing public health infrastructure. The system is affected by numerous constraints including understaffing and lack of basic drugs, supplies and equipment. This situation contributes to the low quality of services and to their underutilization (it is estimated that less than 30% of the population uses public health services). Burkina Faso has a health personnel of 5,850. This number includes: 409 doctors (1 per 22,700 inhabitants), 1,927 nurses (1 per 4,826 inhabitants), 241 midwives (1 per 38,000 inhabitants), and 394 obstetrical assistants (1 per 23,600 inhabitants). With exception of the number of people per doctor which is close to the SSA ratio (24,600), other ratios are low even by SSA standard (one nurse/midwife for 2200 people). In the 1980s, the Government launched a campaign to encourage the establishment of village

health posts, staffed with traditional birth attendants (TBAs) and village health workers (VHWs), both volunteers. Out of about 6,000 village health posts established during this time, a little over 2,000 are currently functional. The problem of poor staffing in health facilities is worsened by the fact that over 50% of health personnel is concentrated in urban areas which account for only 20% of the population according to most recent data. For example, only 38% of Burkina's midwives provide service in rural health facilities.

2.41 The HIV/AIDS epidemic exacerbates existing constraints of the health sector. The technical and operational capacity of MS's personnel to deal with HIV control is extremely weak. A survey undertaken in 1991 among health personnel and social workers in 10 of Burkina's 30 provinces provided following disturbing results:

- only 10% had received any formal HIV/AIDS training;
- about 60% said that AIDS had never been discussed in any meeting;
- 13% was unable to explain the meaning of the AIDS acronym;
- 21% was unaware of the mother/child transmission;
- 20% was unaware that traditional practices such as circumcision and scarring could contribute to the spread of HIV;
- over 30% did not know the etiology of AIDS and its clinical characteristics.

2.42 The poorest information about the infection was found among social workers, with more than 50% either not knowing the infection or being unable to explain its etiology, mode of transmission, and risks for contamination. The survey also revealed that only one third of health personnel took precautionary measures in his/her daily work and that protective supplies were generally lacking. Doctors had a considerable better knowledge about HIV/AIDS than paramedical staff. However, their lack of expertise on how to deal with the infection, leads them to prescribe very costly therapies.

2.43 While strengthening of the health system is the focus of the ongoing health operation and the proposed follow up project in health and nutrition (para. 1.2), the present project addresses the formidable challenge of improving the capacity of the health system to deal with the spread of the HIV epidemics. Improvement in the public health sector will, however, take time to materialize and there are many risks involved given the weakness of the system. It is, therefore, essential to encourage a greater involvement of NGOs, which have more effective access to the community.

2.44 Insufficient Focus on the Implications for Women of HIV. In Burkina Faso, 85% of HIV infections are due to heterosexual transmission. This means that women are increasingly being infected, and soon the infection rate among women will be equal to that of men. Women with HIV infection are younger than men at the time they develop AIDS, reflecting the typical age-gender distribution of sexually transmitted infections. And, as with STDs, the risk per exposure for a women acquiring the infection from her infected male partner is greater than the risk for a man acquiring it from an infected partner. In addition to biological factors, traditional harmful health practices such as circumcision (still widely practiced in Burkina Faso) make women more vulnerable to HIV. Women's low socio-economic status, higher illiteracy, more limited mobility which constrains their access to information, are additional contributing factors to their vulnerability to AIDS. With more women being infected with HIV, perinatal transmission of the infection will also increase. It is estimated that one in every four children born to an infected mother is itself infected. The presence of STDs is known to increase several-fold the susceptibility to acquiring HIV (para. 2.28). This has important implications for women, since in the initial stages of these diseases up to 60% of infected women are asymptomatic. Women and children are also more likely to be exposed to HIV transmission through blood products than men, as they receive a high proportion of blood transfusions administered in the country. All the above issues show that

providing women with information about the connection between HIV/AIDS/STD and reproduction is an urgent priority. HIV/STD prevention need to be integrated into MCH/FP services. Women's groups would need to be mobilized to help address AIDS and other STD issues among women. Finally, research should not only target women as transmitters of the disease but also as recipients and address the social and gender dimension of HIV and STD.

2.45 Legal and Ethical Issues. A number of social, legal and ethical issues are connected with HIV infection and control. These include: patient notification of the results of the HIV test; notification to the authorities; confidentiality of results to protect the rights of infected individuals; the right of society to be protected against the spread of the disease; job protection for those declared seropositive; protection of medical personnel exposed to HIV/AIDS-infected persons; and the care of persons with AIDS. Partner notification is an issue particularly relevant to women.

2.46 The evaluation report of the first MTP showed that in Burkina Faso HIV tests were being undertaken on patients without their knowledge and the results were often not communicated to the interested party. The report proposed the establishment of an ethical and legal committee, composed of representatives of different groups in society: private associations, NGOs, the Government, the judicial system, the medical profession, and religious organizations. Funds have been provided under the ongoing health project to help establish such a committee and develop legislation setting forth Burkina's policy on AIDS. The proposed project would continue providing support in this area.

2.47 Impact on Health and Social Services. At the rate HIV prevalence is increasing, Burkina Faso could have a million HIV-infected people by the year 2000. With the disease spreading to communities, a major burden will be placed on an already weak health system. The number of AIDS patients in the gastro-intestinal and pneumophysiology wards of the national and regional hospitals have dramatically increased in the past few years (about 50% of the beds are occupied by AIDS patients) placing a considerable strain on services that are underfunded and lack basic resources. In addition, there is the longer-term problem of children who lose one and, eventually perhaps, both parents because of AIDS. The number of orphans will increase in the coming years. Public sector social services are too weak and have too few resources to be able to adequately deal with the social problems created by AIDS. There is a need to encourage other, more community-based types of support. NGOs can also help provide affordable and effective coping mechanisms.

2.48 Economic Impact of AIDS. AIDS has more severe economic implications than other prevalent diseases, because it is fatal, it strikes the adult population at the peak of its productivity, it affects both the wealthy and the poor, and it is widespread. A rapid assessment was conducted during appraisal to quantify the direct and indirect costs of the disease. The assessment, the first attempt of this kind in the Sahel, showed that the cost of treating the disease is significant. **Direct economic costs** (or the value of all resources used in patient care) per episode of hospitalization ranged from US$127 to US$352 (at the pre-devaluation exchange rate of US$1 = CFA 275), with an average economic cost per hospitalization of US$238 for diarrheal disease and of US$317 for tuberculosis patients. The most important cost category was that of medications, which represented approximately 54% of the total economic cost for diarrheal disease patients, and 21% of the total cost for tuberculosis patients. Personnel costs accounted for between 11% and 27% of total hospitalization costs, with the remainder representing overhead costs of the health facility. Total average lifetime cost of treating AIDS (ambulatory treatment and hospitalization) was estimated at US$416. Multiplying this cost by the number of new cases reported in 1992 (1,073), total direct costs of HIV/AIDS is estimated to be US$446,000, or 5.2% of the MS recurrent expenditures in 1992. Although a Government decree exempts AIDS and tuberculosis patients from paying for their hospital stay, it is estimated that patients bear a large share of the cost (60% in the

case of diarrheal diseases). Financial outlays per patient/hospital day averaged US$18 in the sample. These figures compare with those found in other African countries.

2.49 Financial outlays for AIDS by the patients and their families is, however, much higher. It was evident from patient interviews that multiple sources of health care had been utilized prior to hospitalization. Total expenses ranged from US$79 to US$2,315 for the disease, an average of US$564 (removing high and low values). This figure is almost twice that of the 1993 per capita GNP of US$ 290, suggesting that treatment and management of AIDS is expensive and the burden is spread over the entire extended family. Traditional healers, used by some patients almost exclusively, were quite an expensive source of care.

2.50 The average age of the interviewed patients was 33. The average income was US$290 equivalent (same as the 1993 GNP per capita), although patients in Ouagadougou had higher income (US$476). The number of days lost from work ranged from 22 to 183 days, with an average of 79 days for the sample. Multiplying this figure by an estimate of daily income (US$1.10) the value of lost work ranged between US$24 and US$201.

2.51 The **indirect costs of AIDS** are a measure of the product lost to the economy which the AIDS victims would have otherwise contributed. To estimate the present value of the indirect cost of AIDS, a loss per AIDS death of 43 years was assumed per man and of 49 years per woman. This results in a total of 48,283 healthy life years lost in the population distributed among men and women (assuming an incidence rate of 0.173 per 1,000 population). Using a discount rate of 3%, approximately 17,900 healthy life years are lost to men and 9,635 to women in 1992, for a total of 27,535 discounted healthy life years lost. Assuming that everyone has the same annual income (US$290), the value of the number of healthy life years lost is US$7.9 million, or about 18 times the direct cost of AIDS, which is similar to the ratio found in countries such as Tanzania and Zaire.

2.52 Using the simplified version of indirect cost estimates (same annual income of US$290), the **total economic impact** per year (the sum of direct and indirect costs) of AIDS is estimated to be US$8.4 million. However, if GNP per capita is adjusted to take into account that 70% of AIDS cases are found in urban areas and that 59% of the urban population earns US$416 a year, 11% about US$1664 a year, and the remainder 30% is between these two categories (while the rural population has an income of about US$150 a year), the total economic impact of AIDS doubles to US$16 million. These figures are substantial and are expected to rise dramatically, as the number of AIDS cases increases.

D. Government Strategy

2.53 Family Planning. In 1991, the DSF prepared the *Politique et standards de SMI/PF*, a document establishing guidelines for all FP and MCH practitioners in public and private health facilities. The document was approved by the Government in July 1993. In November 1992, a multisectorial task force, chaired by the DSF, prepared a National Family Planning Strategy for the period 1993-1998. A preliminary CP target set by the task force for 1998 (15%) has been revised (para. 3.5) in light of the results of the DHS, which showed that the actual CP was much lower than the Government had estimated and that a wide gap existed between rural and urban CP (para. 2.8). The FP strategy, adopted by the Government in December 1993, revises a number of regulations inhibiting the expansion of the FP programs such as the interdiction to obstetrical assistants to prescribe hormonal contraceptives. Allowing these health workers to prescribe and provide contraceptives will considerably increase contraceptive accessibility as they are more numerous than midwives in rural areas. The strategy also recognizes that in order to achieve a meaningful increase in the CP it will be necessary to go beyond the constraints of the public health system by developing an outreach program and intensifying the collaboration with the

private sector, in particular with NGOs. Finally, it allows IHW, TBA and VHW to refill contraceptive prescriptions.

2.54 The Government estimated the cost of implementing the strategy to be about US$15.5 million for the 1993-1998 period. Given the financial constraints it currently faces, the Government will be able to cover only a fraction of these costs, and is requesting the donor community to help finance the remaining costs. With UNFPA facing financial difficulties and USAID planning to substantially reduce its financing of FP activities in Burkina, IDA is expected to become the major supporter of the Government FP strategy.

2.55 Health Services. The key objectives of the Government's current health services strategy are: (a) strengthening the health care pyramid by promoting decentralization, integrating vertical programs, and improving capacity at the central and regional levels to enhance management of human, material and financial resources; (b) improving the supply and minimizing the cost of essential drugs; and (c) encouraging increased accountability and cost recovery mechanisms throughout the health system in line with the UNICEF/WHO-sponsored Bamako Initiative which has been endorsed by the Government. A key element of the Government's health services strategy is the strengthening of health services at the peripheral level through creating "Health Districts" centered around medical centers with surgical facilities (CMAs). District health authorities will supervise and control primary health care activities, through the CSPS at the community level and through CMAs at the district level.

2.56 Control of endemic diseases is an important aspect of the Government health strategy. Epidemiological services are essential to maintain this control. Responsibility for these services at the central level rests with the Service of Epidemiology of the Directorate of Preventive Medicine (DMP). The resurgence of various endemic diseases such as malaria and schistosomiasis and, foremost, the emergence of AIDS, have highlighted the need for a much stronger epidemiological surveillance and control than has been the case so far. The government strategy in this area is based on its Devolution Plan for onchocerciasis, trypanosomiasis, and dracunculiasis first prepared in 1988. It consists of (a) active epidemiological surveillance of these diseases by four trained mobile teams, and (ii) passive surveillance, treatment of cases, and increasing awareness of the characteristics of these diseases among populations by CSPS health workers who will be trained by district medical officers. Strengthening of DMP's Service of Epidemiology to be carried out under the health and nutrition project will be complemented by the strengthening of AIDS and STDs epidemiological surveillance proposed under this project at five sentinel surveillance sites and at the district level.

2.57 STD/HIV/AIDS. The Government's comprehensive strategy for AIDS control is set out in the second MTP (1993-1995) discussed in para. 2.30. The National STD program has been incorporated into this program. The MTP describes in detail major objectives and sub-objectives of the program, strategies and activities to attain stated objectives, the estimated costs (US$7.1 million) and a timetable of activities until 1997. The MTP has also elaborated process and program indicators. The plan is expected to be revised annually.

E. The Bank Group's Role

2.58 Lessons From Project Experience in Burkina Faso. The proposed project would be the Bank's second intervention in the population sector in Burkina Faso and the first in the area of HIV/AIDS/STD control. In population, IDA's first health project (para. 1.2) has helped expand FP services in six selected provinces. The lessons from that project suggest that greater attention needs to be paid to: (i) ensuring that the necessary policy reforms are in place prior to start up of project investments; (ii) decentralization of activities, coupled with training and supervision through district

management teams; (iii) improving the quality of existing health care facilities; and (iv) active demand creation and government support for FP activities are essential to increasing acceptance rates.

2.59 The Bank's role in Burkina's PHN sector has grown considerably in the past few years. Through the policy reforms it has supported under the ongoing project, and through the preparation of the Health and Nutrition Project, as well as through its macro-economic policy dialogue, IDA has been able to make a significant impact in areas where other donors had not succeeded (e.g., essential, generic drugs; financial autonomy of peripheral health facilities; redeployment of staff to rural areas; and reorganization of the health system). The Government, which in the past preferred to use grant funds for expenditures in the social sector and, during the implementation of the First MTP for AIDS, had not solicited IDA's support, has come to rely on IDA for support to carry out its human resources development efforts.

2.60 Lessons from Project Experience Elsewhere. Lessons from Bank Group population projects implemented worldwide and summarized in OED reports suggest that: a) in countries with very scarce resources and just beginning to address population issues a focused approach has better chances of success; b) institutional reforms essential for successful project implementation should be pre-condition for Bank Group lending; c) there is a need to strengthen and maintain a commitment to population and FP on the part of all officials responsible for implementation of the program; d) there should be a firm agreement between the Bank and the Borrower on the objectives to be attained and the need to have a firm organizational base for the FP program; and e) efforts in FP need to be integrated with efforts to directly reduce the demand for children, such as female education, and programs aimed at increasing women's income earning capacity and reduce child mortality. To date, the Bank Group has financed three free-standing AIDs projects (Zaire, India and Brazil), two free-standing Sexually Transmitted Infection (STI) Project in Zimbabwe and Uganda, and AIDS components in several projects. The main lessons provided by those experiences and others gained internationally, both in developing and developed countries, are as follows: (a) interventions in the early stages of the epidemic have a greater impact and a higher benefit-cost ratio than interventions at a later stage; (b) large-scale condom promotion has resulted in large observed changes in sexual behavior and significant increases in condom use; (c) efforts to control STDs should be integrated with AIDS prevention efforts; and (d) NGOs can play an important role in reaching high risk groups. To the extent feasible, all these lessons have guided the development of the proposed project.

2.61 Rationale for IDA Involvement. IDA's country strategy for Burkina Faso is presented to the Board in a free-standing document together with this operation. The strategy rests on the following three elements: (i) assisting the Government in creating a policy and regulatory environment more supportive of the private sector; (ii) helping the Government manage public resources more efficiently: and (iii) supporting critical actions needed to alleviate long-term constraints on economic growth and social development, with a focus on population, health and education. The proposed project is a central part of this assistance strategy. The programs required to implement this strategy need considerable external financial support and a strong Government commitment. IDA has played a catalytic role in a number of important policy reforms recently adopted by the Government in the health sector (para. 2.59) and is best situated to mobilize the needed assistance from the donors' community and to influence the Government's strategies. The proposed project is also consistent with IDA's human resources development and poverty alleviation objectives in the Sahel, as well as with the AF5 AIDS prevention strategy. Finally, the project would provide a framework for enhanced donor coordination in the areas of population and HIV/AIDS prevention.

III. THE PROJECT

A. Project Objectives and Scope

3.1 The overall objectives of the project are to enhance the onset of fertility decline by increasing the use of modern methods of contraception, and slow the spread of HIV infection by promoting behavioral change and treating STDs. To attain these objectives, the project would support policies and investments designed to: (a) support the implementation of the Government's population policy, and (b) strengthen the national capacity to contain the spread of HIV/AIDS/STDs.

3.2 The project finances the bulk of the Government population/FP and HIV/AIDS/STD control programs for the 1995-1999 period. Because a number of traditionally important donors in the health and population sectors, such as USAID and the Canadian CIDA, are phasing out their support to Burkina, while other donors, such as UNFPA and WHO, have had to reduce their participation due to financial difficulties, the Government has increasingly come to rely on IDA for the provision of funds needed to implement the two programs.

B. Project Description

3.3 The activities the project would support are summarized below.

PROJECT COMPONENTS

1. **Support the Implementation of Government's Population Policy (US$15.6 million):**

   (a) Improving the quality of, and access to, MCH/FP services:
   - (i) expanding FP services through the Public Health System
   - (ii) establishing an outreach program

   (b) Promoting information, education, and communications programs:
   - (i) increasing support for population issues among opinion leaders
   - (ii) increasing public knowledge of, and demand for, contraceptive services
   - (iii) enhancing public understanding of women's rights and problems

   (c) Institutional strengthening:
   - (i) strengthening CONAPO's Permanent Secretariat
   - (ii) strengthening the Family Health Directorate (DSF)
   - (iii) strengthening the Family Promotion Directorate (DPF)

2. **Strengthen the National Capacity to Contain the Spread of HIV/AIDS/STDs (US$14.9 million)**

   (a) Strengthening the national AIDS committee and the health system's capacity to deal with AIDS needs
   (b) Promoting safer health practices and behavioral changes through information, education, and communications campaigns
   (c) Promoting the use of condoms
   (d) Treating STDs
   (e) Strengthening clinical management and community care

3. **Encourage Private Sector and NGO Participation in Population, FP, and HIV/AIDS/STD Programs (US$4.0 million)**

   (a) Establishing a Fund

3.4 Project health and FP activities would be integrated into the existing health infrastructure. They would, however, to the extent possible, make use of the existing network of NGOs and of the private sector. The Government's strategy for population and AIDS control is stated in two letters of Sector Development Policies, which include time-bound indicators (Annex 2).

1. Support for the Implementation of the Government's Population Policy (US$15.6 million)

a. Improving the Quality of, and Access to, MCH/FP Services (US$6.2 million)

3.5 This component would support the implementation of the National FP Strategy. A complement to ongoing activities financed by IDA, USAID and UNFPA, it aims at increasing the contraceptive prevalence from 17% to 32% in urban areas and from 1.5% to 9% in rural areas by 1999, thus increasing the number of FP users from 80,000 to about 350,000. To improve the quality of FP services considerable emphasis would be given under the project to upgrading the skills of health workers through training and providing them with the needed supplies. Access to FP services would be improved by (a) expanding services provided by the public health system; and (b) establishing an outreach program.

3.6 Expanding FP Services through the Public Health System. With donors' support, the DSF has established FP services, integrated into MCH services, at the level of national and regional hospitals (CHN and CHR), of medical centers (CM), and in 250 of about 650 existing health centers (CSPS) (para. 2.8). The proposed project would help extend coverage of FP services to the remaining 400 CSPS. To help achieve this objective the project would finance the following activities: (i) FP training of 700 nurses and 400 obstetrical assistants; (ii) training of 60 regional trainers, 50 doctors and 100 nurses in NORPLANT insertion; (iii) provision of contraceptives to meet 80% of national needs; and (iv) support for MCH activities. To develop a standard approach to FP/MCH services, the DSF has elaborated performance norms for each level of service and has established mandatory qualifications for the personnel providing FP/MCH services. Norms and qualifications are summarized in the document *Politique et standards de SMI/PF* (para. 2.53).

3.7 Training will focus on developing the technical competence as well as counselling skills of health personnel and will be reinforced through close supervision. DSF's team of trainers would organize 20 three-week FP workshops to provide FP training to nurses and obstetrical assistants. This training would take place in DSF's five regional training centers. The health districts being established under the ongoing health operation and the new health and nutrition project would gradually take over this training. In addition, 6 two-week workshops would be organized to train regional FP trainers, physicians and nurses in NORPLANT insertion.

3.8 The MS has transferred two physicians to DSF to strengthen its supervisory function. Both training and supervision should improve and become more sustainable as the MS decentralizes its activities and training will become the responsibility of the district medical officer. Staff at DSF's regional training centers would provide support to the districts for FP training. A detailed training program for the project was discussed and agreed upon at negotiations. Approval by the Government of the agreed training program would a condition of credit effectiveness. The training to be supported under the project is summarized in Annex 3.

3.9 The DSF has estimated contraceptive needs for the 1995-1999 period, based on the target CP rates set for 1999 and the mix of contraceptive methods envisaged (Table 2).

3.10 While in the past, UNFPA, USAID and IPPF covered all the country's contraceptive needs, due to reduced support from these donors, in the future, 80% of these needs (about

US$4.4 million) would be met by IDA. The list of contraceptives to be imported in the country has been integrated into the official list of essential drugs. NORPLANT, a surgical implant that provides protection against contraception for up to five years, was successfully introduced in Burkina on a trial basis, in 1992. Women's interest in this contraceptive also became evident during the DSH survey: although the interviewers asked no questions about NORPLANT, women spontaneously inquired about the method.

Table 2: Contraceptive Needs for the 1995-99 Period

Methods	Users 1999 (%)	Costs 1995-99 ($ '000)
Pills	40.0	2,165
IUD	16.0	74
Injectables	11.0	317
Condoms	17.5	1,728
NORPLANT	7.0	828
Vaginal tablets	2.5	418
Sterilization	6.0	24
Total	100.0	5,554

3.11 Contraceptives and condoms for both the FP and AIDS prevention programs would be procured through the new buying agency for essential, generic drugs (CAMEG), established with the assistance of IDA and other donors. However, in view of MS's inexperience in directly procuring these items (their procurement has so far been handled by donors) and the need to base these purchases on detailed procurement tables which take into account current usage patterns and usage projections (oral contraceptives and condoms have a short shelf life), MS would receive assistance from WHO for the procurement of condoms and that of UNFPA for the procurement of contraceptives. These agencies would assist the MS in the preparation of detailed procurement tables and ensure that procurement is made from reliable sources only. WHO has considerable experience in procuring high-quality, low-cost condoms. Government signing of technical assistance agreements with WHO, for the procurement of condoms, and with UNFPA, for the procurement of contraceptives, would be a condition of credit effectiveness. During negotiations, the Government gave assurances that (a) it will review with IDA the above technical assistance arrangements at the end of the second year of project implementation to decide whether to further extend them, and (b) following the first shipment of contraceptives and condoms, it will monitor their distribution and take corrective actions if logistics or stock management are not found satisfactory. Monitoring would include the undertaking of bi-annual contraceptive prevalence (CP) surveys using rapid assessment procedures.

3.12 Successful promotion of FP activities would also depend on the credibility of MCH services being offered in health facilities and their ability to attract potential clients for FP. Preliminary results of an evaluation of the Government's MCH program for the 1988-1992 period point to several shortcomings in the program: (1) lack of essential drugs, supplies and equipment in health facilities; (2) lack of emergency care in rural areas; (3) failure to provide proper information to mothers about their health conditions and that of their children; (4) absence of health education; and (5) poor health provider/client relationships. This last constraint was also identified in the course of a beneficiary assessment conducted in 1992 in three provinces of Burkina Faso as part of the preparation of this and the Health and Nutrition Project, and appears to be an important factor in the low utilization of public health services. Based on the findings of the evaluation, DSF has elaborated a new MCH strategy for 1994-1998, establishing the following priority areas for action: (i) improving the quality of MCH services through training of staff and provision of drugs, supplies and equipment; (ii) ensuring regular supervision; (iii) improving communications skills of health personnel; and (iv) improving data collection and analysis.

3.13 MCH activities at the district level would receive support from the recently approved Health and Nutrition Project, which would finance training, equipment, materials and drugs, and nutrition activities. The proposed project would integrate this support by addressing some of the barriers to prompt and adequate treatment of complications of pregnancy such as the availability of transportation and

encouraging programs within communities (carried out by NGOs and other private organizations with financing provided under the Fund) that would be directed toward educating community members, especially women and TBAs, to recognize the symptoms of serious complications of pregnancy or delivery and educate them about the danger of delays. To address the lack of transportation at the village level for the evacuation of emergency cases, the project would finance the construction of animal-drawn village ambulances for 400 selected villages, which would be responsible for their upkeep. The animals (donkeys) would be provided by the villagers. The DSF would also test, under the project, carts to be drawn by motorcycle. During negotiations, the Government gave assurances that it will (a) construct animal-drawn village ambulances for about 50 selected villages; (b) evaluate the effectiveness of the ambulances after one year; (c) report the result of the evaluation to IDA; and (iv) expand, if found satisfactory and recommended by IDA, such construction to an additional 350 villages.

3.14 Project Support. The project would finance: FP training equipment; the design and construction of 400 carts for the emergency evacuation program; contraceptives; specialist services for the evaluation of the village ambulances pilot operation and for studies and research; training of 400 obstetrical assistants, 800 nurses, 50 doctors and 60 regional trainers (para. 3.6); operating costs for field supervision (the Implementation Manual to be finalized before the project launch seminar will contain detailed terms of reference for field supervision); and the maintenance of training equipment.

3.15 Establishing an Outreach Program. The recently approved national FP strategy (2.53) authorizes itinerant health workers (IHW), traditional birth attendants (TBA), and village health workers (VHW) to refill contraceptive prescriptions (pills) for women who have already been screened by a health facility. This outreach program would be introduced in 400 villages where TBAs have already received some FP/MCH training under a UNFPA-financed project. 400 TBAs would receive one-week training and an initial free supply of pills. They would be able to restock their supply at a public health facility with the proceeds of their sales. The program would be supervised by the DSF. A cost-recovery program for essential drugs (including contraceptives and preservatives) soon to be implemented in the context of the Health and Nutrition Project will establish the benefit margins at each level of the distribution chain down to the TBAs.

3.16 The project would support community-based FP distribution programs to be carried out by NGOs with financing provided under a Fund (para. 3.71). Pilot operations similar to the one carried out by ABSF with USAID financing (para. 2.9) would be given priority in the criteria for Fund allocations.

3.17 The sub-component would include institutional and operational support for the IPPF-affiliated ABBEF. This support would include: (a) the extension of the existing model clinic in Ouagadougou; (b) a pilot project for a community-based distribution (CBD) of contraceptives in the provinces of Houet, Kouritenga and Kadiogo; and FP and AIDS/STD counselling services targeted to the youth in the town of Koudougou. During negotiations, the Government gave assurances that it will support ABBEF through (a) the construction of an extension to the model clinic in Ouagadougou; (b) the implementation of a pilot project of a community-based distribution of contraceptives in three selected provinces; and (c) FP and HIV/STDs prevention counselling to youth in Koudougou.

3.18 Project Support. The project would finance: civil works for the extension of ABBEF's clinic in Ouagadougou; furniture and equipment for the clinic; audio-visual equipment and material for ABBEF's IEC activities; 53 motorcycles for the midwives' supervisory activities (to be placed at the district level); the training of TBA's and ABBEF's staff and volunteers carried out by the DSF; operating cost for field supervision, the details of which will be described in the Implementation Manual.

b. Promoting Information, Education and Communications (IEC) Programs (US$4.0 million)

3.19 There will be three elements to this sub-component. The first will be designed to increase public support for population issues among opinion leaders and will be managed by the Permanent Secretariat of CONAPO in the Ministry of Finance and Plan. The second will focus on increasing public knowledge of, and demand for, modern contraceptive methods, with the DSF having lead responsibility. The third will center on enhancing public understanding of women's rights and problems, with the DPF playing the pivotal role. While two of these elements are not directly focussed on building demand for contraception, they play crucial supporting roles in creating a positive climate for contraceptive use. To ensure that the work of the entities participating in this three-pronged approach is well coordinated, the Permanent Secretariat of CONAPO will convene monthly meetings of the key IEC staff. These meetings will also include the National AIDS Committee's IEC specialist, much of whose work parallels that in population IEC.

3.20 Given the pivotal importance of IEC to the project's success, as well as the need to strengthen the IEC capabilities of the different agencies, the Government will engage an international agency to provide 36 person-months of non-resident technical assistance. This will consist of one lead adviser, supported by other consultants to help with specific tasks, who would periodically visit the country. This IEC assistance will cover both the population and AIDS/STD sub-components of the project. During negotiations, the Government gave assurances that (a) it will recruit an IEC firm for a three-year period for the provision of non-resident specialist services and a national counterpart in CONAPO with qualifications agreeable to IDA, and (b) it will maintain the counterpart in post for the duration of the project. The recruitment of two national IEC specialists by the CNLS is part of the condition of effectiveness concerning the restructuring of the CNLS (para. 3.44).

3.21 A knowledge, attitude and practices (KAP) survey to be conducted before project start with financing provided under the ongoing health operation, will provide baseline data needed to establish quantified objectives and measure the impact at the end of the project when the KAP survey will be repeated. During negotiations, the Government gave assurances that it will undertake a KAP survey in year 5 of the project.

3.22 Since the project will make extensive use of mass media, both for FP and AIDS prevention, the Government will obtain the collaboration of the Ministry of Communications. Funds are provided either to pay for broadcast time or to purchase equipment or materials needed by Burkina's radio and television. During negotiations, the Government gave assurances that the Ministry of Finance and Plan will enter into agreement with the Ministry of Communications for the undertaking of IEC mass media activities under the project.

3.23 Increasing Support for Population Issues Among Opinion Leaders. The Permanent Secretariat of CONAPO will seek to improve the national leaders' understanding of the relationship between population trends and development and to mobilize them on population matters. The main focus will be on political, traditional and religious leaders at the national and regional levels. A national communication specialist will be re-assigned by the Government to the Secretariat to strengthen its capacity to disseminate information and research in a manner most likely to maximize the utilization of information by the agencies and organizations with which it will interact.

3.24 The Secretariat will synthesize policy-relevant information and research findings into a total of 20 short, attractive, user-friendly publications and audio-visual presentations. The kinds of topics to be addressed will be the 1991 population policy, the Demographic and Health Survey, census results, etc. It will also conduct about 30 seminars for a total of 1,500 opinion leaders, working in conjunction

with the regional offices of the Ministry of Finance and Plan on the organization of seminars in the regions. A quarterly bulletin covering topics relevant to all the participants in the project will be produced and disseminated and contact will be maintained with the media to assure coverage of population matters. During negotiations the Government gave assurances that at each year's annual review meeting with IDA, it will agree on the seminars to be undertaken, the content of which to be satisfactory to IDA.

3.25 Increasing Public Knowledge of, and Demand for, Contraceptive Services. The IEC Unit of the DSF has accomplished a considerable amount of work in recent years, with support and technical assistance from Population Communications Services of the Johns Hopkins University. However, with that support expected to end as this project begins, the directorate believes the time is right to rethink its IEC strategy. The challenge will be to take relatively high awareness of contraception in the urban areas and translate it into broader use of modern methods, while beginning to reach out into rural zones. Both quantitative and qualitative IEC research will be used throughout the project to identify target audiences, effective messages and channels of communication, as well as to assess the impact of IEC activities, materials and messages. Such research will serve to refine the DSF's IEC strategy on a continuing basis and will play a particularly crucial role in the development of mass media activities. Ongoing work to integrate family planning messages into popular radio programs will be continued and expanded to television. In addition, the directorate will test the use of short, frequently repeated spots to communicate simple family planning messages. Both for IEC research and for mass media production, the DSF will contract with local research institutions and advertising agencies to undertake much of the work.

3.26 Interpersonal communications play a crucial role in conveying complex messages and strengthening motivation to use family planning. To dramatically expand the level of interpersonal communication, the project will fund decentralized IEC activities through the 10 CRESAs (para. 2.34). The CRESAs will work with the health districts to develop IEC proposals that will be submitted to the central level for funding. In the field, the same people are often responsible for IEC both on family planning and AIDS/STDs; so the decentralized program will focus on both topics. The program will be administered by the CNIEC/Santé in collaboration with the DSF and the CNLS. These agencies will collaborate in phasing in 2-3 CRESAs a year, providing training and technical assistance to ensure the development of solid and accountable programs. Decentralized activities will reach out to women's associations, agricultural cooperatives, traditional healers, schools, large enterprises and other groups beyond the health system, with men, youth and opinion leaders being priority target audiences. The program will provide the means to touch rural areas, to use traditional forms of communication, such as songs and folk theater, and to encourage innovation. Backing up these local efforts, the Family Health Directorate will also conduct four seminars a year for opinion leaders. These will differ from those conducted by CONAPO inasmuch as they will focus on family planning and health issues, as opposed to population and development.

3.27 While decentralized activities will seek to build up demand for contraception outside the health system, the interpersonal communications skills of health workers will also be upgraded through training. The 700 nurses and 400 auxiliary midwives to be trained in the provision of contraceptive care (para. 3.6) will receive more extensive IEC training than in the past. And a new strategy of providing "information packages" to women when they come to a health center will be explored and tested. The "information package" would link family planning with other health interventions such as prenatal care, delivery, vaccination and well-baby check-ups. If it proves successful, 750 health workers around the country will be trained to provide these "packages". The project would also expand the Population Education Project in the Ministry of Secondary Education and Scientific Research initiated with funding provided by UNFPA. Specifically, the project would train 1,000 secondary school teachers to integrate population topics--including family planning, AIDS prevention, information on the status of women and

other topics--into the school curriculum. Support will also be provided for the production of teaching aids and the purchase of slide projectors.

3.28 Enhancing Public Understanding of Women's Rights and Problems. A new Family Code establishing many ground-breaking rights for women was adopted in Burkina in 1991. Since dissemination of information about these rights can be expected to improve the status of women and thus create a climate more conducive to family planning, the project will promote this dissemination. Jointly with the Netherlands Government, the project will support a pilot operation aimed at disseminating the Family Code in four provinces of the country. Legal information centers will be established and a range of information about women's rights will be provided, including information about family planning and AIDS.

3.29 Although outlawed, the practice of excision is still widespread in Burkina, with deleterious health consequences for young women and girls. The National Committee Against Excision is a volunteer body that has established 10 provincial and hundreds of local committees to educate the public about this harmful practice. The project will help support the national committee's plan of action, enabling it to increase the number of provincial and local committees against excision, develop educational materials for use by the committees, reproduce a film and work with the mass media to educate the public about the deleterious effects of excision.

3.30 For several years the DSF has trained social workers in FP communication with the cooperation of the DPF. Under the project, the latter will assume responsibility for this training. The directorate will use the curriculum and training team already in place and will continue to work closely with the Family Health Directorate. Approximately 180 social workers will be trained over the life of the project in FP and AIDS/STD communication. A detailed description of the IEC activities to be carried out under the project is in Annex 4.

3.31 Project Support. The project will finance the production and purchase of educational and promotional materials, 36 person-months of non-resident international specialist services (para. 3.20), local specialist services (artists, theater groups, song writers, researchers, printers, advertising agencies), in-country training and seminars (for health and social work staff, teachers, opinion leaders and others), decentralized IEC activities through the CRESAs, and the establishment of legal information centers for women. IEC equipment and supplies, training abroad, study tours, maintenance and operation of equipment, and costs for supervision are financed under the institutional strengthening sub-components.

c. Strengthening Institutions in Charge of Implementing the Population Policy and of Planning, Managing and Evaluating the National FP Programs (US$5.4 million)

3.32 This sub-component would strengthen three institutions: (a) the Permanent Secretariat of the Interministerial Population Committee (CONAPO) in the Ministry of the Economy, Finance and Plan, in charge of disseminating and operationalizing the Government's population policy; (b) the Family Health Directorate (DSF) of the Ministry of Health (MS), responsible for designing and implementing the Government FP program; and (c) and the Directorate of Family Promotion (DPF) of the MASF, which has the mandate to promote social programs.

3.33 Strengthening the Permanent Secretariat of CONAPO. CONAPO is charged with coordinating all activities related to population, including promulgation and implementation of the official population policy, representation of the government's position at international population fora (such as the UN World Population Conference in Cairo in 1994), and the dissemination of population related

research findings to be applied to government planning, policy making, and program implementation or improvement. In December 1993, the Government signed legislation defining the role and function of CONAPO, its Secretariat and four commissions, in the implementation of the Government population policy. The objective of this sub-component is to enable CONAPO's Permanent Secretariat to effectively assume a leadership role in the implementation of the above tasks. The project would build on efforts begun under a UNFPA-supported project (closing at the end of 1994) to strengthen the capacity of the Secretariat. These efforts have been constrained by understaffing (only recently the staff of the Secretariat, originally composed of two demographers, has been expanded with the addition of two economists) and lack of equipment, material and basic office supplies.

3.34 In addition to its communications and coordination activities, the Secretariat would promote, coordinate and carry out demographic research. The bulk of it would, however, be contracted out to local individuals or agencies. CONAPO would hire the services of local specialists to review existing demographic research and the service of an international consultant to prepare a research program for the project period agreeable to IDA. During negotiations, the Government gave assurances that it will (i) submit to IDA by June 30, 1995, a research program acceptable to the Association, and (ii) complete this program by June 30, 1998. The project would also provide technical assistance (local and international specialist services) to strengthen the Secretariat's capacity to manage its various tasks. A detailed description of CONAPO's strengthening program is in Annex 5.

3.35 The Permanent Secretariat of CONAPO would be also responsible for project coordination. The Permanent Secretary would, however, delegate day-to-day coordination and monitoring responsibilities to a national Coordinator. The Coordinator would be assisted by an administrator, who would be responsible for managing the Fund (para. 3.71) and for procurement; a monitoring and evaluation specialist, an accountant, a junior accountant, and two secretaries. These positions would be financed under the project. The tasks of the coordinating team would be to: a) administer the Fund; b) coordinate the preparation of annual work programs and budgets for all components; c) maintain and consolidate projects accounts, including the Special Account; d) make arrangements for audit of project accounts; e) prepare semi-annual progress reports for IDA, the Government and the cofinanciers; f) monitor project activities, and g) coordinate procurement, as well as carry out procurement of items that would not be procured by the CAMEG. With funds from the ongoing health project, CONAPO will recruit a qualified accounting firm, experienced in working according to the International Accounting Standards and acceptable to IDA, to establish a computerized accounting system and train the project accountants. Prior to negotiations, the MFP appointed a Coordinator, whose qualifications were reviewed and approved during appraisal. Establishment of (a) the Coordinating team within CONAPO with personnel in numbers and qualifications agreeable to IDA, and (b) the accounting system, satisfactory to IDA, would be conditions of credit effectiveness.

3.36 Project Support. The project would finance: computers and other office equipment; office furniture and supplies; audio-visual equipment; three vehicles, of which two 4x4; 12 man-months of local specialist services; salaries of the coordinating unit staff; training of CONAPO's staff (training abroad for the IEC specialist and local training for 8 staff, including staff of the project coordination team); 11 man-months of international specialist services (to strengthen CONAPO's various activities); and operating expenses.

3.37 Strengthening the Family Health Directorate (DSF). The objective of this sub-component is to enhance DSF's capacity to play a leadership role in FP/MCH, nutrition, and vaccination, where numerous national and international players intervene and coordination is weak. The DSF recently completed the preparation of national MCH, FP, and nutrition strategies but has still to finalize a vaccination strategy. The project would help the DSF: (a) establish effective procedures for the

preparation and periodic revisions of its national vaccination, nutrition, and FP/MCH programs, and their integration into a coherent national family health program (although nutrition and vaccination activities are supported under the Health and Nutrition project, strengthening of DSF's capacity to manage these programs has been included under this project); (b) implement a more rational distribution of tasks and personnel inside the organization; and (c) strengthen coordinating and supervisory functions, as well as the capacity to provide effective support to the provinces and districts on family health matters.

3.38 DSF would review the objectives of its sectoral programs with concerned staff, and reach a consensus on activities that would need to be carried out to achieve those objectives. Sectoral programs would be integrated into a comprehensive national family health program. Training in program management would be provided to four of DSF's senior staff to strengthen their competence in this field. Short-term international technical assistance would be recruited to assist DSF's management in the process that would lead to the preparation of the integrated program. The DSF would also obtain professional advice to carry out its internal reorganization aimed at creating a more functional and streamlined structure, and strengthening coordinating and supervisory functions. The project would finance the rehabilitation and expansion of DSF's headquarters. It would also refurbish its five regional training centers. A local consultant would be hired to help the DSF organize its documentation and filing system. Details of the sub-component are provided in Annex 6.

3.39 Project Support. The project would finance: civil works for the expansion of the DSF and the rehabilitation of regional training centers; furniture and equipment for the new offices and the regional training centers; two 4x4 vehicles for supervision activities; local and foreign training (in-service training for 15 trainers, while 6 senior staff would receive advanced training abroad in FP/IEC program management and IEC techniques, and 12 in health management); 6 man-months of a local specialist services, and a total of 9 man-months of international specialist services to help prepare an integrated family health program, and carry out DSF's reorganization; workshops to integrate the national program; O&M of vehicles and equipment; office, audio-visual supplies; subscription to specialized magazines and purchase of books; operating expenses for supervision.

3.40 Strengthening the Directorate for the Promotion of the Family (DPF). In March 1994 the Government re-established the Ministry of Social Action and Family (MASF), which in 1987 had been merged with the Ministry of Health. Within the MASF, the DPF has the mandate to promote women's rights, sensitizing and educating the population about the new family code, and raising awareness among the population about the hazards of certain traditional health practices, such as circumcision. In November 1992, DPF had been selected by a multisectoral group to chair an interagency IEC commission established within (and coordinated by) CONAPO. Under the project, the DPF will play a pivotal role in promoting women's rights and training social workers. It will also develop the AIDS/STD content of the curriculum of the National School of Social Service (ENFS), train teachers in that subject matter, and chair meetings of CONAPO's IEC commission. The project would provide IEC training and equipment to strengthen DPF's capacity to carry out the activities foreseen under the project. This support would complement that envisaged by the Dutch Government and UNFPA in the context of forthcoming operations. DPF's current weakness has raised the concern of a number of donors who might otherwise be interested in supporting the Directorate's activities. The MASF recently agreed with the Netherlands Government that it will (a) undertake, by May 1994, a management review of the different Social Action Directorates, and (b) implement the recommendations that would result from this review.

3.41 Project Support. The project would finance: equipment, including three computers, one printer and one photocopier; audio-visual equipment; office furniture and supplies; one month IEC

training in an African country for two staff; audio-visual supplies; O&M of office equipment; subscription to specialized magazines and purchase of books.

2. Strengthen the National Capacity to Contain the Spread of HIV/AIDS/STDs (US$14.9 million)

3.42 This component aims to radically strengthen Burkina's capacity to respond to the HIV epidemic by preventing HIV transmission through a massive effort to promote behavioral change and reduce the prevalence of STDs and mitigate the impact of AIDS on individuals, families and the community. There are five sub-components: (a) strengthening various institutions and building capacity to deal with AIDS needs; (b) promoting safer health practices and behavioral change through information, education and communications campaigns; (c) promoting the use of condoms; (d) treating STDs; and (e) strengthening clinical management and community care.

a. Institutional Strengthening and Capacity Building (US$4.2 million)

3.43 This sub-component would include: (i) strengthening the capacity of the Permanent Secretariat of the National AIDS Committee (CNLS) to manage and coordinate the AIDS control program; (ii) improving the capacity of the health system to provide basic information on the development of the HIV epidemic, linked with information on STDs; (iii) ensuring blood safety; and (iv) undertaking operational research to improve interventions supported by the project.

3.44 Strengthening CNLS's Capacity to Manage and Coordinate the AIDS Control Program. The limited capacity to manage and coordinate HIV/AIDS control activities is a major constraint to their effective implementation (para. 2.38). While overall policy regarding AIDS control is coordinated by the interministerial CNLS, day-to-day implementation of AIDS activities is the responsibility of CNLS's Permanent Secretariat. The project would strengthen this unit's management capacity. The Permanent Secretary of the CNLS would be given main responsibility for the implementation of AIDS activities. He would be assisted on a full-time basis by three technical officers, two responsible for implementing IEC activities and one responsible for coordinating activities in the areas of epidemiological surveillance, laboratory, and research. While the latter expert is already in post, the two IEC specialists would be recruted by the project from the private sector. During negotiations, the Burkinabé delegation also agreed that the Minister of Health would assign to the CNLS three additional experts on a part-time basis. This arrangement, which takes into account the human resource constraints currently faced by the Ministry of Health, will be reviewed during the project mid-term evaluation. Jointly with this technical staff, the Permanent Secretary would be responsible for planning, coordinating, managing and monitoring all AIDS activities carried out under the project, as described in paras. 3.47-3.70. He would collaborate with the public health system, as well as with NGOs and other private sector organizations. In addition to the technical staff, the Secretariat would have an accountant, an administrative officer and an officer in charge of donor coordination. The MS is currently building an office facility that would house the Permanent Secretariat. The reorganization of the Permanent Secretariat and its staffing with adequate personnel in numbers and qualifications described above, as well as the enactment of a new ministerial decree clarifying the roles and functions of the Permanent Secretary and of the technical subcommittees would be a condition of credit effectiveness.

3.45 CNLS's technical sub-committees (para. 2.38) would constitute an advisory body. They would develop national policies and strategies in AIDS control, assist the Secretariat in developing operational guidelines, and periodically review the HIV/AIDS/STD situation in the country.

3.46 To help build up its capacity to implement and monitor the activities envisaged under the project, the Permanent Secretariat would enter into a twinning arrangement with a specialized institution which would provide non-resident consultant services for a total of about 36 man-months to be used during the project implementation period. During negotiations, the Government gave assurances that the Permanent Secretariat of the CNLS will enter into such an arrangement by March 31, 1995. Funds for this assistance are provided under the Credit.

3.47 Improving Epidemiological Surveillance. As indicated in para. 2.36, underreporting is hampering the Government's ability to control the spread of HIV/AIDS/STD. The project would strengthen the institutional capacity to provide basic information needed to monitor the development of the HIV epidemics and related diseases, as well as that of the STDs. Surveillance may be either active (active search of cases) or passive (using existing data from health centers or hospital records). Active surveillance would be established in five strategically located sentinel sites: Ouagadougou, Bobo-Dioulasso, Gaoua, Fada Ngourma, et Ouahigouya. In all these sites tests would be conducted once a year, over a three-month period, among a given number of low-risk (pregnant women) and high-risk populations (STD clients and commercial sex workers). Surveillance among low-risk cases can help assess the prevalence of HIV in the general population. The size of the populations to be studied would depend on the existing HIV prevalence. Data collected would be analyzed locally with the assistance of the regional epidemiological surveillance centers (CSEs) (para. 2.36), and the results would be sent to the epidemiological surveillance unit at the Preventive Medicine Directorate (DMP). The latter would conduct periodic supervisory visits to the sites to ensure that activities being performed are consistent with required procedures.

3.48 All other health facilities at the district, regional, and national levels, (53, 9, and 2, respectively) that have a laboratory equipped to undertake HIV tests would be required to send every two months data on identified infections to the epidemiological surveillance unit at the DPM, using standard notification forms which would be developed under the project. The regional CSEs and the Provincial Health Directorates would be requested to periodically remind the health facilities to fill and send the notification forms. For this passive surveillance, cases will be reported using WHO (Bangui) AIDS case definition. During negotiations, the Government gave assurances that the above reporting system will be in place by June 30, 1995.

3.49 HIV surveillance training and refresher courses on HIV surveillance would be provided to the staff at the sentinel sites as well as to health workers in health facilities involved in passive surveillance. Since HIV surveillance would be closely linked to STD surveillance, training would cover both STD and HIV surveillance. Details on the epidemiological surveillance are in Annex 7.

3.50 Improving Blood Security Capacity. At the hospital level (national and regional hospitals) the project would finance the provision of medical supplies to ensure the sustainability of existing blood screening facilities. The hospitals handle the country's blood banks, while blood transfusion is carried out by the CMs. The two CHNs, two CHRs (Ouahigouya and Tenkodogo) and the military hospital in Ouagadougou are equipped with ELISA (Enzyme-linked Immuno-sorbent Assay, an in-vitro test) Chains (three financed by IDA under the ongoing project). The remaining CHRs and a number of CMs were provided with rapid HIV tests under the first Medium-Term Plan (MTP). Continuous break downs in the supply of tests and medical and laboratory supplies, have considerably constrained blood screening activities of the above facilities. The project would ensure that the five facilities equipped with ELISA Chains would receive a regular supply of ELISA and Hepatitis B tests, as well as medical and MIS supplies. It would also provide medical supplies for the National Reference Laboratory (LNR) at the CHN of Ouagadougou, thus improving its effectiveness. The laboratory performs Western Blot confirmatory HIV tests and is linked to the country blood screening facilities for quality control. Provisions would be

made for safe disposal of HIV-positive blood and serum samples and instruments by incineration and disinfection and for protective supplies (protective clothing, gloves, and infection control supplies). In addition, the project would assist the Government in strengthening blood collection systems in collaboration with the Burkinabé Red Cross.

3.51 Operational Research. The project would fund research aimed at improving interventions supported by the project, in particular in the following areas: HIV/STD prevalence among gold miners, prisoners, migrants and tuberculosis patients; mother/child transmission of HIV; validation of the syndromic diagnosis of STDs; periodic assessment of the STD surveillance system; and in-depth study of the economic impact of AIDS. During negotiations the Government agreed that the CNLS will conduct in 1995 two researches (mother/child transmission of HIV and HIV/STD prevalence among gold miners). The timetable for other research work would be agreed during the annual joint Government/IDA review meetings. The Government also gave assurances that a) the research program will be undertaken in accordance with the agreed timetable and on the basis of terms of reference for the consultants agreeable to IDA; and b) it will review with IDA the research carried out and implement the agreed follow-up action plan.

3.52 Project Support. The project would finance: the rehabilitation of a cold storage room at the National Hospital in Ouagadougou, where tests to be imported would be stored; audio-visual equipment for the CNLS; four vehicles; 25 motorcycles for the CSEs' staff; two computers and a printer for the CNLS; material and equipment for the CSEs; MIS and lab material; medical and protective supplies; HIV tests; training of sentinel sites personnel (six per site); training in epidemiological surveillance for 76 doctors and 16 nurses; 2 man-months training in maintenance of equipment at the national hospitals; IEC training for two staff at the CNLS; 2.5 person-months of international specialist services and 2.5 person-months of local specialist services to help strengthen CNLS's organization, review the 1993-1995 MTP and prepare the next medium-term AIDS program; local specialist services (6 man-months) for operational research and 39 man-months of international specialist services (3 man-months for a study on the economic impact of AIDS, and 36 man-months for the twinning arrangement between the CNLS and a foreign institution); study tours to other African countries; coordination activities with neighboring countries, subscription to journals and magazines dealing with AIDS; O&M of materials and vehicles; and operating costs for supervision.

b. Promoting Safer Health Practices and Behavioral Change through Information, Education and Communications Campaigns (US$2.6 million)

3.53 Although awareness of AIDS is increasing rapidly in Burkina as a result of the dramatic increase of AIDS cases, efforts to educate the population on the causes of AIDS needs to be strengthened. In particular, there is an urgent need to ensure that the increased awareness is translated into behavioral change. This sub-component will aim at improving knowledge of risk behaviors, providing information about prevention, and dispelling misconceptions related to HIV/AIDS. The youth would be an important target of IEC interventions. The pre-project KAP survey (para. 3.21) will provide baseline data permitting to establish quantitative targets and a repetition of the survey in Year 5 of the project will allow the impact of the IEC sub-component to be measured. Mass media will be used intensively to convince the public as a whole that AIDS is a reality and prevention should be a priority for each individual. Interpersonal communications through a variety of channels will reinforce this message and will provide more detailed information about condom use, particularly to groups at high risk. Considerable efforts will also be devoted to STDs which have received little attention to date. IEC campaigns will provide information on the symptoms and consequences of STDs, the relationship between STD and HIV, the importance of spousal communication regarding STDs, and how to access services for diagnosis and treatment. While all methods of transmission and prevention will be covered, the major emphasis will

be on sexual transmission, as it is the most significant route of infection, and on condom use and sexual behavior change as the primary means of prevention.

3.54 The Permanent Secretariat of the CNLS will undertake both quantitative and qualitative research to guide the development of its IEC program on a continuing basis. While the Secretariat will play a major role in the design of the research and the interpretation of results, the technical aspects of the work will be undertaken by outside researchers whenever possible. Once the results of the pre-project KAP survey are available, there will be a national seminar to define an HIV/AIDS/STD strategy.

3.55 IEC research will also serve as the foundation for intensive mass media campaigns. There will be extensive use of short spots, particularly on radio. This activity will be reinforced by the integration of information about HIV/AIDS and its prevention into ongoing radio and television programs such as those on health, those for women, popular theater, etc. Mass media material will be developed with a local advertising agency, carefully tested before going into production, and assessed after broadcast. Since mass media is costly, however, there will be an outside evaluation after two years of the role of the mass media in advancing the project's AIDS/STD IEC objectives. During negotiations, the Government gave assurances that (a) the national seminar to establish the IEC strategy for HIV/AIDS/STDs will be held no later than June 30, 1995 and that the strategy will be discussed with IDA and finalized no later than September 30, 1995; and (b) at the end of the second year of project implementation, it will undertake the evaluation of the mass-media impact, discuss its recommendations with IDA, and implement an agreed-upon action plan.

3.56 Mass media needs to go hand in hand with interpersonal communications. As described in para. 3.26, the CNIEC/Santé will administer, in collaboration with the CNLS and the DSF, a program of decentralized IEC activities, with particular emphasis on interpersonal communications, through the CRESAs. These activities will have a special focus on groups at high risk of AIDS/STDS. The kinds of activities to be supported will also include peer education; AIDS prevention dances for young people; dissemination of educational materials in hotels, bars, gas stations and elsewhere; workplace presentations; and video presentations--accompanied whenever possible by free condom distribution. The CNLS will pave the way for such initiatives by contacting national leaders and coordinating efforts in Burkina with those in neighboring countries, where appropriate. It will also provide specialized information, training and technical assistance to the CRESAs. AIDS/STD training would also be included in the training curriculum of the DPF (para. 3.40). Annex 4 provides details of the AIDS IEC program.

3.57 Project support. The project would finance: the production and purchase of IEC materials, in-country training for social workers, training for the teachers of the School of Social Services and for CRESAs' staff; seminars for opinion leaders; surveys and studies (including KAP surveys); the salaries of the two senior IEC specialists for the CNLS hired from the private sector; decentralized IEC activities through the CRESAs (hiring of local artists, advertising agencies, theater groups, song-writers, researchers, etc.); mass-media activities to be contracted out by the CNLS, and audio-visual supplies.

c. Promoting Condom Use (US$3.3 million)

3.58 Under the project, condom use for both FP and HIV/AIDS/STD prevention would be vigorously promoted. While condom needs for contraceptive purposes (para. 3.9) have been calculated using the standard assumption that 150 condoms would be needed to provide a couple with one year's protection, condom needs for HIV prevention have been estimated on the basis of a different assumption: i.e., the need for a sexually active adult male to protect himself from "non-regular" sex (adolescent and extra-marital sex). Estimates of the number of condoms needed to provide HIV protection have varied under the various condom social marketing programs, which have so far been implemented worldwide.

Some programs have based their calculation of condom needs on the assumption that a sexually active male would need 52 condoms a year to protect himself from HIV, other programs assume that couples would need to use an average of 100 condoms a year. Population Services International (PSI), a Washington-based NGO, which has been implementing condom social marketing programs in a number of developing countries in Africa and elsewhere and is providing technical assistance to Burkina's PROMACO (para. 2.35), bases its estimates of condom needs on the assumption that an average of 20 condoms a year are needed to protect a sexually active urban male from non-regular sex. The figure is based on a study PSI has undertaken of the sexual behavior of adult urban males in Cameroon. Under this assumption, PSI's social marketing programs reach maturity when condom distribution equals one condom per capita. In the case of Burkina, this would correspond to a distribution of about 11.4 million condoms by year 1998. The provision of condoms under the present project has been estimated under the assumption that 52 condoms a year are needed to protect an adult sexually active male from "non-regular sex" for the 1995-1999 period.

3.59 Current sales of condoms provide HIV protection to about 2.5% of the sexually active adult males, assuming that 52 condoms provide one-year protection from non-regular sex. Burkina Faso health officials aim at increasing condom use to cover at least 20% of the adult male population by 1999. It has, in fact, been suggested by a recent model of HIV transmission that a minimum of 20% use rate may be needed to slow down the growth of new HIV cases. To attain this target, about 30 million condoms would have to be sold yearly by 1999. PROMACO plans to increase its yearly sales of condoms from the current level of 3 million a year to 7 million a year by 1997 (para. 2.35). The project will assist the Government in increasing condom distribution beyond this target to reach about 15 million condoms in 1997 and 30 million in 1999. These seemingly ambitious targets (they represent an increase of about 400% and 900%, respectively, over the 1992 level of about 3 million condoms) are achievable, as shown by the experience of other countries. For example, in Zimbabwe (a country with a population size comparable to Burkina), sales of condoms grew from 3 million a year in 1985 to 35 million in 1992 as a result of a very intensive IEC effort and is estimated to have reached 50 million in 1993.

3.60 Table 3 provides estimates of condom needs for the 1995-1999 period to reach the above targets, taking into account population growth rates. Condoms needs under the project would be reviewed yearly and adjusted to take into account actual results.

Table 3: Condom Needs for the 1995-99 Period

Year	Condoms (million)
1995	7.0
1996	10.0
1997	15.0
1998	22.0
1999	30.0
Total	84.0

3.61 The massive condom distribution and promotion described above would be achieved through the use of different distribution channels. Specifically, condoms would be provided: a) through public health facilities (mainly MCH/FP services); b) through NGOs to high risk population; and c) in conjunction with IEC campaigns. A particular effort would be made under the project to reach such risk groups as the military, the police, prisoners, truck drivers, miners, and commercial sex workers. Distribution of condoms to these groups would be done either through peer groups or through NGOs. The latter are expected to play an important role in condom promotion. A number of them (Plan de Parrainage International, the ABBEF, Save the Children Fund, Femmes Africaines Face au SIDA) are already quite active in AIDS prevention and the Government is increasingly appreciating their valuable contribution and the complementarity of their efforts in this area. Condoms would be sold at a highly subsidized price (as is currently the practice) through a variety of programs carried out by NGOs and the the public sector. Free distribution of condoms would also be envisaged in the course of IEC campaign and in programs targeted to high-risk groups. Under the project the Government would also encourage private pharmacists to step up promotion and sale of condoms by supplying theses items to them at a subsidized prices. For the distribution of condoms to the public health facilities the essential generic drugs logistics system would be used. Promotion of condoms

through the public MCH/FP program is very important in the light of the high prevalence of HIV among women attending antenatal clinics.

3.62 The project would provide 73% of the 84 million condoms expected to be purchased during the 1995-99 period for HIV protection, with PROMACO providing the remaining 27% through its social marketing program. In addition, the project would finance condoms needs for contraceptive purposes (para. 3.9). Condoms for both the FP program and for AIDS prevention would be procured by the CAMEG with the technical assistance of WHO (para. 3.10). Condom costs for both the FP and AIDS prevention program are estimated at US$5 million over the life of the project.

d. Treating STDs (US$3.8 million)

3.63 Treatment of STDs would be a key intervention in the prevention of HIV/AIDS, since STDs are an important risk factor for HIV infection (para. 2.37). This intervention involves prevention as well as prompt diagnosis and effective treatment. As indicated in para. 3.53, IEC activities would target those at risk of acquiring STDs and would encourage safer health practices (including the use of condoms), and care seeking behavior, such as early diagnosis and treatment. STD services would be integrated into the primary health care system. Diagnosis and treatment of STDs in pregnant women would be included in the MCH services. To ensure more accurate diagnosis in the absence of lab tests and allow treatment during one single visit, diagnosis and treatment would be based on the WHO-developed syndromic approach, which bases diagnosis on a group of symptoms and treats for all diseases that could cause that syndrome. This approach would be coupled with regular drug and condom supply. An intensive effort would be made to reach risk groups mostly through NGOs, with financing provided under the Fund. NGOs would also help in enlisting the support of traditional practitioners, who would be trained to diagnose STDs and encouraged to refer the patients to health facilities for treatment.

3.64 The project would train 54 doctors and 16 nurses currently heading CM or CMA (para. 3.6), who would, in turn, train the personnel in their health facilities who would be in charge of treating STD patients. Training would be extended to health providers in the more peripheral CSPS, after the evaluation of the doctors' training. A system of continuous refresher training would also be envisaged under the project. A workshop to elaborate STD treatment protocols would be organized by the end of 1994 when the results of the rapid STD assessment (para. 2.37) are expected to be available. Financing for the rapid STD assessment and the workshop to finalize treatment protocols is provided under the ongoing health project.

3.65 The project has estimated a total need for STD drugs of US$6.1 million for the 1995-1999 (including contingencies). These are mostly basic antibiotics to treat the ulcer diseases and genital discharges (syphilis, gonorrhea, chlamydia) that facilitate HIV transmission. The recommended drugs are already included in Burkina's list of essential drugs. The project would finance about 61% of these needs; the balance is expected to be financed by other donors outside the framework of this project. Given the interest shown by a number of bilateral donors to finance essential drug purchases, the appraisal mission does not foresee problems for the Government to obtain the funds required to cover its total needs of STD drugs. Distribution of these drugs to health facilities would be through the essential drug logistics system being put in place under the ongoing and new health projects (para. 2.59).

3.66 The proposed project would complement a three-year project approved in November 1993 by the European Community (EC) for the strengthening of STD treatment and control in health facilities in the Kadiogo and Houet provinces. The bulk of the proposed activities would be carried out in the cities of Ouagadougou and Bobo-Dioulasso. In particular, the EC project (with a total cost of about ECU 1 million) would finance: (a) the upgrading of a number of health centers and dispensaries; training/refresher courses for health personnel; provision of drugs, medical, and laboratory materials; and operating costs.

3.67 Project Support. The project would finance: STD drugs (US$3.7 million) and training (US$100,000).

e. Strengthening Clinical Management and Community Care (US$1.0 million)

3.68 The objective of this component is to assist the Government in a) establishing an integrated system for HIV/AIDS that would include testing, health care, counselling, psychological and social support; b) rationalizing the cost of care by i) developing standard treatment protocols for each type of AIDS-related opportunistic infection and disease symptoms; ii) experimenting with alternative delivery mechanisms such as outpatient care; and iii) providing a balance between hospital care and home care, through the establishment of linkages with NGOs and other community support; and c) counseling for affected individuals and the family. A number of activities in these areas are being supported under the ongoing health operation. These include: a) workshops to sensitize the medical, religious and village communities about HIV-related infections and the importance of counselling; b) guidelines for psycho-social counselling; and c) preparation of an AIDS legislation. The proposed project would strengthen the skills of paramedical staff (700), social workers (162), and community members (240) in the provision of counselling and community care. Furthermore, the project would assist MSASF in acquiring scientific documentation on HIV/AIDS/STD and distributing it to concerned personnel. It would help maintain an adequate supply of drugs to treat the different infections. Funds have been provided under the project for trips to other African countries to learn from their experience in the preparation of treatment protocols for HIV related diseases. During negotiations, the Government gave assurances that these trips will be undertaken in the first six months of project implementation and that treatment protocols would be finalized by December 31, 1995. Any change in these protocols that would affect the use of drugs to be financed under the project would be submitted to IDA for information.

3.69 To reduce the direct cost of AIDS and the workload of health facilities, the project would support social interventions to help households cope with the impact of AIDS. Training would be provided to NGOs to strengthen their capabilities to intervene in this area. NGO activities in support of individuals and families affected by AIDS and other HIV-related diseases would be financed under the Fund. The project would also support the designing of survivors programs, with particular emphasis on programs for orphans, widows and elderly dependents.

3.70 Project Support. The project would finance: drugs for opportunistic infections (US$ 860,000); training for health and social workers, and community and religious leaders (training would include study tours to other African countries and participation in international conferences on clinical management); training for NGOs; 1 man-month of international specialist services to help the preparation of a seminar on the problem of orphans; AIDS-related documentation; and funds for supervision.

3. Encourage Private Sector and NGO Participation in Population, FP and HIV/AIDS/STDs Programs (US$4.0 million)

3.71 The project would establish a Fund, in the amount of US$4.0 million equivalent, to provide grant-financing for activities and programs in the areas of population, FP, and prevention and control of HIV infections and STDs. Beneficiaries of the Fund would be NGOs, associations, private organizations and individuals. Activities to be financed include: (a) in the area of population/FP: activities aimed at expanding MCH/FP services, beyond those provided by the public sector, such as social marketing and community based distribution projects; and IEC activities utilizing both formal (e.g. radio) and informal channels of communications such as "griots" and folk groups (40% of the funds); (b) in the area of HIV/AIDS/STD: projects proposing counseling, education, and condom distribution; community and home care of patients with AIDS or HIV related illnesses; and IEC activities using formal and informal methods of communication (60% of the funds). Within the limits of US$100,000 per beneficiary, the project would finance up to 85% of project cost for the following types of expenditures: local

consultants, equipment and supplies, training, mass media and traditional forms of communications, and essential operating expenses. The remaining 15% would be covered by counterpart financing from participating NGOs and private agencies. The project coordination team in CONAPO would be responsible for the administration of the Fund (para. 3.35). An independent multisectoral project selection committee would be established to review and approve financing proposals. A procedural manual for the Fund, setting out criteria for the establishment of the project selection committee, as well as NGOs eligibility criteria and rules for the use of the funds, and including a standard contract between the Government and eligible NGOs was discussed and agreed upon at negotiations.

3.72 Government/NGO collaboration was the highlight of a two-day seminar organized in Ouagadougou during project appraisal with the participation of government officials and representatives of major NGOs operating in the concerned sectors. The seminar strongly endorsed the establishment of the Fund and agreed on the criteria and regulations set for its operation. The Governments of Norway and Denmark have indicated their interest in principle to participate in the financing of the Fund. The establishment of an independent committee for the selection of NGOs' proposals (para. 3.71), satisfactory to IDA, and Government's approval of the procedural manual and the standard contract, agreeable to IDA, would be conditions of credit effectiveness.

3.73 During negotiations, the Government gave assurances that: (a) it will make available to participating NGOs the amounts allocated to the Fund under agreement to be entered between the Government and NGOs satisfactory to IDA and based on the terms and conditions detailed in the procedural manual; and (b) it will submit to IDA for review and approval (i) the first three proposals regardless of the amount, and (ii) any proposal in excess of US$75,000 equivalent.

C. Project Cost and Financing Plan

3.74 Summary of Costs. The total cost of the project, net of taxes, has been estimated at US$34.5 million, with a base cost of US$29.7 million, and a foreign exchange component of US$24.2 million. Price contingencies, estimated at US$3.9 million, assume an annual domestic inflation rates of 9.1%, 6.8%, 4.2%, 4.2%, 2.5% for years 1995-1999, respectively, and a foreign inflation rate of 2.9%, 3.0%, 2.7%, 2.7%, 2.5% for the same periods. Physical contingencies are estimated at US$0.9 million of base costs. IDA would finance about 76% of total project costs (US$26.3 million). The Government would contribute 6.4% of total project costs (US$2.2 million). The Governments of Norway and Denmark would contribute about US$3 million each for the financing of the Fund and drugs for STDs. The effectiveness of grant agreements between the Government and the Governments of Norway and Denmark to assist in the financing of the project would be conditions of effectiveness. Details of project costs are given in Annex 8.

3.75 Basis of Cost Estimates. All costs are estimated and are subject to change. The costs of contraceptives and condoms are US CIF Ouagadougou. Cost of drugs, medical equipment, supplies, and materials, and protective supplies are provided in the 1993-1995 MTP for AIDS Control prepared by the CNLS with WHO assistance. Prices of furniture and vehicles are based on World Bank staff information about current international tender prices. The exchange rate used is FCFA 590 for US$1.

3.76 Incremental Recurrent Costs and Project Sustainability. Incremental recurrent costs directly generated by project investments are small. Building construction is very limited and most staff involved in project implementation are already on the MS, MASF and MFP payroll. Operation and maintenance cost of equipment and vehicles purchased under the project (estimated at about 20% of purchase price) would be borne by IDA on a declining basis during the project period, as follows: first year, 100%; second and third years, 65%; and fourth and fifth years, 35%. Government's contribution would compensate for the difference.

3.77 The project contributes essential inputs to two government programs, the FP and the HIV/AIDS control programs and these have important recurrent cost implications. In addition to the financing of an increased number of drugs, contraceptives, condoms, medical materials and protective supplies to be used in the country, there are important distribution costs that the Government would also have to take over at the end of the project. The annual cost at the end of the project of supplying the above material has been estimated at about US$3.4 million equivalent. These costs are expected to remain substantial for a number of years and donor funding for the above commodities will be necessary for the foreseeable future. As cost recovery is being gradually introduced in Burkina's health system jointly with decentralization, charges will be made for drugs, with the proceeds of these charges being retained within the district health budget. Contraceptives and condoms are currently being sold by the public health system at a highly subsidized price, and this practice will continue under the project. However, given the urgency to dramatically increase the demand of condoms, free distribution of these items would be envisaged in the course of IEC campaigns and in some programs targetted to high-risk groups.

3.78 Recurrent Cost Savings. The recurrent costs generated by the activities supported under this project would need to be compared with the long-term costs of not launching an aggressive FP and AIDS prevention program. Without the inputs provided by the project, a much more serious sustainability problem would arise in terms of factors such as: (a) costs for increases in social services to cater to a rapidly growing population; (b) costs for caring for AIDS and STD patients if the HIV infection and the STD were left unchecked; and (c) costs of caring for the children of AIDS victims. The rapid assessment of the economic impact of AIDS carried out during project appraisal (paras. 2.48-2.52) estimated the average direct lifetime treatment costs for an AIDS case to be about US$416 (pre-devaluation cost). The total indirect cost of one case of AIDS has been estimated 18 times greater (US$7,488). The direct cost of one year supply of condoms for one sexually active male was estimated at appraisal to be about US$2.

3.79 Drugs for STDs- and AIDS-related opportunistic infections and protective supplies for health workers would help restore health or prevent illnesses. Every STD or TB patient treated, or every HIV infection averted reduces the number of future potential patients seeking health care. Drugs and other medical supplies provided by the project would help ensure the sustainability of existing and forthcoming large investments in health care infrastructure. Without detailed epidemiological data, it is difficult to ascertain the total number of AIDS cases prevented by the project. By the year 1999, an estimated 570,000 sexually active males will be using condoms, thereby protecting a total of 513,000 couples (90% efficacy). In the extreme case of all these couples becoming HIV-positive without condom protection, then a total of US$211 million is saved by the project in that year, based on a US$416 HIV/AIDS treatment cost per person.

IV. PROJECT IMPLEMENTATION

A. Status of Project Preparation and Readiness

4.1 Throughout project preparation, discussions were regularly held with the technical staff of the MS, the MASF and the MEFP to agree on the priorities within the population and AIDS control strategies. The national FP strategy which the project would help implement was prepared by a multisectoral national working group with technical assistance financed under a Japanese Grant Fund. Working papers for the project components have been prepared. A beneficiary assessment was carried out during preparation, using rapid appraisal procedures to determine beneficiaries' perception of public health services and its recommendations have been incorporated in the design of the project. Training needs have been identified and the content, scope and time-schedule of the training programs would be discussed in detail during negotiations. Lists of equipment, medical and laboratory supplies was reviewed

at appraisal. The Government has prepared an implementation manual for the NGOs Fund and a list of monitorable project activity and program impact indicators, which was reviewed at negotiations. Both the implementation manual for the NGOs Fund and the indicators will be incorporated into a project supervision and implementation manual to be finalized for the project launch seminar (expected to take place prior to credit effectiveness).

B. Project Organization and Management

4.2 All project activities would be implemented by existing units or directorates located in the MEFP, the MS, and the MASF. More specifically, the Permanent Secretariat of CONAPO would be responsible for (i) implementing IEC population activities and coordinating population activities undertaken by other government agencies and NGOs; (ii) undertaking demographic research, and (iii) overall project coordination. The DSF would be responsible for implementing and monitoring the Government's FP program, integrated into its MCH program. The DPF would be responsible for supporting population and AIDS/STD IEC activities, and enhancing public understanding of women's rights and problems. The Permanent Secretariat of the CNLS would be responsible for implementing all HIV/AIDS/STD activities. NGOs' and other private sector's interventions (either financed under the Fund or contracted out by the Government) would be implemented under the supervision of the concerned Government agencies or directorates. Mechanisms for periodic consultation among the different implementing units would be laid out in the project supervision and implementation manual.

4.3 CONAPO would be strengthened to enable it to coordinate project implementation in the manner described in para. 3.35. The Project Coordinator and his team will work in close coordination with the heads of the executing agencies. The Coordinator's role would be to facilitate project implementation, including administrative and financial matters. Training in accounting and procurement would be provided to the coordinating unit staff to strengthen their capacity in these areas.

C. Monitoring and Evaluation

4.4 Each agency involved in the implementation of the project would report semi-annually on progress of specific components and sub-components. The reports would be consolidated by the coordinating team and sent to IDA every six months. It would also organize, no later than March 31 of each year, starting in 1995, a joint Government/IDA review of project implementation, based on the progress reports, annual work programs, and budgets for the following years. IDA and the Government would conduct a mid-term project review in March 1997. Terms of reference for the mid-term review would be agreed-upon between IDA and the Government six months prior to the review. Government would also prepare a project completion report within four months of the project's closing date, prepared in accordance with terms of reference satisfactory to IDA. During negotiations, the Government gave assurances that (a) a mid-term evaluation of the project will be held in March 1997 in accordance with the agreed-upon terms of reference, and (b) a project completion report will be prepared within four months of the project closing date. The establishment of a monitoring and evaluation system, satisfactory to IDA, would be a condition of effectiveness.

4.5 The ZOPP (objective-oriented project planning system) methodology would be used as a tool of project monitoring and evaluation. A workshop was organized in early February 1994 - with financing provided under the ongoing health project and the assistance of a consultant very familiar with the ZOPP methodology - to develop a monitoring and evaluation system based upon a logical framework, which will be updated and reviewed as project implementation is carried on. Preliminary monitorable project activity and program impact indicators developed during the workshop were discussed at negotiations. They will be finalized prior to the project launch seminar. Operational research will be conducted to determine the effectiveness of selected intervention.

D. Procurement

4.6 Table 4 summarizes the project costs by disbursement category and proposed arrangements. Burkina's procurement laws and regulations conform to IDA procurement guidelines. No special exemptions, permits or licenses need to be specified in Credit documents for International Competitive Bidding (ICB) as Burkina's procurement regulations allow IDA procedures to take precedence over any contrary provisions in local regulations.

4.7 Civil Works. The civil works program financed by IDA (US$0.6 million) concerns an extension of ABBEF's clinic, construction of offices for the Family Health Directorate, rehabilitation of five regional training centers and a cold storage room. Contracts for construction works and rehabilitation of the cold storage room would be awarded through LCB. Due to their small size, geographic spread, and high transportation costs, these civil works are unlikely to attract foreign or large firms that use modern construction equipment. However, foreign bidders would not be precluded from submitting bids. Contracts would be grouped, to the extent practical, into packages estimated to cost less than US$0.2 million each. In the event that any contract exceeds this amount, ICB procedures would apply. No preferential margin would be given to domestic contractors when LCB is used. Contracts for the rehabilitation of the regional training centers would be awarded through price quotations, provided that the aggregate amount of such procurement does not exceed US$100,000. The LCB award would be made in accordance with the Bank's Guidelines for Procurement under IBRD loans and IDA credits (May 1992).

4.8 Goods. Goods financed under the Credit include medical and laboratory materials and supplies, office equipment and supplies, vehicles, IEC materials, furniture. Goods would be grouped into packages of at least US$150,000 each and procured through ICB in accordance with the Bank's Guidelines for Procurement under IBRD loans and IDA credits (May 1992). A preferential margin of 15%, or the applicable custom duties whichever is less, over the CIF prices of competing goods for all ICB procurement would be given to domestic firms, in accordance with the Bank's Guidelines. Goods that cannot be grouped into packages of at least US$150,000 each would be procured through local competitive bidding. Equipment, material, furniture, and carts with contract values of less than US$150,000 would be awarded through LCB, provided that the aggregate amount of such procurement does not exceed US$1,500,000 equivalent. Office supplies, spare parts for operation and maintenance of equipment and vehicles, small IEC items, consumable materials needed for training, and items for operating the project coordination team, which are available off-the-shelf and cannot be grouped into bid packages of at least US$50,000, may be procured through prudent local shopping, based on price quotation obtained from at least three reliable suppliers, provided that the aggregate amount of such procurement does not exceed US$1,000,000 equivalent. All bids under ICB will be submitted on a Carriage and Insurance Paid to Ouagadougou basis for imported goods and on an ex-factory basis for locally manufactured goods.

4.9 Drugs, Condoms and Contraceptives. Drugs would be procured by the CAMEG through International Competitive Bidding on the basis of the Bank's Standard Bidding Documents for the Procurement of Pharmaceuticals (September 1993). Condoms would be procured by the CAMEG with technical assistance from WHO for at least the first two years of the project. Contraceptives would also be procured by the CAMEG with technical assistance from UNFPA for at least the first two years of the project. Both goods would be procured in accordance with the Bank's Guidelines for Procurement under IBRD loans and IDA credits (May 1992).

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Table 4: Summary of Proposed Procurement Arrangements
(US$ million, including contingencies)

	Procurement Methods			Not Bank-	
	ICB	LCB	Other	Financed	Total
1. Civil works					
1.1. Construction	-	0.5	-	-	0.5
		(0.5)			(0.5)
1.2. Rehabilitation	-	0.03	0.1	-	0.1
		(0.03)	(0.1)		(0.1)
2. Goods					
2.1. Equipment	0.1	0.5	0.02	-	0.6
	(0.1)	(0.5)	(0.02)		(0.6)
2.2. Material	1.7	0.01	0.6	-	2.2
	(1.7)	(0.01)	(0.6)		(2.2)
2.3. Furniture	-	0.2	-	-	0.2
		(0.2)			(0.2)
2.4. Vehicles	0.6	0.1	-	-	0.8
	(0.6)	(0.1)			(0.8)
2.5. Lab. Materials & Supplies	-	-	0.1	-	0.1
			(0.1)		(0.1)
2.6. Medical material and supplies	2.2	-	-	-	2.2
	(2.2)				(2.2)
3. Drugs /1	4.6	-	-	-	4.6
	(2.6)				(2.6)
4. Contraceptives	4.3	-	-	-	4.3
	(4.3)				(4.3)
5. Condoms	3.3	-	-	-	3.3
	(3.3)				(3.3)
6. Specialist Services					
6.1. National					
6.1.1. Studies, Surveys and Research	-	-	0.9	-	0.9
			(0.9)		(0.9)
6.1.2. Pilot Projects	-	-	0.2	-	0.2
			(0.2)		(0.2)
6.1.3. Capacity-Building	-	-	0.6	-	0.6
			(0.6)		(0.6)
6.2. International	-	-	1.3	-	1.3
			(1.3)		(1.3)
7. Training					
7.1. Abroad	-	-	0.8	-	0.8
			(0.8)		(0.8)
7.2. Local	-	-	1.7	-	1.7
			(1.7)		(1.7)
8. Fund for Population & HIV Activities /2	-	-	4.0	-	4.0
			-		-
9. IEC					
9.1. Mass Media	-	-	2.5	-	2.5
			(2.5)		(2.5)
9.2. CRESAS	-	-	0.1	-	0.1
			(0.1)		(0.1)
10. Recurrent costs					
10.1. O&M of Equipment and Vehicles	-	-	0.7	0.4 /3	1.1
			(0.7)		(0.7)
10.2. Office and audio-visual supplies		-	0.2	-	0.2
			(0.2)		(0.2)
10.3. Personnel					
10.3.1. Supervision missions	-	-	0.03	-	0.03
			(0.03)		(0.03)
10.3.2. Salaries of contractual staff of the Coordinating Team	-	-	0.3	-	0.3
			(0.3)		(0.3)
10.3.3. Salaries of Ministry staff /4	-	-	-	1.8	1.8
Total	16.8	1.4	14.2	2.2	34.5
	(14.8)	(1.4)	(10.2)	-	(26.3)

Notes: Totals may not add up due to rounding.
Figures in parentheses are amounts financed by the IDA Credit.
/1 Cofinanced by Norway and Denmark, in the amount of US$1 million equivalent each.
/2 Financed by Norway and Denmark but managed by the Bank.
/3 Government's contribution to the financing of recurrent costs.
/4 Salaries of civil servants participating in project execution, financed 100% by the Government as part of its contribution to project costs.

4.10 Review by IDA. IDA-financed contracts for works and goods above a threshold of US$200,000 equivalent would be subject to IDA's prior review procedures. The review process would cover 83% of the total value of the amount contracted for goods and 80% of the amount contracted for civil works. Selective post-review of awarded contracts below the threshold level would apply to about one of four contracts.

4.11 Consultant and Other Services. Specialist consultant services financed by IDA (US$3.2 million) would be contracted with the Bank's Guidelines for the Use of Consultants (August 1981). There is no long-term resident technical assistance under the project (the 36-months contract with a foreign IEC firm and the twinning arrangement between the CNLS and a specialized institution are for the provision of non-resident consultants, periodically visiting the project). Services to be contracted out include local and international consultancy services, training services, IEC specialist services, studies and surveys, pilot projects, capacity-building, and procurement and financial auditing services. Total cost of local consultants is estimated at US$1.9 million, while the cost of foreign consultants is US$1.3 million. Prior Association review or approval of budgets, short lists, selection procedures, letters of invitation, proposals, evaluation reports and contracts would not apply to (a) contracts for the employment of consulting firms estimated to cost less than US$75,000 equivalent each, or (b) contracts for the employment of individuals estimated to cost less than US$30,000 equivalent each. However, said exceptions to prior Bank review would not apply to (a) the terms of reference for such contracts, (b) single-source selection of consulting firms, (c) assignments of critical nature, as reasonably determined by the Bank, (d) amendments to contracts for the employment of consulting firms raising the contracts value to US$75,000 equivalent or above, or (e) amendments to contracts for the employments of individuals consulting raising the contract value to US$30,000 equivalent or above.

4.12 Procurement Status of Ongoing Projects and Proposed Arrangements. Disbursements under the ongoing project (Cr. 1607-BUR) were on schedule. The coordinating team and the CAMEG would be responsible for all other procurement with support from consultants when necessary. The coordinating team would promptly report bid evaluation and contract award information and review procurement progress in bi-annual reports.

E. Disbursements

4.13 Disbursements from the IDA Credit would cover the percentage of total expenditures as indicated in Table 5.

Table 5: Allocation and Disbursement of the IDA Credit

Category of Expenditures	Proposed IDA Allocation (US$ million)	% of Expenditures Financed by IDA
1. Civil works	0.5	100
2. Equipment, Materials, Furniture, Vehicles, Lab and Medical materials and supplies	5.5	100
3. Drugs, Contraceptives, Condoms	9.1	100
4. Specialist Services	2.9	100
5. Training and fellowships	2.1	100
6. IEC	2.2	100
7. Incremental Operating Costs:		
(a) Salaries	0.5	100
(b) Other	0.7	*
8. Unallocated	2.8	-
TOTAL	26.3	

* 100% through December 31, 1995; 65% through December 31, 1997; 35% thereafter.

4.14 The project is expected to be completed over a five-year period, with the IDA Credit disbursed in six years, according to the categories shown in the table above. The estimated disbursement profile is shown in Annex 9. Burkina's standard disbursement profile for all sector is 8 years. Disbursement of the Credit would be fully documented except for expenditures (contracts, training, and incremental operating costs) valued less than US$20,000 equivalent which would be made against Statements of Expenditures (SOEs). Documentation for withdrawals under SOEs would be retained at CONAPO for review by IDA supervision missions and for semiannual audits. Disbursements for contracts for the Fund that meet the eligibility criteria established for the Fund and valued to a maximum of US$10,000 equivalent will be made on the basis of SOEs, with relevant documentation also retained by the Coordinating Unit for review by IDA supervision missions and external auditors. To facilitate disbursement, the Government would open a Special Account (SA) in a commercial bank to cover IDA's share of eligible expenditures managed by CONAPO. The authorized allocation for the Special Project Account would be US$500,000, and would be only for making payments against contracts estimated less than US$250,000. At the request of the Borrower, IDA would replenish the SA upon receipt of satisfactory proof of incurred eligible expenditures. Replenishment requests would be accompanied by up-to-date bank statements and reconciliations of the SA. Given the availability of the Special Account, the minimum application for direct payments, reimbursement or requests for special commitments would normally be for the equivalent of US$20,000 equivalent.

F. Accounting, Auditing and Reporting

4.15 CONAPO would be responsible for the financial management of the project and would maintain, with the assistance of a private accountant, consolidated project accounts in accordance with International Accounting Standards (IASs). Project accounts, including the SA, would be audited annually in accordance with International Standards on Auditing (ISAs) by auditors acceptable to IDA.

The project accounting system should be capable of producing, on a timely basis, information used by management to plan, evaluate and control within the project use of, and accountability for, its resources. This should include the regular production of financing situations for all loans and credits, showing funds utilized, committed and available by category of expenditure and project component, in the currency of the respective agreement. It should also include information to enable management to compare and control costs with appraisal estimates. SOEs would be accepted as basis of disbursements only if the internal control and accounting system and auditing arrangements are satisfactory. If the absence of auditors absolutely precludes this practice, then disbursements under SOEs would be audited semiannually. The annual audit report would be submitted to IDA within six months of the end of each fiscal year; the semi-annual audit reports would be submitted to IDA within three months of each period; the Government would submit a short-list of independent auditors, including the related draft contract and terms of reference. During negotiations, the Government gave assurances that it will submit to IDA audit reports of reasonable scope and details within: (a) six months of the end of each fiscal year in the case of the annual audit report; (b) and three months of the end of each semester in the case of the SOEs. The appointment of an independent auditor under a multi-year contract acceptable to IDA would be a condition of credit effectiveness. The auditor should be appointed under an "open" contract and his mandate reconfirmed each year. Project management should be encouraged to prepare the financial statements for audit as early as possible so as to advance the date of the audit and permit early reconfirmation of the auditor in time for him to carry out the interim audit of the current year. If the project is properly equipped with an appropriate accounting and financial management system by the time it is effective, there is no reason why financial statements cannot be available for audit within one month of the year end and the audit completed within three months of the year end; these would be acceptable "targets".

V. PROJECT BENEFITS AND RISKS

A. Benefits

5.1 The project's interventions would help increase by 1999 the prevalence of modern methods of contraception in rural areas from 1.5% to 9% and in urban areas from 17% to 32%. The number of FP users would grow from an estimated 80,000 to about 350,000 in 1999. The wider practice of FP would have a particularly beneficial impact on the health of women and children. The project would help slow the spread of the HIV infection and alleviate the burden of HIV/AIDS on individuals, families and the nation. The project would have significant returns in terms of years of healthy life saved and would hold down the indirect economic cost of AIDS - the losses of productivity and human capital, which threaten the long term economic development of Burkina Faso. Most importantly, the cost of dealing with the disease now would be small in comparison to the cost if the disease were allowed to become more widespread. The project would help combat STDs, which is one of the most effective strategies to inhibiting the spread of HIV. By 1999, reliable supplies of condoms would provide protection from HIV/AIDS/STD, to about 570,000 sexually active adult males (about 20% of the estimated sexually active male population) who are expected to be persuaded by the public information campaigns to use condoms, to do so. Distribution of condoms to high-risk populations supported by intensive IEC effort, is expected to cover a much higher percentage of these populations. Protective supplies would safeguard an estimated 4,500 health personnel. By integrating HIV/AIDS/STD prevention in FP/MCH activities, the project would contribute to alleviating the number of infections transmitted to women. Neonatal infection would be reduced.

B. Risks

5.2 The project faces two major risks. First, attainment of project goals may be hampered by the fact that changing reproductive and health behavior is a difficult and time-consuming undertaking. To mitigate this risk, the project would provide heavy support to IEC activities and would use NGOs and

other private sector organizations to reach those at risk. To mobilize continued, strong support for FP as well as for HIV/AIDS/STD prevention and control among political, traditional and religious leaders, the project would support (i) actions to increase the awareness of these leaders to the urgency of addressing these issues, and (ii) extensive information campaigns to which national leaders are expected to contribute actively. Second, Government's weak capacity may result in poor project implementation. This risk would be addressed through the strengthening of the institutions involved in the implementation of the project, and through heavy reliance on the private sector and NGOs. Activities in this area would complement those undertaken under other Bank Group operations to strengthen the health services delivery system.

VI. ASSURANCES AND RECOMMENDATION

6.1 During Negotiations, the Government gave assurances that:

(a) (i) it will review with IDA the technical assistance arrangements with WHO for the procurement of condoms, and with UNFPA for the procurement of contraceptives at the end of the second year of project implementation to decide whether to further extend them; and (ii) following the first shipment of contraceptives and condoms, it will monitor their distribution and take corrective action if logistics or stock management are not found satisfactory (para. 3.11);

(b) it will (i) construct animal-drawn village ambulances for about 50 selected villages; (ii) evaluate the effectiveness of the ambulances after one year; (iii) report the result of the evaluation to IDA; and (iv) expand, if found satisfactory and recommended by IDA, such construction to an additional 350 villages (para. 3.13);

(c) support ABBEF through (i) the construction of an extension to the model clinic in Ouagadougou; (ii) the implementation of a pilot project of a community-based distribution of contraceptives in three selected provinces; and (iii) FP and HIV/STDs prevention counselling to youth in Koudougou (para. 3.17);

(d) (i) it will recruit an IEC firm for a three-year period for the provision of non-resident services and a national IEC counterpart in CONAPO with qualifications agreeable to IDA, and (ii) it will maintain said counterpart in post for the duration of the project (para. 3.20);

(e) it will undertake a KAP survey in year 5 of the project to measure the project's impact (para. 3.21);

(f) an agreement will be signed between the Ministry of the Economy, Finance and Plan and the Ministry of Communications for carrying out the project's mass media IEC activities (para. 3.22);

(g) it will (i) during the annual review meeting with IDA, agree on the number and content of seminars CONAPO will organize during the upcoming year, and (ii) CONAPO will prepare a research program for the project agreeable to IDA by June 30, 1995; and will complete this program by June 30, 1998 (paras. 3.24 and 3.34);

(h) the Permanent Secretariat of the CNLS will enter into a twinning arrangement with a specialized institution such as the Dutch Royal Institute for Tropical Diseases or the Center of Disease Control in Atlanta (USA) by March 31, 1995 (para. 3.46);

(e) a reporting system for epidemiological surveillance would be put in place by June 30, 1995 (para. 3.48);

(j) HIV/AIDS/STD research will be implemented in accordance with an agreed timetable and the studies will be reviewed with IDA and agreed follow-up actions will be carried out (para. 3.51);

(k) it will (a) organize a seminar to define the AIDS/STD IEC strategy by June 30, 1995, and discuss with IDA and finalize said strategy by September 30, 1995; and (b) carry out at the end of the second year of project implementation, an evaluation of the mass-media program, discuss its recommendations with IDA, and implement agreed upon action plan (para. 3.55);

(l) (i) it will undertake in the first six months of project implementation trips to other African countries to learn from their experience in the preparation of treatment protocols for HIV-related diseases, (ii) it will finalize such protocols by December 31, 1995, and (iii) will submit to IDA any proposed change in the treatment protocols for both HIV related diseases and STDs that affect the use of the drugs to be procured under the project (para. 3.68);

(m) it will (i) make available to participating NGOs portions of the amounts allocated to the Fund under agreements to be entered into between the Government and NGOs on terms and conditions satisfactory to IDA, and (ii) submit to IDA for review and approval the first three proposals of NGOs, regardless of the amount involved, and any proposal in excess of US$75,000 equivalent (para. 3.73);

(n) it will (i) review with IDA each year by March 31 the progress of project implementation over the previous 12 months, starting in 1995; (ii) by March 1997 carry out with IDA a mid-term review of the project in accordance with terms of reference agreeable to IDA, and take into account comments and suggestions made by IDA at such review, during project implementation; and (iii) four months after credit closing prepare a project completion report (para. 4.4);

(o) (i) an audit of the project accounts, audited by independent auditors acceptable to IDA, will be made available to IDA within six months of the close of each fiscal year, and (ii) and audit of the SOEs would be available within three months of the end of each semester (para. 4.15).

6.2 Prior to Board Presentation, the Government submitted two Letters of Population Sector Development and AIDS Prevention Policies, both including time-bound indicators (para. 3.4).

6.3 As Conditions of effectiveness, the Government would:

(a) approve a training program satisfactory to IDA (para. 3.8);

(b) sign technical assistance agreements with WHO for the procurement of condoms and with UNFPA for the procurement of contraceptives (3.11). Such agreements would be reviewed two years after their implementation to determine the need to further extend them (para. 3.11);

(c) establish (i) the project coordination team within CONAPO's Permanent Secretariat in numbers and qualifications satisfactory to IDA, and (b) an accounting system satisfactory to IDA (para. 3.35);

(d) (i) reorganize the Permanent Secretariat and staff it with adequate full-time personnel in numbers and qualifications satisfactory to IDA, and (ii) enact a new ministerial decree clarifying the roles and functions of the Permanent Secretary and those of the technical subcommittees (para. 3.44);

(e) (i) establish an independent committee for the selection of NGOs' proposals, satisfactory to IDA, to review and approve financing proposals prepared by NGOs; and (ii) approve the procedural manual regulating the management of the Fund and the standard contract, agreeable to IDA, between the Government and NGOs benefitting from financing under the Fund (para. 3.72);

(f) establish a monitoring and evaluation system acceptable to IDA (para. 4.4); and

(g) appoint an independent auditor under a multi-year contract acceptable to IDA to carry out yearly review of the project accounts (para. 4.15).

The effectiveness of grant agreements between the Government and the Governments of Norway and Denmark to assist in the financing of the project would be an additional condition of effectiveness (para. 3.74).

6.4 Recommendation. Subject to the above terms and conditions the proposed project would be suitable for an IDA credit of US$26.3 million equivalent to the Republic of Burkina Faso on standard IDA terms, with 40 years maturity.

ANNEX 1
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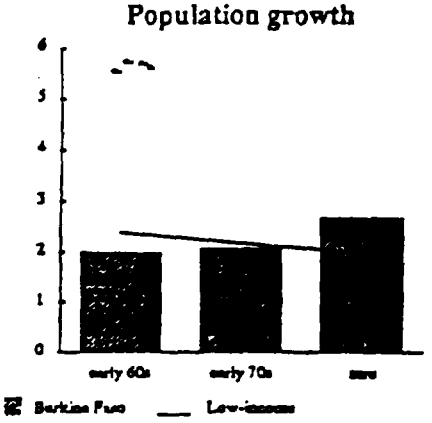
BURKINA FASO

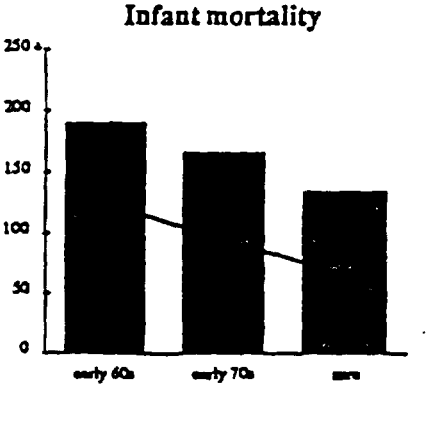
POPULATION AND AIDS CONTROL PROJECT

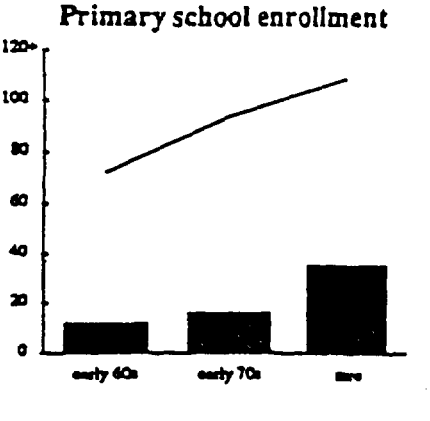
SOCIO-ECONOMIC INDICATORS

	Unit of Measure	25-30 years age	15-20 years age	Most Recent Estimate (mre)	Same Region Sub-Sah. Africa	Income Groups Low-Income	Next Higher Income
Income Indicators							
GNP per capita (mre = 1990)	US$	80	130	290	340	350	1,530
Social Indicators							
Public Expenditures on Basic Social Services	% of GDP	-	-	10	-	-	-
Gross Enrollment Ratio:	% school age group						
Primary: Total		12	16	36	69	109	101
Female		8	12	28	72	99	98
Secondary: Total							
Female							
Mortality	per '000 live births						
Infant Mortality Rate		190	166	134	104	70	50
Under-5 Mortality Rate		-	-	199	167	167	80
Immunization (under 12 months)	% age group						
Measles		-	-	40	49	44	85
DPT		-	-	30	38	43	67
Life Expectancy	years						
Overall		38	42	48	51	62	65
Females		40	44	49	52	63	68
Total Fertility Rate	births per woman	6.4	6.5	6.5	6.5	3.7	3.7
Maternal Mortality Rate	100,000 live births	-	-	810	-	-	-

Source: Social Indicators of Development, 1991-1992, The World Bank, 1992.
World Development Report 1993: Investing in Health, the World Bank, 1993.







In Burkina Faso, two different Ministries - Economy, Finance and Plan, and Health - play a leadership role in, respectively, population and AIDS control issues. Each of them has prepared a separate letter of sector development policy, the translation of which is here provided.

TRANSLATION OF THE ORIGINAL LETTER IN FRENCH

MINISTRY OF THE ECONOMY, FINANCE AND PLAN

Ouagadougou, May 4, 1994
TO
The President of the
International Development Association
1818 H Street, NW
Washington, DC 20433

Subject: **Letter of Population Sector Policy**

Dear Mr. President,

With reference to the proposed Population and AIDS Control Project (PPLS), I am pleased to transmit to you the following letter of population sector policy.

Burkina Faso is a landlocked Sahelian country of 272,527 km2, with a population of 9.2 million, according to a demographic survey conducted in 1992/93. At that time, the annual population growth rate was estimated to be 2.68%, with about 87% of the population living in rural areas. The rapid population growth rate endangers any effort to bring about improvements in health and nutrition; the literacy rate; training; under- and unemployment. This rate of growth also has negative effects in terms of deforestation, soil erosion, and desertification. From an economic and financial point of view, growing deficits in public finances have caused the Government of Burkina Faso to adopt a structural adjustment program in order to eliminate macro-economic disequilibria. Fully aware of the possible negative social repercussions of the adjustment measures, the Government has chosen to adopt a socio-economic development policy which also includes population issues. It is in this context that it prepared in 1991 a population policy statement, with the ultimate objective of improving the living conditions of the population. The Government has also integrated in its population policy the problems related to the spread of the Human Immunodeficiency virus (HIV), and of the acquired immune-deficiency syndrome (AIDS).

The Government population policy is multisectoral and its main objective is to improve the quality of life of the population. Within this overall objective, a number of spe- cific objectives have been set, of which the most important are:

1. Increasing contraceptive prevalence (CP) from 4.4% to 60% by year 2005;
2. By the year 2005, providing to all people, but in particular to the youth, extensive information on population issues to encourage them to become responsible parents;
3. Reducing the fertility rate by 10%, every five years, starting in year 2005.

The Government has also defined the strategies and the actions that should allow the above objectives to be attained. Its main strategies concern the following areas:

Maternal and Child Health (MCH)
Family Planning
Adult Morbidity and Mortality

Information, Education and Communication (IEC)
Role and Status of women
Education and Training
Employment
Migration and Urbanization
Rural Development
Demographic Studies and Research

The Government has also created the political conditions and the institutional framework needed for a successful implementation of its population policy. Steps taken include: (a) the adoption in June 1992 of a Program of Priority Actions for the 1991-95 period; (b) the establishment of the National Population Council (CONAPO), responsible for the implementation of the population policy and for the coordination of all activities related to the population sector; (c) the establishment of the Permanent Secretariat of CONAPO and its four specialized commissions: i) demographic research, ii) population and development; iii) family well being; and iv) information, education and communication (IEC) in the area of population; and (d) the adoption of the National Family Planning Strategy for the 1993-1998 period.

The adoption of a number of action programs such as the program of priority actions in the area of population, the family planning action program, the action program to address women's issues, provide further evidence of the Government's commitment to addressing the country's population problem.

The Government also intends to collaborate with other public and private sector organizations for the implementation of its population and AIDS control program . To this end, it organized in May 1992 a meeting of all agencies active in the area of population, both in the private and public sector, with the view to establishing a coordination mechanism.

The Government hopes that through the implementation of its first population program it will be able to provide a better understanding of the country's demographic dynamics and of the social and economic implications of rapid population growth. The expected outcome is a change in people's attitude vis-à-vis human reproduction as well as a more responsible attitude towards parenting. Equally, the implementation of this first program of priority actions in the area of population should bring about a decline in the fertility rate through the implementation of the family planning program and a halt in the spread of AIDS.

To ensure a more successful implementation of its population policy, the Government requests the technical and financial support of the International Development Association for the implementation of the Population and AIDS project, and will ensure its full integration into the existing population program.

The project will thus assist the Government in the implementation of its population policy. More specifically, it will help reduce the rate of population growth and slow the spread of AIDS.

These are the Government's broad directions and strategies regulating the implementation of its population policy in which context I request the financial support of the International Development Association for the Population and AIDS Control Project.

I am also including a list of quantified monitorable indicators of results to be achieved by the end of 1999.

Truly yours
The Minister of Economy, Finance and Plan
Zephirin Diabré

TRANSLATION OF THE ORIGINAL LETTER IN FRENCH

MINISTRY OF HEALTH

GENERAL SECRETARIAT

NATIONAL AIDS COMMITTEE (CNLS)

Ouagadougou, April 1, 1994

TO

The President
International Development Association
Washington, DC 20433

Subject: **Letter of AIDS Sector Policy**

Dear Mr. President,

Burkina Faso is currently one of the countries in West Africa more severely affected by HIV. Seroprevalence among the general population is estimated at 7%, while it reaches 13.1% among truck drivers, 8.5% among pregnant women, 29% among persons infected with tuberculosis, and 23% among STD-infected persons. In urban areas where prostitution is widespread, the seroprevalence rate among persons with multiple partners is quite high. About 64% of commercial sex workers in Ouagadougou and 43% of those in Bobo Dioulasso are estimated to be seroprevalent. Because of limited epidemiological surveillance, it is not possible to determine what the real situation is in rural areas. However, widespread traditional practices such as the levirate, female circumcision, scarring etc., considerably increase the risk of HIV transmission.

The youth is particularly affected by the infection and the number of AIDS cases among young people has increased from 3% in 1987 to 7% in 1992. Women are also being increasingly infected and while in 1988 women represented 25% of AIDS cases, their proportion has now increased to 38%.

Reported AIDS cases have increased dramatically, from 10 in 1986 to 2,886 as of December 1992. This situation places Burkina Faso third, after Côte d'Ivoire and Ghana, among the West African countries most affected by the disease.

Currently, a new AIDS case is recorded every day at the National Hospital in Ouagadougou. Particularly affected is the sexually active and economically productive population. In fact, 75% of those hospitalized for AIDS are of age 15 to 40.

Clinically, the most common symptoms of HIV/AIDS patients presenting to hospitals are chronic diarrhea, and respiratory and skin infections. These diseases progressively destroy the capacity of an individual to function and the cost of the treatment of AIDS victims becomes more and more expensive as the disease progresses.

To fight this deadly disease, the Government established in 1986 a National AIDS Committee, with the mandate of preparing, executing, coordinating, and evaluating the national AIDS policy, in

collaboration with numerous national and international partners. This policy has been translated into short- and medium-term programs.

The objective of the first short-term plan prepared in 1986 was to a) measure the evolution of the disease in the country, determine the national capacity to respond, and identify possible partners, who could support the Government actions, and b) develop a national Information, Education and Communication policy focusing on providing information.

The short term plan achieved its objectives, making it possible for the Government to prepare a first medium term plan (MTP I 1988) for the 1988-1992 period and expand CNLS's activities. Specifically, the objectives of the MTP I were to:

- control the sexual transmission of AIDS through mass information, sensitization campaigns, education programs targeted at risk groups (the youth, commercial sex workers, the military, traders, etc.) and through the social marketing of condoms;

- improve blood security by training health personnel and providing funds to finance the operating expenses of laboratories:

- reduce mother-child HIV transmission;

- improve the management of AIDS cases through training of social and health workers, provision of drugs and protective supplies:

- promote and coordinate AIDS research:

- improve AIDS surveillance by strengthening sentinel sites.

The First Medium-Term Plan received about US$ 3.5 million, provided by the Burkinabé Government and its partners (WHO/UNDP, USAID, the German Government, the EC, Canada and UNICEF).

The Health and Demographic Survey (DHS) carried out in 1992/93 by the National Institute of Statistics (INSD), showed that AIDS awareness was high among men (94%) and women (83%). This is an important outcome of the first MTP. The DHS also showed that AIDS awareness was equally high in rural areas (92%).

The financing provided under the plan allowed to undertake the rehabilitation of the country's blood banks and improved the supply of rapid tests. It also contributed to the training of about 1500 social and health workers. Through the implementation of a social marketing program, condoms were made available to the population in all of Burkina's 30 provinces. A number of socio-behavioral studies were conducted between 1989 and 1992 to improve the IEC program. Hospitals were also provided with medical and protective materials.

In 1992, the Government realized that its efforts notwithstanding, the number of AIDS victims continued to grow, reaching 2,886 (recorded) cases, and that the seroprevalence among the general population was touching levels between 5% and 7% of the population. A number of surveys also showed that AIDS awareness had not contributed to a change in behavior, and that there were still considerable misconceptions related to the disease and prejudices towards AIDS victims.

To improve its capacity to control the disease, the Government prepared a MTP II for the 1993-95 period, largely focusing on prevention. The strategy laid out in this plan emphasizes the need to mobilize all of the countries' forces (public institutions, NGOs, religious and traditional leaders) in a massive information, education and communication campaign to bring about a change in sexual behavior and the elimination of professional and traditional practices that put a person at risk of contracting AIDS.

The budget for the MTP II covering the 1993-1995 period was estimated at US $ 7.1 million. During a donors' meeting organized in December 1992, a number of institutions including the World Bank, pledged to support the plan.

The main objectives of the new MTP are:

- improve people's knowledge of risk behavior;
- bring about a change in behavior,
- slow the spread of HIV;
- support social interventions to help victims to cope with the impact of AIDS.

To achieve above objectives it will be necessary to mobilize considerable human and financial resources, and I am convinced that your institution, with the support provided in the context of the Population and AIDS project, will be extremely useful.

I am also attaching to this letter a list of annual monitorable indicators of results to achieve in the context of the project by the end of 1999.

Yours truly,

Christophe Dabiré
Minister of Health

Quantified Annual Monitorable Indicators - 1995-1999

Indicators	1995	1996	1997	1998	1999
1. CSPS offering FP services	40	60	100	100	100
2. Village ambulance	50	-	150	200	-
3. Contraceptives distributed (1000 one-month doses of pill) /1					
- rural areas	356.1	393.6	432.9	473.9	517.0
- urban areas	559.6	676.8	800.1	930.0	1,066.3
4. Social workers trained in IEC/FP	36	36	36	36	36
5. Health workers trained in IEC/FP	250	250	250		
6. CRESAs operational	2	2	3	3	10
7. Demographic research undertaken	1	1	1	1	1
8. Opinion leaders sensitized in population and AIDS control	300	300	300	300	300
9. Teachers trained in population and AIDS control	200	200	200	200	200
10. NGOs' projects initiated	8	16	30	30	20
11. Sentinel sites in operation	5	-	-	-	-
12. Operational research	2	3	1	-	-
13. HIV/STD tests provided (# of kits)	465	465	465	465	465
14. Number of mass media messages (FP/population and AIDS control)	150	150	150	150	150
15. Social workers trained in STD/AIDS	20	40	40	40	40
16. Health workers trained in AIDS/STD surveillance	25	25	25	25	25
17. Persons (paramedical staff, social workers, community members) trained in counselling	-	275	275	275	275
18. Condoms sold (million) /2	5.1	7.3	10.95	16.1	21.9

/1 Since the pill is the most popular method of contraception, its distribution pattern is a good indicator of the trend in contraceptive prevalence during the implementation of the project.

/2 The project covers 73% of estimated needs.

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

PROPOSED TRAINING PROGRAM

Participants	Type of Training	POPULATION COMPONENT																		
		Expanding FP Services through the Public Health System			Establishing an Outreach Program			FP/IEC			Strengthening CONAPO			Strengthening DSF			Strengthening DPF		
HEALTH PERSONNEL		No.	SW	Exec. Agency	No.	SW	Exec. Agency	No.	SW	Exec. Agency	No.	SW	Exec. Agency	No.	SW	Exec. Agency	No.	SW	Exec. Agency
- Doctors	- Norplant	50	200	DSF															
- Nurses	- Norplant - FP/MCH & IEC - FP/IEC	100 700	200 2,100	DSF DSF				750	1,500	DSF									
- Regional trainers	- Norplant	60	120	DSF															
- Auxiliary midwives	- FP/MCH & IEC	400	1,200	DSF															
- TBAs/ VHWs	- contraceptives supply				400	400	DSF												
- CRESAS health workers	- FP/IEC							10	50	DSF, ABBEF									
- Social workers	- FP/IEC							90	270	DPF									
OTHER																			
- Opinion leaders	- seminars on pop./development/AIDS							1,500 /a	1,500	CONAPO/ DSF/CNLS/ Plan									
- CONAPO IEC Coordinator	- advanced IEC techniques										1	4	Region						
- CONAPO staff	- computer										7	7	Nt'l TA						
- DSF staff	- MPH program - Advanced IEC techniques - Regional fellowships in health management - IEC program management - Study tours in program mgt													4 1 12 1 4	144 4 48 4 4	Abroad Region Abroad Abroad Abroad			
- Teacher training	- Population dynamics, FP							1,000	2,000	MESSRS									
- Regional trainers	- In-service training in delivery services													15	15	Nt'l TA			
- DPF staff	- Basic IEC																2	8	Region

/a Total number of participants to attend the seminars on both Family Planning and AIDS IEC.

ABBEF = Association Burkinabe du Bien-Etre Familial
Abroad = Overseas fellowships and seminars
DSF = Family Planning Directorate
DPF = Family Promotion Directorate
CONAPO = Interministerial Population Committee
Plan = Ministry of Finance and Planning
REGION = African countries
MESSRS = Ministere de l'Enseignement Superieur et de la Recherche Scientifique

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

PROPOSED TRAINING PROGRAM

Participants	Type of Training	HIV/AIDS/STDs COMPONENT											
		AIDS/IEC			Strengthening the CNLS			Building capabilities for HIV/AIDS/STDs prevention and control			Strengthening clinical mgmt and community care		
HEALTH PERSONNEL		No.	SW	Exec. Agency	No.	SW	Exec. Agency	No.	SW	Exec. Agency	No.	SW	Exec. Agency
- Doctors	- Epid.surveillance/ STDs/counseling - Study tours in other African countries to share experience in case mgmt of AIDS patients							76	76	Doctors	2	2	Region
- Nurses	- Epid.surveil./ STDs/counseling - Study tours in other African countries to share experience in case mgt of AIDS patients							16	16	Doctors	3	3	Region
- CRESAS health workers	- AIDS/IEC	10	50	DSF, ABBEF									
- Social workers	- AIDS/IEC counseling - study tours in other African countries to share experience in counseling of AIDS patients	90	270	DPF							162 7	162 7	Region
- Medical staff from sentinel sites	- Epid. surveillance							30	30	Doctors			
- Lab. staff	- Maintenance of equipment of the national hospital							1	8	Abroad			
- Researchers	- Research methodology							30	3 days	seminar			
- Paramedical staff	- counseling/community care										700	1 day	
- STDs team	- STDs/AIDS seminar - Int'l AIDS conference							3 7	3 7	Region Abroad			
OTHER													
- CNLS staff	- Coordination of AIDS/IEC activities w/ other countries - IEC program management - Study tours in program mgt - Basic IEC				2 1 4 2	2 4 4 8	Region Region Region Abroad						
- Religious leaders, youth, women	- counseling, community care	240	240								120	120	
- Teacher training	- AIDS/IEC		6 weeks	Health									

ABBEF = Association Burkinabe du Bien-Etre Familial
Abroad = Overseas fellowships/seminars
DSF = Family Planning Directorate
DPF = Family Promotion Directorate
CONAPO = Interministerial Population Committee
MESSRS = Ministry of Higher Education and Scientific Research
Region = African countries
Plan = Ministry of Finance and Planning

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Information, Education and Communications (IEC)

51. Both the population and the AIDS/STD components of the project contain information, education and communications (IEC) subcomponents. These subcomponents are designed to achieve two broad objectives:

- The **Population IEC subcomponent** is designed to increase public knowledge of, and demand for, modern contraceptive methods

- The **AIDS/STD IEC subcomponent** is designed to increase public understanding of AIDS and STDs and to promote preventive practices.

2. A variety of communications techniques and channels will be used, including mass media, traditional communications and interpersonal communications through health workers, social workers and other organized channels. IEC activities will be carried out by a number of governmental and nongovernmental entities. The main governmental entities participating in achieving the population IEC objective will be: the Permanent Secretariat of CONAPO in the Ministry of Finance and Plan, which will promote understanding of population issues; the Family Health Directorate in the Ministry of Health and the Directorate for Family Promotion in the Ministry of Social Affairs and Family, which will educate the public about women's rights as well as participate in family planning promotion. Other governmental entities will play supporting roles and nongovernmental organizations will participate through the project Fund. The National AIDS Committee will assume the lead role with respect to the AIDS/STD IEC objective, with support from NGOs through the project Fund.

3. The IEC activities of the key entities will be coordinated through monthly meetings convened by CONAPO's Permanent Secretariat. These meetings will ensure that activities are complementary, rather than duplicative, that activities (such as research or training) are undertaken jointly when appropriate, that resources such as equipment and materials are shared among the partners in the project and that the messages going out into the field and to the public are coordinated and coherent. CONAPO will also convene meetings of its IEC commission, in consultation with the commission's chair, the Directorate for Family Promotion, at least once a year. (Funds for the latter activity will come from the institutional development subcomponent.)

4. Among the governmental entities participating in IEC activities, only the Family Health Directorate has staff specializing in the management of a broad IEC program. Under both IEC subcomponents of the project, there will be a significantly greater level of effort. To help achieve the population objective, the Government will re-assign an IEC specialist to work full-time with the Permanent Secretariat of CONAPO. The Family Health Directorate's staff may also soon grow from four to five. In order to quickly create momentum for IEC activities aimed at AIDS prevention in the face of an extremely serious HIV/AIDS situation, the project will finance a full-time senior communications specialist from the private sector to manage the National AIDS Committee's IEC program. This staff will be assisted by another IEC specialist, also recruited by the project.

In order to enhance the impact of this staff, both in population and AIDS, a number of important tasks under the project will be contracted out. For example, advertising agencies will undertake most of the creative and technical work of developing radio and television spots and research institutions will conduct most of the IEC research.

5. To support the staff of all the main entities participating in IEC, the project will finance 36 person-months of short-term technical assistance during the first three years from an international agency specializing in IEC. The project coordinating unit will be responsible for identifying and hiring the IEC agency, in consultation with the Permanent Secretariat of CONAPO, the Family Health Directorate, the Directorate for Family Promotion and the National AIDS Committee's National Coordinator; it will also coordinate technical assistance visits by the agency. The IEC agency will provide a minimum of 12 months of one person's time to visit Burkina at least twice each year; once to assist in the development of annual work-plans and once to ensure that plans are progressing smoothly. This person will spend at least four months in Burkina as the project is starting up to help with the organization of IEC activities and, later, he/she will participate in the design of IEC research, and the development of IEC strategies and mass media. The remaining 24 person-months will be available to meet specific technical assistance needs as they arise, such as training, analysis of IEC research, evaluation of materials or mass media, support of decentralization of IEC, etc.

6. In addition, under the project's institutional development subcomponent, key national IEC staff will receive training abroad appropriate to their needs: training in IEC program management for the National AIDS Committee's IEC coordinator and the Family Health Directorate's new staff member (if he/she is assigned to the directorate and has sufficient seniority); advanced IEC training for the CONAPO IEC coordinator and one person at the Family Health Directorate; and basic IEC training for the two IEC staff at the National AIDS Committee and two at the Directorate of Family Promotion. Funds will also be available under that subcomponent for two study tours abroad--one to observe a family planning IEC program and one for an AIDS IEC program--for four people each. The institutional development subcomponent will also finance basic audio-visual equipment needed for the key entities involved in IEC activities, where such equipment is lacking and will provide funds to purchase books and subscriptions.

7. In order to measure the impact of the project's IEC subcomponents, a brief national KAP survey will be undertaken before project start-up to assess public knowledge and attitudes on family planning, AIDS and STDs, and will be repeated at the end of the project. The Family Health Directorate and the National AIDS Committee together will be responsible for this survey.

I. Population IEC

8. The specific objectives of this subcomponent will be to double the proportion of young people (age 15-25) who knows of a modern method of contraception and double the proportion of the general adult population who knows where contraceptive services are available. Once data from the pre-project KAP survey are available, these "doubling" objectives will be quantified. IEC activities will be targeted primarily to young people--both because of the size of this population group and also because they are more apt to change their behavior--and will begin to touch rural areas where most of the population resides. A multi-media approach will be adopted, using modern mass media as well as interpersonal communications. The latter will reach out well beyond the health system, using social workers and the newly established regional health education centers (CRESAs) to work with organized groups in the population. Extensive use will be made of traditional communications techniques and channels, such as folk theater, story telling and traditional healers.

9. There will be three elements to this subcomponent: (a) increasing public support for population issues among opinion leaders; (b) increasing public knowledge of, and demand for, modern contraceptive methods; (c) and enhancing public understanding of women's rights and problems. While two of these elements are not directly focussed on building demand for contraception, they play crucial supporting roles in creating a positive climate for contraceptive use.

A. Increasing Support for Population Issues among Opinion Leaders

10. The Permanent Secretariat of CONAPO will be responsible for educating opinion leaders about population issues, with a view to improving their understanding of the relationship between population trends and development and mobilizing their support on population matters. The main focus will be on governmental leaders at the national and regional levels and all activities will be undertaken in close consultation with the Family Health Directorate and the National AIDS Committee to ensure that there is no duplication of effort.

11. Materials Development. The Secretariat will develop and distribute educational materials such as booklets, brochures, posters and audio-visual presentations on issues related to population and development. It will synthesize policy-relevant information and research findings into short, attractive, user-friendly publications and audio-visual presentations. The kinds of topics to be addressed will be the 1991 population policy, the Demographic and Health Survey, census results, the relationship between population and agriculture, etc. It is anticipated that 10 publications and 10 audio-visual presentations will be prepared over the life of the project for dissemination and use at seminars and distribution to decision-makers in government and outside.

12. Information Bulletin. CONAPO plans to prepare a quarterly bulletin with news about population and development, reports on the meetings of its commissions as well as on government and private sector activities in the field. A distribution of 3,000 - 5,000 is anticipated, comprising decision-makers in government and outside.

13. Seminars for Opinion Leaders. Thirty national and regional seminars for a total of approximately 1,500 people will be held on a variety of topics related to population and development. The primary target groups for these seminars will be government decision-makers at the national, regional, provincial and department levels. A small seminar will be held early in the project to finalize a population IEC strategy. Over the life of the project, it is anticipated that the regional offices of the Ministry of Finance and Plan will become increasingly involved in organizing seminars for decision-makers in their regions, with the staff of the Permanent Secretariat participating primarily to provide a national perspective.

14. Mass Media. The Permanent Secretariat will maintain close contact with the media in order to ensure coverage of population topics. While most of this contact will be informal, the Secretariat anticipates occasional meetings of the cadre of journalists specializing in population matters to update their information or to develop a strategy for covering a matter of special importance.

B. Increasing Public Knowledge of, and Demand for, Contraceptive Services

15. The Family Health Directorate's IEC bureau has accomplished a considerable amount of work in recent years, with support and technical assistance from Population Communications Services. However, with that support expected to end as this project begins, the directorate believes the time is

right to rethink its IEC strategy. The challenge will be to take relatively high awareness of contraception in the urban areas and translate it into broader use of modern methods, while beginning to reach out into rural zones.

16. Training of Health Workers in IEC. There has been a considerable amount of training of health workers in IEC but the Family Health Directorate is not satisfied with the results of that training and wishes to consider new strategies. It is also interested in better integration of the maternal and child health services under its jurisdiction and wants to explore the possibility of providing "information packages" to women when they have contact with the health system. For example, at childbirth, they would be informed about the importance of a postpartum check-up, family planning and vaccination. The strategy of asking mothers at the time of delivery to return on the 40th day for postpartum care, vaccinations and family planning has proven very successful in Tunisia and elsewhere. The directorate plans to explore the possibility of implementing this approach in Burkina, conducting pilot projects in Years 1 and 2. When a new strategy for IEC in health centers is adopted, training and re-training of health workers will begin. It is anticipated that 750 nurses, midwives and other medical personnel will be trained in Yrs 3-5. In the meantime, however, plans will proceed to train 700 nurses and 400 auxiliary midwives in the provision of contraceptive care. This training will include an expanded and strengthened IEC component.

17. Decentralized IEC Activities. To dramatically expand public education on family planning, the project will fund decentralized IEC activities conducted through the 10 CRESAs and the health districts. Since the same people are often expected to conduct IEC activities on family planning and AIDS/STDs, the decentralized IEC program will focus on both topics and will be administered jointly by the Family Health Directorate and the National AIDS Committee's Permanent Secretariat. The decentralized IEC program will reach out to women's associations, agricultural cooperatives, traditional healers, schools, large enterprises and other groups beyond the health system with key messages on family planning and AIDS. It will be the project's chief vehicle to reach audiences other than those who are already users of the organized health system. Men, youth and opinion leaders will be priority target audiences. The program will also reach out into rural areas, will provide the means to mobilize traditional forms of communication, such as story-telling, songs and folk theater, around family planning and AIDS and will encourage innovation. The methods used will be based on active community participation at all levels: in developing messages and activities and in their execution.

18. The CRESAs, in conjunction with the health districts in their regions, will develop proposals for a specific program of family planning and AIDS/STD IEC activities and will submit them to the central level for funding. The newly established National Center for IEC activities in the Ministry of Health (CNIEC/Santé) will be responsible for approving and disapproving the proposals, jointly with the Family Health Directorate and the Permanent Secretariat of the National AIDS Committee. The latter two will also be responsible for monitoring the CRESAs' activities and ensuring that funds are properly accounted for. Criteria for funding proposals will be developed at the central level by December 31, 1994, in consultation with the CRESAs and the districts, taking the criteria developed for the project Fund as a model. Decentralized activities will emphasize interpersonal communications rather than mass media, although the CRESAs could work to integrate family planning and AIDS information into ongoinglocal radio programming. (It is not anticipated that the CRESAs will develop radio or television spots, since this task calls for a considerable amount of research and experience in message development. As discussed in the section on mass media, however, the CRESAs will be called upon to participate in the development of radio spots for their regions.)

19. The CRESAs have only recently been established and most of them will need a considerable amount of assistance to develop strong and accountable programs. The Family Health Directorate and the National AIDS Committee's Permanent Secretariat together will undertake to provide this assistance, along with ABBEF (where it is present). Before any regional activities are begun, a month-long training program will be conducted to provide the CRESAs with basic information on family planning, AIDS and STDs as well as to strengthen their interpersonal communication and program management skills. Each year, there will be a further week of training to advance their communication and management skills and to provide an opportunity for the group to exchange experiences. In between, central staff will work closely with the CRESAs and the districts and ABBEF will provide on-site technical support in those areas where it is represented. Decentralized IEC activities will be phased in slowly, starting with two CRESAs each in Years 2 and 3 and adding three each in Years 4 and 5.

20. IEC Research. The Family Health Directorate has a considerable amount of experience in IEC research and its application in developing IEC activities. It appreciates the importance of such research and plans to continue conducting both quantitative and qualitative studies and surveys, to identify target audiences, effective messages and channels of communication. In addition, in order to improve the effectiveness of its program activities, it plans to begin conducting studies to assess the impact of its activities, materials and messages. The research will serve to refine the directorate's IEC strategy on a continuing basis. Whenever possible, the technical aspects of the work will be contracted out to research specialists and/or institutions.

21. Mass Media. The Family Health Directorate has undertaken a number of public education activities using the mass media. Generally, these have involved the integration of family planning messages into popular ongoing radio programs. The rationale for this approach is, on the one hand, that it is more consistent with the local tradition of oral communications and, on the other hand, that the messages involved in helping the Burkinabe understand the benefits of family planning and adopt a contraceptive method are too complex to be conveyed in a few seconds. The directorate plans to pursue this approach and to extend it to television. It is also ready, however, to test the use of short, frequently repeated spots to communicate simple messages. Three radio spots in two languages are planned for the first year, with a higher level of activity--and an expansion to television--in subsequent years, if the early experience is positive. All messages will be based on the findings of the IEC research and will be carefully tested before being produced and their impact assessed after broadcast. The directorate expects to avail itself of the services of a local advertising agency to develop spots.

22. It is often costly for entities of the government--not to mention nongovernmental entities--to gain access to broadcast time, print and cinema advertising and billboards. Thus, early during project implementation, the Ministry of Finance and Plan and MOH will seek the collaboration of the Ministry of Communications in reaching the public with crucial messages about AIDS and family planning. Specifically, they will seek to obtain free broadcast time and space for the project's messages in return for financing some equipment or supplies needed by Burkinabe radio and television. A written agreement will be developed between the parties early in the project making it possible for AIDS and family planning topics to receive the intense mass media attention they merit.

23. Production of Materials. A number of materials have been developed to help the public understand why family planning is beneficial and how to use the different methods of contraception. However, the Family Health Directorate recognizes that there are problems with distribution of these materials around the country, that they are often not used by health workers and that they are not as effective as they might be in conveying the desired message to the public. Accordingly, a study is planned to better understand these problems and to propose solutions. Once the study is completed, the

production of further materials is anticipated as well as the re-printing of existing ones. The kinds of materials envisioned are updated versions of the booklets on the various contraceptive methods, contraceptive sample kits, a new series of posters and production of a flip chart and flannellograph. It is anticipated that at least four different items per year will be produced and disseminated, once the study done. At least three videos will be produced in conjunction with a local advertising agency. All materials will be tested before going into production. Funds will be available not only to produce materials locally but also to purchase films, videos, bulk orders of publications, etc. from abroad.

24. Seminars for Opinion Leaders. Family planning is still not well understood by opinion leaders around the country and it will be enormously important to continue activities to inform this crucial target population about family planning, its benefits and availability. These seminars will differ from those conducted by CONAPO inasmuch as they will focus on family planning and health, rather than on population and development, and will touch decision-makers in the nongovernmental as well as governmental sectors. Four seminars per year are planned and will be coordinated closely with CONAPO and the National AIDS Committee. One of the early seminars will focus on the development of a new IEC strategy, setting out specific measurable objectives, along with priority target audiences, key messages and the media to be used. Workshops for the media can also be conducted under this rubric.

25. Resource Center. The directorate already has a significant collection of literature on topics related to family planning and maternal and child health. Funds are provided under the institutional development subcomponent to subscribe to specialized publications and purchase books and materials for this center.

26. Population Education in the Schools. The Population Education Project in the Ministry of Education integrates topics related to population dynamics, sexuality, family planning and the status of women into the formal school curriculum and provides training for teachers in this subject matter. The project has been financed primarily by UNFPA which is curtailing its support. Thus, funds will be available under this project to conduct five training courses a year, beginning in 1995, for 200 teachers a year. It will also provide some support for the production of teaching aids, which are in short supply, and for the purchase of four slide projectors so that each region of the country is equipped with one.

C. Enhancing Public Understanding of Women's Rights and Problems

27. The Directorate for Family Promotion will be the lead agency for this element of the project. However, it could benefit from a management review and the appraisal mission recommends that such a review--already proposed by the Dutch--be undertaken and that steps be taken to implement the recommendations of that review before project activities are undertaken.

28. Promoting the Family Code. In 1991, Burkina Faso adopted a new Family Code which includes ground-breaking provisions advancing the status of women. Since dissemination of information about these rights can be expected to improve the status of women and thus create a climate more conducive to family planning, the project will work in this area. Plans are under way to educate the public about the code, starting with a four-year pilot program in four provinces financed by the Netherlands and other donors. This project will help support these activities. The Directorate for Family Promotion will work closely with the General Directorate of Social Affairs and the Family as well as the Dutch in planning and executing its activities. The emphasis will be on the identification of specific problems facing women in different areas of the four provinces, followed by educational activities targeted on the specific reforms contained in the Family Code that address those problems. Legal

information centers will also be established and a range of information about women's rights will be provided, including information about family planning and AIDS.

29. National Committee Against Excision. The practice of excision is still widespread in Burkina, with deleterious health consequences for young women and girls. The National Committee Against Excision is a volunteer body that has accomplished some important work in educating traditional leaders and the public about the harmful consequences of excision. It is attached to the office of the Minister of Social Affairs and the Family and has established 10 provincial committees and hundreds of local committees that seek to educate the public about the harmful effects of excision. The national committee has developed a four-year plan to enable it to expand and intensify its educational activities, while still preserving its volunteer character. Specifically, it will seek to increase the number of provincial and local committees against excision, develop educational materials for use by the committees, work with the mass media and reproduce a film on excision. These activities will be supported under the project.

30. Training Social Workers. A family planning IEC curriculum has been used to train a substantial number of social workers in Burkina in recent years. The Directorate for Family Promotion has participated actively in developing and teaching the curriculum, but training has been organized by the Family Health Directorate which had funding for this activity. Under this project, the Directorate for Family Promotion will take over the training. The current curriculum and training team will continue to be used and the directorate will continue to work closely with the Family Health Directorate. Approximately 180 social workers will be trained over the life of the project.

31. Nongovernmental Organizations. The chief vehicle for NGO participation in population IEC activities will be through the Fund. Since NGOs contribute in an important way to IEC, however, they will be represented in the monthly IEC meetings convened by CONAPO and an NGO representative will be involved in the decision-making group responsible for decentralized IEC activities.

II. AIDS/STDs IEC

32. This subcomponent of the project aims to increase public knowledge of AIDS and STDs and to increase the practice of preventive practices. Since awareness of AIDS is already high in Burkina, the objective will not be simply to increase knowledge. Rather, the objectives will be to double the proportion of young people (aged 15-25) in the population who believe they personally are at risk of AIDS, while also doubling awareness of condoms as a means of AIDS prevention among the general adult population. The pre-project KAP survey already mentioned (para. 7) will provide baseline data permitting the "doubling" objectives to be quantified and a repetition of the survey in Year 5 will allow the impact of the IEC subcomponent to be measured.

33. Mass media, including not only radio and television but also billboards, cinema promotions and videos, will be used intensively to convince the public as a whole that AIDS is a reality and prevention should be a priority for each individual. Interpersonal communications through a variety of channels will reinforce this message and will provide more detailed information about condom use, particularly to groups at high risk, such as women with multiple partners, truckers, miners, the military and others. Considerable effort will also be devoted to STDs which have not received the attention they deserve to date. While all methods of transmission and prevention will be covered, the major emphasis will be on sexual transmission, as it is the most significant route of infection, and on condom use and sexual behavior change as the primary means of prevention.

34. This subcomponent will be managed by the Permanent Secretariat of the National AIDS Committee which will, for the first time, have a staff devoted to IEC (para. 4). The specific activities to be financed are the following:

35. IEC Research. There has been little action-oriented research on AIDS and STDs thus far in Burkina and a number of qualitative and quantitative studies will be undertaken throughout the life of the project to assist in identifying target audiences, communications channels and effective messages as well as to assess the impact of ongoing IEC activities. Such research will be crucial to the success of the AIDS/STD IEC program, and especially its mass media activities. While the National AIDS Committee's IEC staff will play a major role in the design of the research and the interpretation of results, the technical aspects of the work will be undertaken by outside research institutions whenever possible. As a prelude to the project's IEC research activities, the findings of past research will be synthesized into a single document.

36. Mass Media. To date, there has not been extensive use of the mass media to convey AIDS or STD messages and it is anticipated that several different types of mass media will be used, including radio and television, press, billboards and cinema promotions. Because of the impact of short, repeated messages, there will be extensive use of short spots, particularly on radio which reaches a larger audience than television. A total of six radio spots a year, each in four languages, are planned, as well as four television spots, each in three languages. (In the first year, the number of spots will be halved, because of the need to start up program activities and to conduct the basic research.) The radio spots will be broadcast not only on national radio but also on the private stations and regional radio that attract large audiences. Over the life of the project, the spots will seek to move the Burkinabe public along the spectrum of behavior change, from awareness of AIDS, to concern about their personal risk, understanding the means of prevention and where to obtain them and, finally, the use of preventive measures, particularly condoms. The development of spots in local languages will be done in collaboration with the CRESA for the region and will involve the population in testing messages and images. Cinema promotion will also be used as well as billboards in the five largest cities. The development of the mass media activities will be undertaken through one of the local advertising agencies, under the supervision of the National AIDS Committee. As with family planning, AIDS/STD messages, too, will be based on the results of IEC research and will be carefully tested before going into production.

37. This intense promotion will be reinforced by the integration of information about AIDS/STDs and their prevention into ongoing radio and television programs such as those on health, those for women, popular theater, etc. Since mass media activities are costly, it is crucial that they have an impact. Thus, after two years, there will be an outside evaluation of the role they have played in advancing the project's AIDS IEC objectives. The evaluation will recommend whether to continue the mass media program as planned, to modify it or discontinue it.

38. Decentralized IEC Activities. These activities will be the backbone of the subcomponent's interpersonal communications activities. As described in paras. 17-19, they will be a joint undertaking of the CNIEC/Santé and the National AIDS Committee and the Family Health Directorate. Decentralized AIDS/STD education activities will have as one of their major goals to reach groups at high risk of AIDS/STDs, such as commercial sex workers, migrants, truckers, the military, miners and others. The kinds of activities to be supported will likely include peer education; AIDS prevention dances for young people; dissemination of educational materials in hotels, bars, gas stations and elsewhere; workplace presentations; and video presentations--accompanied whenever possible by condom distribution. The National AIDS Committee will pave the way for such initiatives by contacting national leaders and coordinating efforts in Burkina with those in neighboring countries, where appropriate. Funds are provided under the institutional development subcomponent for two trips abroad to ensure that activities

in Burkina are properly coordinated with those in neighboring countries where the incidence of HIV/AIDS is high. The National AIDS Committee will provide specialized information, training and technical assistance to the CRESAs to ensure the development of solid, accountable programs.

39. Materials Development. All of the AIDS/STD IEC activities will require the development of supporting educational and promotional materials. Among the materials to be produced will be a flip chart, bumper stickers, posters, models to demonstrate condom use and at least three videos (the latter to be produced in collaboration with an advertising agency). It is anticipated that at least four items per year will be developed and distributed. Funds will be available not only to produce materials locally but also to purchase films, videos, bulk orders of publications, etc., from abroad.

40. Seminars for Opinion Leaders. The National AIDS Committee will convene four to six seminars each year, with an average of 50 participants each, to ensure that key opinion leaders are kept up to date on the AIDS crisis in Burkina and its implications for the country. One of the early seminars to be held, once the first results of IEC research are in, will develop an AIDS IEC strategy to guide the first phase of the program. It will set out specific measurable objectives, along with priority target audiences, key messages, the media to be used and a theme for the campaign. Workshops for the media can also be held under this rubric.

41. Resource Center. The National AIDS Committee should be a resource for information about AIDS and STDs. Accordingly, funds are provided under the institutional development subcomponent to subscribe to specialized publications and purchase books and materials to start a resource center.

42. Training Social Workers. Social workers are important IEC agents and the project will provide for the training of approximately 180 social workers on AIDS and STDs, their prevention and effective communications techniques. This training will be conducted by the Directorate for Family Promotion, in close collaboration with the National AIDS Committee, and combined with family planning training whenever possible. This training will focus on local level social workers, as opposed to medical and social work staff higher up in the system who will be caring for persons found to be HIV positive.

43. In order to ensure that future generations of social workers receive pre-service training on AIDS and STDs, the Directorate for Family Promotion will be responsible for working with the National School of Social Service and the National AIDS Committee to update the school's curriculum to include AIDS and STDs and then to train appropriate faculty to teach the curriculum.

44. Non-governmental Organizations. The chief vehicle for NGO participation in IEC activities on AIDS and STDs will be through the Fund. Since NGOs contribute in an important way to IEC, however, they will be represented in the monthly IEC meetings convened by CONAPO and an NGO representative will be involved in the decision-making group responsible for decentralized IEC activities.

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Renforcement Institutionnel du CONAPO

I. Presentation du CONAPO

1. Le Conseil National de la Population (CONAPO) a été créé en 1983 essentiellement avec l'appui du Fonds des Nations Unies pour les Activités de Population (FNUAP). Il comprend quatre commissions et un secrétariat permanent. Le CONAPO est un organe consultatif interministériel présidé par le Ministre chargé du Plan. Le Secrétariat Permanent est directement rattaché au cabinet du Ministre chqrgé du Plan. Dès le début le Secrétariat a reçu l'appui du projet Unité de Population financé par le FNUAP dont la phase présente est prévue jusqu'à la fin 1995.

2. Le Secrétariat Permanent du CONAPO - assisté de l'Unité de Population - est l'organe essentiel dans le fonctionnement du CONAPO et de ses commissions spécialisées et donc dans l'élaboration et la mise en oeuvre des politiques de population au Burkina Faso. Ses responsabilités sont considérables. Le Secrétariat Permanent est responsable de la préparation des propositions de politique à soumettre au Conseil et aux commissions spécialisées : à cet effet il entreprend des recherches qu'il estime nécessaires pour la préparation des propositions. Les propositions de modification de la Politique de la Population qui ne concernent pas l'ensemble du document mais seulement des domaines particuliers peuvent être directement soumises à la commission spécialisée pertinente ou même à d'autres agences telles que, par exemple, les Directions Provinciales du Plan et être finalement adoptées sans qu'il soit nécessaire de convoquer le Conseil National.

3. Le Secrétariat est également en charge de veiller au bon fonctionnement du système de coordination des activités en matière de population en organisant des réunions de concertation des intervenants à tous les niveaux. Il s'agit en principe d'une coordination horizontale des activités conduites dans l'ensemble du secteur public et privé qui ont une composante Population ou dont la réalisation a une incidence sur la Population. Les domaines où cette coordination horizontale s'exerce sont nombreux : (i) les recherches en matière de population; (ii) l'intégration de la variable Population dans les plans et programmes; (iii) l'IEC; et (iv) le bien-être familial. Ces domaines correspondent aux attributions des commissions spécialisées.

4. Le Secrétariat Permanent joue aussi un rôle d'appui vis-à-vis des administations et agences publiques qui veulent monter des projets avec une composante population (i) en réalisant des recherches ou études opéationnelles relatives à ces progammes, et (ii) en cherchant des financements. Le Secrétariat Permanent est en position de jouer ce rôle d'appui du fait que tous les projets avec une composante population lui sont soumis au CONAPO pour avis par le Ministre du Plan.

5. Enfin le Secrétariat est responsable du suivi et de l'évaluation des programmes et stratégies en matière de population. Il a mis au point à cet effet un document technique destiné à standardiser les indicateurs d'évaluation et les méthodes et approches d'évaluation des projets.

Réalisations à ce jour

6. Les activités du CONAPO ont vraiment débuté en 1989. Le CONAPO a tenu ses premières assises en avril 1990, assises au cours desquelles a été finalisé un avant projet de Politique de Population qui avait été préparé par le Secrétariat Permanent avec l'assistance du projet Unité de Population du FNUAP. La politique de population a été officiellement adoptée en juin 1991. Du 16 au 20 décembre 1991 s'est tenu à Bobo-Dioulasso un séminaire national sur la finalisation du Programme d'Actions Prioritaires en matière de population avant de la soumettre pour adoption au Gouvernement. En mai 1992 le Secrétariat Permanent a organisé un séminaire national sur la coordination des activités en matière de population au cours duquel le rôle des ONG a été pleinement reconnu.

7. La commission spécialisée sur la Recherche Démographique se réunit régulièrement sur convocation du SP afin de faire le point sur les lacunes dans les recherches en matière de population en vue de proposer des études prioritaires en réponse à des problèmes particuliers tels que par exemple les réticences de la population à l'utilisation de telle ou telle méthode de contraception. Le Secrétariat Permanent a lui même exécuté de petites études (telles que des enquêtes CAP) mais en général il procède en diffusant vers les projets et bureaux de recherche les résultats de ses investigations.

8. Le Secrétariat a établi des projections de population avec le Direction de la Démographie du l'Institut National de Statistiques et de Démographie (INSD), il assiste régulièrementles Dirtections des Etudes et de la Planification (DEP) dans la prise en compte des variables démographiques lors de la préparation des plans sectoriels et a tenu deux séminaires sur l'intégration de la variable démographique avec les DEP des différents ministères. Aucune étude de suivi sur les effets de ces actions n'a encore été réalisée càd sur l'intégration effective de la variable population dans la préparation des plans de développement. Au début 1993 le Secrétariat Permanent a entrepris l'élaboration de trente monographies provinciales en collaboration avec les Directions Régionales du PLAN (DRP) et d'autres compétences des différents ministères et de l'Université. Le but des monographie est triple: (i) rassembler une masse de données socio-économiques et démographiques dans un document unique (et donc valoriser les données collectées lors des recensements et enquêtes démographiques); (ii) fournir de la matière première aux DRP pour la préparation du prochain Plan, et (iii) faciliter l'intégration des variables démographiques dans les plans et et programmes provinciaux. Enfin - et toujours pour renforcer l'activité d'intégration des variables démographiques dans la planification du développement - le Secrétariat Permanent a entrepris d'organiser d'ateliers de modélisation démo-économique: un tel atelirr s'est tenu du 22 novembre au 3 décembre 1993 à Ouagadougou regroupant toutes les DEP autour d'un modèle appelé "INTGRA".

9. Un forum sur la définition d'une stratégie en matière d'IEC/Population s'est tenu fin novembre 1992 avec l'ensemble des services et agences ayant des activités de IEC. Aucune activité de coordination importante n'a encore été enregistrée dans le domaine du Bien-être familial.

Ressources du CONAPO

10. Le CONAPO et son Secrétariat Permanent ont travaillé jusqu'ici avec des ressources limitées. Mis à part le salaire des deux fonctionnaires du Ministère du Plan détachés au CONAPO - et dont l'un cumule les fonctions de Directeur National du Projet Unité de Population et de Secrétaire Permanent du CONAPO - toutes les activités ont été financées par le biais du projet "Unité de Population" du FNUAP.

11. En plus du Secrétaire Permanent du CONAPO, l'équipe actuelle comprend un Démographe Géographe en provenance du Plan et un expert du FNUAP qui remplit les fonctions de Conseiller Technique Principal (CTP) au Projet. Ces trois spécialistes sont responsables pour l'ensemble des réalisations du CONAPO à ce jour avec les contributions ponctuelles de consultants nationaux ou des membres des commissions spécialisées. Deux autres fonctionnaires sont sur le point d'être affectées au Secrétariat en détachement d'autres ministères. C'est le désir du Secrétaire Permanent actuel que les administrations qui font partie du Conseil National contribuent au fonctionnement du Secrétariat en lui détachant des fonctionnaires.

12. Le Secrétariat Permanent et le Projet sont logés dans un petit bâtiment comprenant 3 bureaux exigus, est équipé de deux véhicules dont un seulement en état de marche, deux micro ordinateurs et d'une imprimante: il ne dispose pas d'un téléphone. Le CONAPO a reçu une aide substantielle du FNUAP sans lequel il n'aurait pas vu le jour. Il devrait devenir le partenaire privilégié de cette organisme et assumer le rôle de coordinateur national de l'exécution du Programme de Population du FNUAP.

Status Administratif du Secrétariat Permanent

13. Un projet de décret modifié portant réorganisation du CONAPO récemment été adopté par le Conseil des Ministres décrit dans leurs grandes lignes les modes de fonctionnement de ses différents organes ainsi que les rôles respectifs du CONAPO, de ses Commissions Spécialisées et de son SECRETARIAT PERMANENT. Ce dernier est attaché administrativement au Cabinet du Ministère du Plan mais ses attributions premières sont celle de secrétariat du Conseil National de la Population. Ses missions consistent à conduire des activités qui contribuent directement à l'élaboration et à la révision de la politiques de population; à sa diffusion et à sa dissémination; à la coordination des activités en matière de population, et au suivi des différents programmes sectoriels dans la mesure où ces programmes ont une composante population. Il n'a toutefois pas de responsabilité directe dans la préparation et l'exécution d'un programme national de population.

14. On peut donc distinguer dans les responsabilités du Secrétariat celles qui sont orientées vers la définition et les révisions de la politique de population et celles qui sont tournées vers le suivi de l'exécution de ces politiques. Dans la première catégorie on trouvera la recherche démographique y compris la mesure de l'impact des programmes sectoriels ayant une composante population, et dans la deuxième toutes les activités de sensibilisation et de coordination des programmes. Là où il a des responsibilité de conduire des activités directes le Secrétariat aura souvent recours, dans la mesure où ses ressouces le lui permettent, aux agences, services publics et privés du pays disposant des compétences spécialisées, notamment dans le domaine de la recherche démographique et de la production et conduite de campagnes médiatiques ou d'IEC.

II. Actions pour le Renforcement Institutionnel du CONAPO

15. L'objectif des actions proposées ci-après est le renforcement du leadership du Secrétariat du CONAPO dans la mise en place, la coordination, le suivi et l'évaluation de la politique de population du Burkina Faso. Dans ce but le PPLS prévoit d'apporter son assistance dans trois domaines:

(1) Assistance dans le domaine de la coordination des activités en matière de population

(2) Assistance dans le domaine de la recherche démographique
(3) Assistance pour le développement de la capacité de gestion du Secrétariat Permanent population.

16. L'exécution de ces activités est toutefois soumise à une conditionalité à savoir la promulgation du décret portant réorganisation du CONAPO et définissant clairement les attributions du Secrétariat Permanent du CONAPO.

A. Assistance dans le domaine de la coordination des activités en matière de population

17. Une des fonctions principales du CONAPO et de son Secrétariat Permanent est la coordination pour l'exécution de la politique de population et notamment l'intégration des variables démographiques dans les progammes et plans sectoriels. Le PPLS assistera dans ce domaine en finançant 20 réunions de concertation dont 15 pour des secteurs déterminés et cinq (soit une par an) pour l'ensemble des ministères, organismes public ou parapublic et organisations privées dont les programmes et interventions ont une incidence sur la population. Ces réunions pourront coïncider avec celles des Commissions Spécialisées.

18. Le but de ces réunions sera d'engendrer la coordination en créant des consensus entre les responsables de programmes au moyen de l'information pertinente et du dialogue. Les objectifs spécifiques de ces réunions seront: (i) d'évaluer ensemble l'impact des différents programmes ou activités sur la population - notamment en diffusant les résultats des recherches récentes -, (ii) d'identifier les domaines où l'absence de programme ou d'intervention est dommageable, (iii) de vérifier la cohérence des actions des différents intervenants en matière de population dans chaque secteur ou dans l'ensemble des secteurs, et (iv) d'harmoniser les stratégies d'intervention dans chaque secteur, et (v) de recommander des mesures appropriées.

19. Le Secrétariat Permanent du CONAPO sera responsable de la programmation de ces réunions dont l'exécution pourra toutefois être confiée au travers d'un contrat de service à des ONG ou associations privées selon les secteurs. La contribution du PPLS à l'organisation de la concertation entre les différents intervenants dans les activités de population représente un investissement dans la crédibilité/légitimité du CONAPO en tant qu'agence ayant le leadership dans la préparation des politiques de population et dans la coordination des actions en vue de l'exécution de ces politiques.

20. Le PPLS fournira 10 PM d'expertise locale pour la programmation des réunions de concertation et financera 10 contrats d'organisation des réunions de concertation entre le CONAPO et des ONG d'un montant de 10.000 USD chacun.

B. Assistance dans le domaine de la recherche démographique

21. La recherche sur l'impact des différents facteurs influençant la démographie au Burkina Faso est nécessaire à la fois (i) pour la la révision et la mise à jour des politiques de population et (ii) pour contribuer à augmenter la pertinence des programmes d'actions sectoriels ayant une composante population ou ayant un impact sur la démographie du pays. La définition et l'exécution d'un programme actif de recherches en matière de population est une priorité pour le CONAPO et constitue d'ailleurs une de ses attributions principales au travers de la Commission Spécialisée sur la Recherche Démographique

22. Les activités qui seront réalisées sous ce chapître sont les suivantes :

(a) Une revue des recherches en population déjà entreprises comprenant une présentation synoptique de leurs résultats ainsi que les réactions qu'ils ont suscités et la dissémination de ces résultats et réactions auprès des patenaires et des clients du CONAPO.

(b) Un inventaire de tous les organismes exécutant ou finançant des recherches en matière de population au Burkina Faso ou dans la région et relatives au Burkina Faso ainsi que si possible une identification de leur programme de recherches dans les années 1995 - 1998 et une évaluation de leurs performances et de leurs ressources en chercheurs.

(c) Définition d'un agenda de recherche en matière de population à exécuter dans les 3 prochaines années (1995 -1997) qui comprendra les éléments suivants (i) la définition des axes de recherche prioritaires; (ii) l'identification des domaines déficitaires; (iii) l'identification des domaines ou l'intervention complémentaire du CONAPO est requise sera complémentaire; et enfin (iv) la mise au point d'un programme d'ensemble de recherche avec des composantes qui seront financées par le CONAPO.

(d) Financement de contrats de recherche entre le CONAPO et des centres et organismes de recherche compétents du Burkina Faso.

23. Le PPLS contribuera 3 PM d'expertise internationale et 6 PM d'expertise nationale pour mettre le programmes de recherches au point et financera 10 contrats de recherche en matière de population, d'un montant de 50.000 USD chacun, à exécuter durant la prériode du projet par un bureau ou centre de recherche local.

C. Dévelopment de la capacité en gestion du Secrétariat Permanent

24. Une série d'interventions légères sont prévues afin de renforcer les capacités gestionnaires du Secrétariat Permanent dans les domaines d'intervention de la Composante Population du PPLS, visant les résultats suivants :

(1) mettre en place une distribution des responsabilités correspondant aux fonctions du Secrétariat Permanent du CONAPO et examiner le mode de fonctionnement du système de coordination;

(2) mettre en place une capacité améliorée dans la préparation, la négociation et la gestion de contrats de services, notamment en recherches démographiques et en production de matériel IEC et exécution de campagnes;

(3) mettre en place une capacité améliorée dans le montage et la gestion d'actions d'appui (programmation, exécution, suivi et évaluation)

25. Ces interventions consisteront essentiellement en ateliers tenus avec des spécialistes et au cours desquels des instruments de gestion appropriés seront présentés, examinés et adaptés aux nécessités des activités et du contexte dans lequel travaille le staff du Secrétariat.

26. **Organisation du travail sein du système de coordination du CONAPO et au sein du SECRETARIAT DU CONAPO.** - Les experts sous la supervision du Secrétaire Permanent procèderont à l'inventaire de toutes les fonctions des différents comités du CONAPO et à l'examen des relations entre eux et avec le Comité National et le Secrétariat Permanent: ils feront des propositions sur les modes les plus rentables de fonctionnement de ces différents organes et une estimation des ressources annuelles nécessaires pour atteindre un niveau de performance suffisant. Ils passeront également en revue les tâches du SECRETARIAT PERMANENT et procéderont à leur regroupement par poste en fonction des attributions du Secrétariat, ainsi qu'à la rédaction - si nécessaire - de protocoles et de procédures opérationnelles. Puisque le staff est peu nombreux et que les attributions et tâches du SP sont diverses il est suggéré qu'on ne procède pas à une répartition rigide des tâches entre les différents postes mais qu'au contraire on laisse la latitude au SECRETAIRE PERMANENT d'attribuer les tâches en fonction des disponibilités de personnel dans le cadre d'opérations ponctuelles.

27. Le projet financera six PM d'expertise locale et trois PM d'expertise internationale pour le développement des instruments de programmation, de négociation et d'adjudication de contrats de service et pour l'organisation des tâches au sein du Secrétariat.
Il financera également l'acquisition de (i) deux véhicules de service, (ii) trois micro ordinateurs avec périphérique, et (iii) des fournitures et matériel de bureau pour trois unités.

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Renforcement Institutionnel de la DSF

I. Objectif de la sous-composante

1. L'objectif général de la sous-composante est de faire de la DSF une organisation capable d'imposer une ligne directrice aux opérations des nombreux intervenants dans les programmes de SMI/PF, Nutrition et Vaccinations et de transformer en appui efficace aux structures de distribution de soins et services les ressources humaines, matérielles, techniques et financières mises à la disposition de ces programmes pa le Gouvernement et les doneurs internationaux.

2. Cet objectif général sera accompli à travers la réalisation des objectifs spécifiques suivants:

Objectif UN: Mettre au point une procédure efficace d'élaboration et de révision périodique d'un Programme Intégré de Santé de la Famille (PISF) et des sous-programmes nationaux en SMI/PF, en Nutrition et en Vaccinations préventives

Objectif DEUX: Exécuter une rationalisation (une répartition fonctionnelle) des tâches de programmation, de supervision et suivi et d'appui à la DSF en vue de l'exécution effective du Programme par l'ensemble des formations sanitaires du pays

Objectif TROIS: Mettre au point un mécanisme de coordination régulier des activités des divers intervenants et des systèmes de supervision et d'appui aux équipes cadre de district hautement performants.

Justification de l'Intervention

3. La DSF doit remplir son mandat dans un environnement compliqué caractérisé par (i) un volume d'assistance internationale technique et matérielle représentant des contributions financières importantes (ii) par la présence de nombreux intervenants dans des domaines spécifiques, disposant de leurs propres approches dans ces domaines mais ne fournissant souvent qu'une couverture partielle des besoins, (iii) par la multiplication d'initiatives en provenance d'agences internationales et d'organisations privées diverses, (iv) par des services de santé en pleine réorganisation et (v) par une infrastructure de distribution des soins encore fragile.

4. Le rôle de la DSF dans l'intégration des activités dans les divers domaines de la Santé de la Famille et dans la coordination des différents acteurs est crucial pour que les efforts et les investissements consentis aboutissent aux résultats recherchés tant d'un point de vue des politiques de population que du point de vue de la santé de la famille. Le renforcement des capacités organisationnelles de la Direction est une nécessité.

II. Organisation Actuelle

Les Fonctions de la DSF

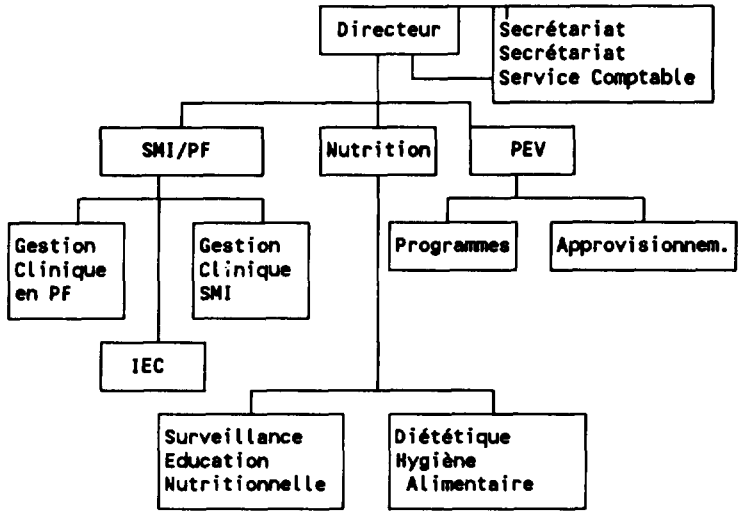
5. Le décret présidentiel du 24 août 1992 portant organisation du Ministère de la Santé, de l'Action Sociale et de la Famille stipule en son article 40 que "La Direction de la Santé de la Famille est chargée d'organiser, de coordonner et de contrôler les programmes d'action relatifs à la protection de la santé de la mère et de l'enfant, à la planification familiale, à la nutrition et à la prévention par les vaccinations". La DSF est une des quatre directions composant la Direction Générale de la Santé Publique (DGSP). Il est à noter que ce décret stipule également que la DGSP est chargée de traduire en programme d'actions la politique de développement sanitaire définie par le Gouvernement.

6. La DSF est mandatée pour assister le Directeur Général de la Santé Publique (DGSP) dans la programmation, l'appui, la supervision et le suivi des prestations des services en SMI/PF, en Nutrition et en Vaccination Préventive. La DSF a une relation fonctionnelle avec les responsables SMI/PF des Directions Provinciales qu'elle peut superviser régulièrement. En plus de ces fonctions la DSF a la responsabilité de la coordination des activités du programme de PF avec l'ensemble des partenaires nationaux et internationaux.

Organigramme et Ressources de la DSF

7. Le service en SMI/PF de la DSF comprend 11 personnes à savoir un chef de service, un bureau de Gestion des Prestations de Service Clinique en PF comprenant deux agents, un Bureau IEC/PF comprenant 4 agents, et un Bureau SMI de 4 agents. Un relevé des tâches accomplies par ce personnel indique que cette équipe remplit rien que pour les activités de PF plus de 40 tâches différentes. Parmi ces tâches la cogestion, la coordination et le suivi des projets de PF financés par l'aide internationale (à l'exception des activités financées par l'IDA/Banque Mondiale qui le sont à partir du Projet de Développement des Services de Santé (PDSS) installé comme une Direction auprès du Secrétaire Général. Le service de Nutrition comprend un chef de service et regroupe 8 nutritionnistes répartis dans deux bureaux de 4 unités chacun : un bureau de surveillance et un bureau de diététique. Chacun des 8 nutrionnistes est coordinateur d'un projet différent, tous financés par l'aide extérieure. Le Service de Vaccination Préventive, récemment encore une Direction, a été rattaché à la DSF dans le cadre du décret d'août 1992.

8. La DSF est structurée comme suit:



9. La DSF est également à la tête d'un système d'approvisionnement en produits de PF (commande, stockage et distribution des fournitures en PF) distinct du système classique de la Direction des Services Pharmaceutiques (DSPH). L'achat des contraceptifs distribués par la DSF est financé par les bailleurs de fonds essentiellement par l'USAID et par le FNUAP. Les contraceptifs distribués par l'ABBEF sont achetés par International Planned Parenthood Federation (IPPF). L'USAID est en train de modifier la formule de financement des contraceptifs mais sa contribution est garantie jusqu'en 1996.

10. Le service SMI/PF (11 personnes) est logé dans un bâtiment de 7 bureaux organisés autour d'une cours intérieure. Le service de la nutrition y compris le laboratoire (9 agents et deux volontaires intyernationales) est également abrité dans un bâtiment de 7 locaux. Ces deux blocs jouxtent un bâtiment identique abritant les bureaux de la Direction une salle d'informatique et une salle de conférence. Un quatrième bâtiment sert de magasin pour le stockage des produits contraceptifs, et autres matériels de consommation courante. Enfin, la section PEV est logée de façon séparée dans un complexe moderne de bureaux éloigné de la Direction d'environ 0.8 Km.

11. La DSF ne dispose pas d'un budget de fonctionnement propre. Son personnel est payé directement par le Ministère des Finances sur base du budget de fonctionnement du MSASF. Il dispose d'une somme annuelle de 132.000 CFA par an et par véhicule pour l'entretien des véhicules et de bons d'essence pour un montant de 1.214.000 CFA/trimestre.

III. Faiblesses dans le Fonctionnement Actuel

12. Les déficiences organisationnelles dans le fonctionnement de la DSF ont été identifiés dans le document sur la Stratégie Nationale en matière de PF (Novembre 1992) et bien que ce diagnostic ait été établi à partir d'une analyse sur le fonctionnement de la section SMI/PF on s'accorde en général pour reconnaître qu'on retrouve ces mêmes déficiences dans le fonctionnement des autres sections.

13. Au niveau de central on peut identifier les faiblesses institutionnelles suivantes : (i) l'absence de documents de programme pour l'exécution des stratégies et politiques nationales en matière de population et de santé familiale;(ii) la faiblesse des mécanismes en place pour assurer l'adoption par les responsables des provinces et des districts des objectifs du programme national de santé familiale dans leurs plans d'action annuels; (iii) l'insuffisance des mécanismes de coordination entre la DSF et ses partenaires du programme de PF; (iv) l'absence d'organigramme détaillé et de description des tâches et le sous-équipement des services à la DSF par rapport à leurs responsabilités; et (v) le faible rendement à ce jour des systèmes d'information. Tous ces problèmes constituent autant d'obstacles à l'expansion des services.

14. La préparation des Plans d'Action Annuels par les districts sanitaires (ou les DPSASF) dans lesquels sont prévues les affectations de personnel et ressources matérielles aux différentes FS de la province, représente évidemment une étape essentielle pour l'exécution des programmes dont la DSF est responsable au niveau central. Les mécanismes actuellement en place ne permettent pas à la DSF de s'assurer que chacune des 30 Directions Provinciales (et les équipes cadre de district qui vont progressivement les remplacer) intègrent les objectifs des programmes adoptés au niveau national dans leurs plans d'action annuels. D'autant plus que les budgets provinciaux ne sont pas élaborés sur base des programmes ou des projets et n'expriment donc pas les intentions des DPSASF ou des districts sanitaires pour la réalisation des différents programmes. L'intégration des objectifs d'un programme national de Santé Familiale au niveau des provinces ou des districts sanitaires ne peut donc être vérifiée qu'à postériori, soit lors de l'ouverture de nouvelles unités de prestations, soit par l'observation des activités lors de visites de supervision.

15. Dans ces conditions il est crucial que la DSF poursuive un programme de visites de supervision intense autour de l'exécution d'un programme clairement défini. On observe toutefois que les **visites de supervision ne sont pas systématiques**. La cause de cette situation ne réside pas nécessairement dans l'absence de systèmes et protocoles de supervision ou dans l'absence de compétence du personnel puisque dans la plupart des cas ces systèmes et leurs divers protocoles existent et qu'un nombre conséquent de personnel a été formé à leur utilisation. Mais les activités prévues par ces systèmes ne sont pas exécutées ou le sont avec retard. (Il en est ainsi également de la collecte, de l'expédition et de la compilation des données de base du système d'information ou des réquisitions d'approvisionnement). **L'absence de documents de programme en Santé Familiale PF et en Nutrition** rend plus aléatoire encore l'adoption des objectifs des programmes au niveau provincial.

16. **L'absence d'un organigramme détaillé** spécifiant les fonctions des différentes unités opérationnelles et l'absence d'une description des tâches des différents postes rend évidemment le contrôle et l'organisation du travail difficile.De plus les Services sont **démunis en personnel et en moyens et ils n'exercent qu'un contrôle limité sur les ressources et sur les activités de agents.** D'une part les ressources proviennent presque uniquement de l'aide extérieure et sont souvent affectées à l'exécution des activités d'un des projets gérés par la DSF et, d'autre part, une bonne partie du temps d'activités du personnel ayant la responsabilité de coordination d'un projet est consacré à des tâches directement commandées par la mise en oeuvre de ces projets.

Enfin, le système central d'informations sanitaires connaît des insuffisances manifestes et chaque service tente de doubler le système central en créant le sien propre.

Restructuration des Services de Sante en Cours

17. Une restructuration du MSASF est en cours dans le cadre du PDSS et du PDSN. Un élément important des réformes en cours concerne la restructuration des services de santé sur le terrain. Les Directions Provinciales sont maintenues mais on procédera à la création de districts médicaux autour des CMs existants, et à la mise en place dans chaque district d'une antenne chirurgicale et d'une équipe cadre composée d'au moins cinq personnes dont deux médecins. Un des aspects de cette restructuration est que désormais ce seront les deux médecins de l'équipe cadre qui seront en charge de la supervision de toutes les activités de service y compris de celles des programmes dits verticaux à l'échelon des CSPS. Les équipes de district seront progressivement mises en place. On compte que 12 équipes cadre de districts seront opérationnels d'ici la fin 1993.

IV. Acitivtés de la Composante Renforcement Institutionnel de la DSF

18. La stratégie de renforcement institutionnel de la DSF retenue par le PPLS est centrée sur le préparation par chaque section - au cours d'ateliers animés par des experts - du sous-programme des activités de leur ressort. Les sous-programmes sont ensuite regroupés en un Programme Intégré de Santé de la Famille (PISF). Le PISF et les sous-programmes de section seront élaborés de façon à (i) en faire des instruments de travail performants pour la préparation et l'exécution des plans d'action annuels nationaux et le suivi de leur exécution, (ii) fournir une référence incontournable pour la coordination des partenaires et augmenter ainsi la rentabilité des apports extérieurs, et (iii) servir de tremplin à une distribution plus fonctionnelle des tâches à l'intérieur de la DSF. Les activités de renforcement institutionnel proprement dites seront les suivantes :

1) Ateliers de préparation d'un premier Programme Intégré de Santé de la Famille
2) Introduction progressive d'une distribution plus fonctionnelle des tâches et responsabilités à l'intérieur des sections y compris une description détaillée des postes et des tâches
3) Fournitures d'intrants pour le renforcement des fonctions de supervision, de coordination, de secrétariat, et diverse fonctions d'appui de la DSF telles que la formation.
4) Construction d'un bâtiment pour la DSF

1) Elaboration du Progamme Intégré de Santé de la Famille

19. L'élaboration et la révision périodique du Programme Intégré de Santé de la Famille (PISF) devrait constituer désormais l'activité pivot de la Direction: ce programme intégré sera préparé à partir des programmes des sections SMI/PF, de Nutrition et de Vaccination Préventive. Il sera conçu pour une période de 5 ans au minimum selon les principes de la planification glissante et donc revu et révisé périodiquement. Il devra toujours être d'actualité.

20. Les programmes seront rédigés en termes opérationnels, câd identifieront les contraintes pour l'exécution des politiques et stratégies nationales retenues, fixeront des objectifs spécifiques ainsi que des échéances pour leur réalisation, et des listes d'activités devant conduire à leur accomplissement. Chaque sous-programme comprendra une section établissant les stratégies en IEC retenues pour assurer la promotion des services offerts auprès des populations cibles et des clients potentiels. Il devra établir clairement les relations avec les activités et opérations des projets en cours d'exécution. Une annexe sera consacrée à la liste des projets et des intervenants (donneurs, bureaux d'études et ONG) impliqués dans

l'exécution du programme et constituant des ressources potentielles pour des actions d'appui. Chaque programme devra également inclure les coûts estimés d'exécution. Afin de faciliter l'intégration des services aux niveaux opérationnels les responsables des programmes connexes seront invités à participer à la préparation et à la révision du programme.

21. L'exécution du programme intégré de santé de la famille commence avec la préparation des plans annuels d'action nationaux et provinciaux ou de district sanitaire. Au **niveau national** le plan d'action annuel est élaboré par la DSF : il sera préparé par sous-programme et les actions retenues figureront par sous-programme dans le document de plan sur base du PISF. Il en sera de même pour le budget du Plan d'action qui devra être composé par sous-programme. La budgétisation des plans d'action nationaux pour les différents sous-programmes se fera en étroite concertation avec la DAAF laquelle participe au projet de modernisation de l'administration qui inclut l'instauration de nouvelles nomenclatures budgétaires tenant compte des dépenses par programme.

22. La rédaction des **plans annuels d'action provinciaux** relève des Districts Sanitaires ou des Directions Provinciales. Il est utopique d'attendre dans l'immédiat que la préparation des plans d'action aux niveaux provincial et central soit synchronisée: ils seront pratiquement préparés simultanément. La DSF peut toutefois influer sur la préparation des plans annuels d'actions provinciaux en diffusant et faisant la promotion active du Programme Intégré de Santé Familiale et en suggérant des objectifs et des listes d'activités et de ressources à affecter dans chaque province. Cette diffusion et promotion du PISF est une des rôles de la Supervision (voir Supervision).

2) Coordination des efforts des différents acteurs

23. Il faudra procéder à la mise en place effective d'un mécanisme de concertation et de coordination entre la DSF d'une part et les donneurs et les organisations privées responsables de projets dans les domaines de la SMI/PF, de la Nutrition d'autre part, ainsi qu'avec les commissions du CONAPO et la DPF pour ce qui concerne les activités d'IEC correspondantes. Cette concertation aura comme but d'assurer une meilleure réalisation du PISF de la DSF en rationalisant les contributions des différents partenaires à leur réalisation.

24. Plus spéciquement la concertation devra assurer (i) que les objectifs de projets ou opérations envisagés soient alignés sur les objectifs du PISF, (ii) que les approches retenues par les différents partenaires soient compatibles avec les stratégies nationales, (iii) qu'il y ait complémentarité (éviter les duplications) des ressources offertes et des zones couvertes par les partenaires. La concertation sera assurée essentiellement en utilisant les moyens suivants : (i) la diffusion par la DSF d'une information homogène à destination de tous les partenaires, particulièrement la diffusion des différents Programmes et (ii) des réunions régulières permettant des échange d'information entre les partenaires et centrées, soit sur les objectifs et stratégies futures du programme, soit sur les évaluations et rapports d'exécution et de suivi des différents projets, soit enfin sur les problèmes rencontrés par les différents intervenants dans l'exécution présente du programme.

3) Redistribution des tâches du personnel de la DSF

25. Les ateliers d'élaboration des programmes de section et du PISF seront conçus et conduits de façon à sensibiliser les responsables aux déficiences des modes de gestion actuels et à la nécessité de

les modifier. Le PISF sera ensuite utilisé pour faciliter l'introduction progressive d'une redistribution plus fonctionnelle des tâches à l'intérieur des sections, redistribution centrée sur l'exécution des programmes. Cette réorganisation progressive s'accompagnera d'une opération de description détaillée des postes et des tâches dans les sections et d'une revue du mécanisme de contrôle de la performance des agents.

4) Supervision des équipes cadre et des provinces

26. Les activités de supervision seront renforvcées et poursuivront les objectifs opérationnels suivants: (i) insertion des objectifs des programmes nationaux dans les plans d'action annuels provinciaux ou des districts, et (ii) suivi de l'exécution des programmes avec relevé des problèmes par district, notamment dans le fonctionnement des systèmes d'information et de distribution des produits, (iii) appui sur place aux équipes cadre et DP, et (iv) identification d'actions d'appui soit directement par la DSF soit avec le concours de la DSF dans chaque province ou district : ces actions d'appui sont destinées en premier lieu aux équipes provinciales ou de districts mais avec leur accord elles pourront être dirigées directement vers des niveaux opérationnels (CSPS).

27. Ces objectifs en matière de supervision impliquent les activités suivantes sur une base régulière

- relevé périodique des ressources (type, volume et qualité) de chaque province ou district disponibles pour la réalisation des programmes

- revue critique des rapports d'exécution des Plans d'Action des provinces ou districts avec les responsables locaux des programmes supervisés par la DSF

- suivi du fonctionnement des systèmes d'information (collecte et traitement des données au niveau du district ou de la province) ainsi que de la distribution de matériels divers et revue périodiques des problèmes et contraintes existant dans ces domaines

- mise au point en concertation avec chaque DP et chaque équipe cadres de district des méthodes (approche intégrée, fréquences, protocoles) de supervision utilisés entre le niveau district et les formations sanitaire : cette activité sera conduite en consultation avec le noyau de formateurs/superviseurs chargés de la mise en place des équipes cadres de district et basée à l' ENSP.

- identification avec les DP et équipes cadre de district des contraintes rencontrées pour la réalisation des programmes et des actions d'appui à fournir par la DSF (ou avec le concours de la DSF) pour les surmonter (formations, changement dans les allocations de ressources, dans les approches et les procédures)

V. Activités et Intrants de la Composante Renforcement Institutionnel de la DSF

Activité UN Elaboration du programme national de Santé de la Famille

28. **Contenu de l'activité** : élaborer un programme intégré de Santé de la Famille à partie

des programmes de SMI/PF, Nutrition, et Vaccination Préventive dans le but d'en faire des instruments (i) d'intégration des objectifs du programme dans les plans d'action des districts, (ii) de coordination des activités de tous les intervenants, (iii) de rationalisation de l'organisation du travail dans la Direction et les sections.

29. **Déroulement de l'activité** : quatre phases sont prévues

Phase UN : mise au point du modèle de Programme National dans lequel est mise en évidence la relation entre les composantes du programme et leur utilisation ultérieure comme un instrument de coordination, d'intégration provinciale,de rationalisation organisationnnelle

Phase DEUX : revue des objectifs des programmes de SMI/PF, de Nutrition et de Vaccination Préventive et intégration dans le cadre des objectifs du Programme de la DSF en Santé de la Famille

Phase TROIS: convocation et tenue d'un atelier par section dans le but d'établi les liste d'activités pour l'accomplissement des objectifs du programme intégré de santé familiale. La participation est la suivante :

- le personnel de la ou des section(s) intéressée(s)
- un représentant des autres sections de la DSF
- un représentant de la DEP
- un représentant de la DGSP

Phase QUATRE: intégration des listes d'activités par section en une liste intégrée de activités du programme national de santé de la famille par un groupe constitué essentiellement des Chefs de Service sous la présidence du Directeur de la DSF.

30. Les **intrants** suivants seront nécessaires pour la réalisation de l'activité:

- 2 PM d'expertise internationale pour assistance lors des phases UN, DEUX et QUATRE
- 3 PM d'expertise internationale pour la préparation et l'animation de 3 ateliers (PHASE TROIS)

Activité DEUX — Introduction progressive - et en association avec le personnel - d'une distribution des tâches à la DSF centrée sur la préparation et l'exécution du programme intégré de santé familiale.

31. Cette activité se déroulera en plusieurs phases

Phase UN: préparation par un expert en organisation et méthodes de plusieurs propositions de rationalisation de l'organisation des tâches au sein de la DSF et des section sur la base du programme intégré de santé familial.

Phase DEUX: discussion de ces propositions par le Directeur et Chefs de Service et adoption finale d'un mode de redistribution des postes et des tâches

Phase TROIS : descriptions des tâches des différents postes - avec la participation du personnel - et adoption d'un calendrier d'introduction progressive de nouveau mode d'organisation . Cette phase comprendra si nécessaire le développement de procédures opéationnelles pour le Bureau IEC de la Section SMI/PF

Phase QUATRE: exécution du calendrier

32. **Les intrants suivants seront nécessaires** pour l'exécution de cette activité:

- 3 PM d'expertise internationale et 3 PM d'expertise nationale pour l'élaboration des différentes propositions, les analyses et descriptions des tâches, les procédures opérationnelles en gestion de programmes d'IEC, et l'élaboration du plan/calendrier de mise en place

- 4 Bourses d'un an de formation en gestion des programmes de santé et santé de la famille

- 12 Bourses de trois mois de formation sur place ou dans des pays voisins en gestion en santé

Activité TROIS Développement de la capacité opérationnelle de de la DSF dans le domaine de la coordination, de la supervision, de l'appui aux districts et du secrétariat

33. Cette activité consiste essentiellement dans la fourniture d'intrants pour le renforcement de diverses fonctions de la DSF. Il n'est pas nécessaire d'attendre les résultats de la rationalisation des tâches à la DSF pour procéder à ces fournitures d'intrants.

34. La DSF préparera une directive sur **l'organisation de la coordination des intervenants** dans la perspective des activités de renforcement institutionnel : (i) buts de la coordination pour l'exécution du programme intégré de santé familiale, (ii) responsabilités respectives de la DSF et des partenaires (donneurs et intervenants divers) dans l'exécution du programme, (iii) réunions de coordination (participants, fréquence). Une Personne Mois d'expertise locale sera requise.

35. La fourniture d'intrants pour **le renforcement de la supervision** est soumise à la condition de l'affectation par le Secrétaire Général de la Santé de deux médecins pour les activités de supervision à la DSF: les intrants suivants seront fournis à la DSF

(a) trois véhicules tout terrain dont deux à livrer en l'année 2 du projet et le troisième à l'année 3

(b) Bons d'essence pour 300 litres/trimestre pour la supervision et 50.OOO CFA/an pour l'entretien de chaque véhicule à justifier tant pour lq DSF que pour chaque équipe provinciale de supervision.

36. **Les services de formation offerts par le DSF aux districts et aux formation sanitaires** nécessitent la restauration ou la construire d'un centre de formation dans 5 provinces pour y accueillir des formations organisées au niveau régional. Cette formule permet d'éviter de mobiliser tous les travailleurs de santé d'une même province au même moment. L'équipement des cinq centres comprendra

la fourniture des intrants suivants:

25 TABLES et chaises individuelles
Flip charts avec support
Matériel de soutien à la formation (une photocopieuse et une ronéo par centre)
Formathèque INTRAH (minibibliothèque de soutien aux formateurs)
Recyclage à l'année 2 du projet des formateurs provinciaux formés en 91 et 92 par INTRAH en technique de PF
indemnités pour les sorties de suivi des personnes formées

37. **Le renforcement du Secrétariat** de la DSF requiert la fourniture des intrants suivants:
- 2 PM d'expertise locale pour l'établissement d'un système de classement et de localisation facile de l'information à la DSF, de mise en ordre des archives et d'organisation de la bibliothèque
-Matériel de classement (armoires, cartons, archives)
-Formation de courte durée du personnel de secrétariat au classement et à la programmation
- Formation d'un bibliothécaire au niveau local
- Formation complémentaire en informatique du personnel du secrétariat

Activité QUATRE Construction et équipement d'un bâtiment à usage de bureaux plus une salle de conférence à la DSF

38. Pour assurer le rendement de tous les autres efforts de renforcement instituionnel il est urgent que le DSF puisse abriter ses services et son personnel dans des locaux adéquats. Il s'agira de procéder à la construction d'un petit édifice de 400 M2 pour compléter les infrastructures existantes dans le cadre de la réorganisation des services et du renforcement institutionnel. Cet édifice abriterq au moins dix bureaux et une salle de conférence pour une cinquantaine de personnes et une salle de reproduction en annexe. Un premier plan a été dessiné et se trouve à la DSF. L'équipement de ce bâtiment comprendra les intrants suivants:

Pour chacun des 10 bureaux :
un bureau, un fauteuil et deux chaises, un classeur de grande taille et une armoire, une tablette pour téléphone ainsi que la climatisation

Pour la salle de conférence :
Tables et chaises pour 50 personnes, deux armoires, une phocopieuse et périphériques, une table deux chaises et une armoire

Pour l'ensemble prévoir 12 appareils de téléphone

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Composante VIH/SIDA/MST

Surveillance Epidémiologique

A. Définition et Généralité

1. La surveillance épidémiologique peut être le plus simplement définie comme un processus dynamique incluant la collecte, l'analyse et la dissémination des données importantes pour les activités de contrôle et Prévention d'un problème de santé publique bien déterminé. La surveillance épidémiologique peut être active ou passive. Dans la surveillance active on effectue une recherche active des cas se rapportant au problème de santé auquel on est intéressé, contrairement à la surveillance passive dans laquelle on met en place un système passif de notification des cas. Chacune de ces 2 formes de surveillance a ses avantages et désavantages. L'avantage majeur de la forme active sur la méthode passive est qu'elle fourni des données plus complètes mais par contre elle est associée une mobilisation des ressources tant humaines que matériels très importante, ce qui est un avantage pour la surveillance passive qui est en général moins coûteuse.

B. Surveillance dans le cadre de l'épidémie de SIDA

2. De manière générale les méthodes de surveillance pour le VIH/SIDA sont les mêmes que celles pour les autres pathologies, mis à part quelques aspects particuliers lies à l'impact du SIDA sur l'individu et la société, ainsi qu'aux capacités de diagnostic existantes dont il faut tenir compte dans cette surveillance particulière. Dans le cadre de l'épidémie du SIDA, il est important de faire la différence entre la surveillance de l'infection au virus de l'immuno-déficience humaine (VIH) et la surveillance du syndrome d'immuno-déficience acquise (SIDA). Pour la première l'élément d'intérêt et l'agent étiologique (VIH), alors que la seconde s'occupe des manifestations cliniques du SIDA maladie.

a. Surveillance VIH

3. Comme dit plus haut la surveillance du VIH s'intéresse à suivre l'évolution de l'épidémie en se basant sur les cas des infections à VIH avec ou sans signes cliniques. Ceci est rendu possible par l'existence des tests de laboratoire permettant la détection du VIH. Bien qu'associée avec des problèmes éthiques liés à au fait que la mise en évidence de l'infection chez un individu (l'informer de son résultat ou non? demander son consentement ou non pour être tester? etc...), les données fournies par la surveillance du VIH sont plus importantes que les données sur le SIDA pour les activités du programme de contrôle et prévention car elles sont plus proches de la réalité en ce qui concerne le nombre des nouveaux cas et l'ampleur du problème, le SIDA survenant seulement plusieurs années après l'infection. En plus le diagnostic du VIH est plus précis que celui du SIDA; ceci est surtout vrai pour les pays en développement où les tests de laboratoire ne sont toujours pas disponibles pour confirmer une présomption clinique. Comme toute surveillance, la surveillance du VIH peut être active ou passive.

(i) La surveillance active du VIH

4. Surveillance des sites sentinelles. Elle se fait suivant une périodicité déterminée, dans des sites choisis et parmi des sous groupes définis de la population. L'activité consiste à effectuer régulièrement suivant la périodicité choisie, des tests pour le VIH chez un certain nombre des personnes venant des sites ou groupes (femmes enceintes, prostituées, patients présentant une MST, nouveaux nés etc...) retenus. De manière générale, le type de population à inclure dans ce type de surveillance dépend de la prévalence estimé de chaque pays ou région. Pour les pays ou régions à très faible prévalence, la surveillance doit cibler les groupes définis comme "à haut risque" et dans ceux (pays ou régions) à prévalence élevée la surveillance doit inclure en même temps des groupes "à faible risque" et des groupes "à haut risque". Le nombre de personnes à tester dépend essentiellement de la prévalence estimée du VIH dans la population d'où vient l'échantillon et de la précision escomptée. Toutefois on doit aussi tenir compte des autres facteurs tels que les ressources existantes, l'accessibilité de la population à étudier etc... Pour maximiser la précision des résultats obtenus et minimiser le biais lie a l'auto-selection des sujets au cours de cette surveillance, il est préférable d'effectuer des tests anonymes et non corrélés qui n'offrent pas la possibilité aux sujets de décider de leur participation et ne nécessitent pas un système de counseling pour l'annonce des résultats sérologiques. A cet effet, on utilise des échantillons de sang collectes pour d'autres raisons (ex: sang prélevé pour le dépistage au cours de la grossesse) sur lesquels tous les éléments d'identification d'une personne ont été enlevés.

5. Surveillance active par échantillon de la population générale. la population à l'étude est la population générale, un échantillon choisi au hasard par méthode statistique appropriée est testé pour le VIH. Si il était possible de conduire ce type de surveillance dans les conditions idéales, elle donnerait des estimations de prévalence plus proches de la réalité et plus d'informations sur la population que la surveillance sentinelle. Malheureusement, étant donné que le sang lors de cette activité est collectée spécifiquement pour le test du VIH, il devient obligatoire que les sujets donnent leur consentement ce qui rend difficile l'interprétation des résultats ne connaissant pas les caractéristiques des personnes refusant de participer (biais de participation); en plus cette activité nécessite des dépenses considérables surtout dans les pays qui sont vastes et elle est très difficile à répliquer.

(ii) Surveillance passive du VIH

6. La surveillance passive du VIH se fait essentiellement par l'utilisation des résultats des tests effectués au niveaux des différentes institutions sanitaires où les tests sont effectués. Elle demande la participation des ces institutions qui doivent notifier les résultats à la structure chargée de la surveillance épidémiologique. Ses avantages sont qu'elle est peu coûteuse et peut fournir des informations sur différents sous groupes de la population. Elle a néanmoins des limitations telles que: différence de stratégie de testing suivant les laboratoires; les zones urbaines étant les plus souvent mieux équipées en laboratoires, on aura tendance à avoir seulement les données sur les populations urbaines; elle dépend fortement de la volonté des institutions participantes à notifier les cas ce qui n'est pas toujours facile.

b. Surveillance du SIDA

7. La surveillance du SIDA suit la distribution des cas déclarés de SIDA maladie et nécessite de ce fait pour sa conduite une définition de cas à utiliser pour la notification. Actuellement, cette définition est variable suivant les pays. Dans certains pays comme les USA, la définition de cas de SIDA inclus une longue série de manifestions pathologiques, les tests d'identification de VIH et le nombre de lymphocytes T4, dans d'autres la définition se limite aux manifestations cliniques et aux tests d'identification de VIH, et dans les pays (essentiellement l'Afrique) où les tests de laboratoire pour l'identification de VIH ne sont

pas toujours disponibles, seuls les manifestations cliniques sont utilisées pour définir le cas de SIDA. La notification des cas de SIDA n'est pas complète au même degré pour tous les pays. Si la majorité des cas diagnostiqués dans la plus part des pays développés est notifiée, il est estimé qu'en Afrique, de manière générale seulement 10 à 20% des cas de SIDA sont notifiés. Les données sur la surveillance du SIDA sont importantes pour les autorités dans la planification sanitaire (besoins en capacité clinique, traitement et prise en charge des personnes malades de SIDA), mais elles ont moindre valeur dans le suivi de l'épidémie du fait que le SIDA survient plusieurs années après l'infection.

c. Surveillance des MST traditionnelles

8. Dans un passé encore récent le Contrôle et la Prévention des MST était un domaine négligé, surtout dans les pays en développement. Ceci a comme une des conséquences une infrastructure très insuffisante pour le diagnostic et traitement des MST dans ces pays. Depuis l'avènement du SIDA voici plus d'une décennie, il est de plus en plus démontré une inter-relation entre les maladies sexuellement transmissibles et le SIDA. Ces 2 entités partagent la voie sexuelle comme mode prédominant de transmission, les MST traditionnelles faciliteraient la transmission et l'acquisition du virus responsable du SIDA, et l'infection à VIH modifieraient la présentation clinique et la réponse thérapeutique des certaines MST traditionnelles. Ces faits ont dicté la nécessité de développer une bonne surveillance des MST intégrée dans la surveillance du VIH/SIDA, dans le but d'améliorer le contrôle et la Prévention des ces affections. Quelques arguments soutiennent cette nécessité: 1) La majorité des cas de SIDA étant acquis par voie sexuelle, les actions visant la Prévention des MST traditionnelles, préviendraient aussi le SIDA; 2) Le diagnostic des MST traditionnelles peut être assez facilement discuter avec les patients, permettant ainsi une action de Prévention effective vis à vis des personnes concernées; et 3) Les MST traditionnelles ayant une période d'incubation assez courte comparée à celle du SIDA, il est plus facile d'évaluer l'impact des activités de Prévention pouvant se traduire en une réduction de l'incidence des MST, réduction qui est impossible à observer à court terme pour le SIDA.

C. Situation actuelle de la surveillance au Burkina

9. Comme dans la quasi-totalité des pays en développement, la surveillance épidémiologique VIH/SIDA/MST est très faible à l'heure actuelle au Burkina Faso. Le sous-comité de la surveillance du comité national de lutte contre le SIDA a la responsabilité théorique de cette surveillance. Dans la réalité, un seul membre de ce sous-comité qui travaille à la direction de médecine préventive est en charge des toutes les activités de surveillance tant pour le SIDA/MST que pour les autres pathologies dans l'ensemble du pays. Le système de surveillance n'est pas bien défini, les personnes et les formations médicales devant participer à la notification des cas ne sont pas identifiées clairement et responsabilisées pour cette activité. La définition de cas de SIDA à utiliser pour la notification n'est pas vulgarisée au niveau du personnel médical suppose participer à la notification des cas. Il n'y a pas un notification régulière des cas, la plupart des cas répertoriés les sont à l'occasion de recherches actives périodiques des cas effectuées par la DMP dans les formations sanitaires facilement accessibles. La serosurveillance par sites sentinelles qui avait été initiée dans 8 sites n'a pu se faire par manque de matériel et réactifs, manque de supervision et manque de formation du personnel des sites retenus. Le seul des 8 sites qui a pu fonctionne l'a été par le soutien de la GTZ, et les résultats disponibles de ce site datent de 1991.
Les seules MST traditionnelles reprises dans la fiche de notification de la DMP sont la gonococcie et la syphilis. Alors que la grande majorité des formations sanitaires n'ont pas la possibilité de faire le diagnostic étiologique, il n'existe pas encore un système établi de notification par définition syndromique.
Il y a donc nécessité urgente d'intervenir pour améliorer cette situation qui peut constituer un frein au programmes de contrôle et prévention du VIH/SIDA/MST, car si seulement un nombre infime des cas

qui existent réellement sont répertoriés, cela peut faire croire que l'ampleur de l'épidémie est moindre et détourner par conséquent l'attention des autorités sanitaires et surtout celles des leaders politiques.

D. Renforcement de la surveillance dans le cadre du présent Projet

10. Le système sanitaire burkinabe étant en pleine mutation, les recommandations faites ici pourront être réadaptées en fonction de la réorganisation prochaine du système sanitaire. Dans le cadre du présent Projet, en vue d'améliorer la surveillance épidémiologique, nous recommandons qu'elle se fasse de la manière suivante:

Surveillance de l'infection à VIH/MST

a. Surveillance active par sites sentinelles

11. Périodicité: une fois par an, pendant un maximum de trois mois au niveau de chaque site sélectionné, l'équipe chargée de la serosurveillance procédera à la collecte des échantillons de sang pour les sérologies VIH et syphilitique. Sites: tenant compte des difficultés de faire marcher 8 sites antérieurement prévus, dans le cadre du présent Projet nous retenons 5 sites en tenant compte de la prévalence estimée, de l'accessibilité des ces sites aux équipes de supervision, de la capacité de conduire les activités de surveillance et dans une certaine mesure de leur situation géographique. Ces sites sont: Ouagadougou, Bobo Dioulasso, Gaoua, Fada Ngourma, et Ouahigouya. Populations: pour tous les sites, les femmes enceintes se présentant pour leur première consultation prénatale dans les SMI sélectionnées seront incluses dans l'étude par ordre d'arrivée à la clinique jusqu'à ce que le nombre prévu soit atteint. Pour les sites de Ouagadougou et de Bob Dioulasso ou les prostituées sont accessibles, elles seront invitées à participer aux activités de la surveillance. Méthodologie: la méthodologie de la séro-surveillance est décrite en détail dans le protocole de la surveillance au Burkina révisé dans le cadre du présent projet. De manière générale, les échantillons de sang seront testés de façon anonyme et non correlée pour éviter d'éclore le statut sérologique des sujets étant donne que la composante counseling et prise en charge n'est pas prévue pour cette activité. Tous les échantillons seront identifiés seulement par un numéro et transmis à Ouagadougou, Hôpital Yalgado où toutes les sérologies se feront.

12. Les autres MST: gonorrhée, chlamydiose, trichomoniase, et candidose vaginale seront aussi recherchées pour les sites ayant la capacité de laboratoire de le faire et les patientes seront soignées gratuitement. Analyses des données et dissémination des résultats: Les données de chaque site seront analysées localement avec l'assistance de l'équipe de CSE, les résultats seront rendus disponibles pour les responsables locaux et un rapport sera envoyé au niveau central à la Direction de médecine préventive, sous-comité surveillance du SIDA qui fera les analyses d'ensemble pour transmettre les résultats aux utilisateurs (CNLS, DEP, et niveaux périphériques ayant participe au travail).

13. Responsabilités: équipe locale de serosurveillance, équipes des Centre de Surveillance Epidémiologique (CSE) du réseau PASE , équipe centrale de supervision à la DMP (sous-comité surveillance).

b. Surveillance passive de l'infection à VIH

14. Les dispositions pratiques sont prises pour que les différents laboratoires offrant les tests pour le VIH transmettent les données sur les infections diagnostiquées à l'équipe de la surveillance épidémiologie tous les deux mois. Le sous comité laboratoire doit mettre en place une fiche standard de demande d'analyse VIH comprenant les données essentielles pour la surveillance. Dans la ville de Ouagadougou

et dans les provinces où il existe déjà des CSE du réseau PASE, un membre du CSE s'occupera de rappeler aux différents laboratoires de sa circonscription l'activité de notification. Pour les provinces où les CSE ne sont pas encore en place, le sous-comité surveillance épidémiologie doit sollicité l'appui de la direction régionale de la santé (DSP) pour designer une personne qui devra s'assurer que la notification est régulièrement faite.

15. Surveillance du SIDA/MST. Au 31 décembre 1992, 2886 cas de SIDA au Burkina ont été notifiés à l'OMS. Si l'on tient compte de la sous-estimation importante, ce nombre peut être multiplié par 5 ou 10 pour avoir une image plus proche de la réalité. Il est donc important de renforcer le système actuel. Le personnel médical auquel on demande de faire la notification des cas doit être formé en conséquence pour être en mesure de remplir cette tache. La notification des cas de SIDA devra être faite sur base de la définition de l'OMS (définition de Bangui) pour toutes les formations sanitaires de l'ensemble du pays participant à la notification. Les formations ayant les moyens techniques de laboratoire leur permettant de confirmer le diagnostic clinique peuvent le faire, mais l'absence des tests ne doit pas être une raison de non notification des cas. Toutes les formations sanitaires qui délivrent des soins aux malades de SIDA et ayant une capacité minimale de diagnostic clinique doivent participer à la notification des cas. Une fiche (une page) de notification, simple et facile a remplir doit être mise a la disposition permanente des formations sanitaires impliquées dans la surveillance. Elles devront transmettre mensuellement leurs fiches de notification à leur direction provinciale de la santé (section surveillance épidémiologie). Les CSE veilleront à la régularité de la notification par les formations sanitaires de leur ressort et seront responsables de l'analyse des données pour les mettre à la disposition de la direction régionale de la santé et ils enverront les données au CSE central qui se chargera de l'analyse des toutes les données venant des provinces pour les mettre à la disposition du sous-comité surveillance épidémiologique. A chaque niveau, un feed-back régulier sera organisé vers les structures périphériques.

16. Le processus de base sera le même pour les MST. Etant donné que la disponibilité des tests de laboratoire pour la mise en évidence étiologique des autres MST est très limitée, la notification des cas de MST doit être basée sur les syndromes (écoulement urétral, ulcération génitale, écoulement vaginal etc...) pour les formations médicales qui ne disposent pas des tests de laboratoire.

Burkina Faso

Population and Aids Control Project
Expenditure Accounts by Components
Totals Including Contingencies
(CFAF Million)

	Support the Implementation of the Government's Population Policy							
	Improving the quality of, and access to, MCH/FP services		Promoting IEC Programs			Institutional strengthening		
	Expand FP services through the Public Health System	Establish outreach program	Increasing support for population issues among opinion leaders	Increasing public knowledge of, and demand for, modern contraceptive methods	Enhancing public understanding of women's rights and problems	Strengthening the Permanent Secretariat of CONAPO	Strengthening the Family Planning Directorate (DSF)	Strengthening the Family Promotion Directorate (DPF)
I. Investment Costs								
A. Civil Works								
Construction	-	146.7	-	-	-	-	121.5	-
Rehabilitation	-	-	-	-	-	-	50.8	-
Subtotal Civil Works	-	146.7	-	-	-	-	172.3	-
B. Goods								
Equipment	115.5	33.7	-	-	-	57.7	57.9	25.6
Material	-	-	289.4	358.6	344.4	0.0	-	-
Furniture	-	-	-	-	-	57.7	60.5	1.2
Vehicles	191.0	92.5	-	-	-	44.5	35.9	-
Lab. Materials & Supplies	-	-	-	-	-	-	-	-
Medical material and supplies	-	-	-	-	-	-	-	-
Subtotal Goods	306.5	126.2	289.4	358.6	344.4	159.9	154.3	26.7
C. Drugs	-	-	-	-	-	-	-	-
D. Contraceptives	2,501.1	-	-	-	-	-	-	-
E. Condoms	-	-	-	-	-	-	-	-
F. Specialist services								
1. International	-	-	-	-	-	388.1	70.6	-
2. National								
Studies, Surveys, and Research	-	-	-	80.6	-	137.5	-	-
Pilot Projects	4.8	117.3	-	17.5	-	-	-	-
Capacity-Building	-	-	-	-	-	179.7	6.8	-
Subtotal National	4.8	117.3	-	98.1	-	317.2	6.8	-
Subtotal Specialist services	4.8	117.3	-	98.1	-	705.3	77.3	-
G. Training								
Abroad	-	-	-	-	-	39.2	321.6	10.4
Local	194.6	-	81.9	488.6	14.3	12.3	1.3	-
Subtotal Training	194.6	-	81.9	488.6	14.3	51.5	322.9	10.4
H. IEC								
CRESAS	-	-	-	34.3	-	-	-	-
Mass Media	-	-	-	625.7	-	-	-	-
Subtotal IEC	-	-	-	660.0	-	-	-	-
I. Fund for Population and HIV Activities	-	-	-	-	-	-	-	-
Total Investment Costs	3,007.0	390.2	371.4	1,605.3	358.7	916.8	726.9	37.1
II. Recurrent Costs								
A. O&M of Equip. & Veh.	178.7	84.0	-	-	-	119.4	128.7	10.6
B. Office and audio-visual supplies	-	-	11.8	-	-	37.8	17.6	14.0
C. Personnel								
1. Supervision missions	-	1.3	-	-	-	13.5	-	-
2. Salaries Ministry staff	-	-	-	-	-	369.4	356.6	-
3. Salaries of contractual staff of the Coordina	-	-	-	-	-	199.4	-	-
Subtotal Personnel	-	1.3	-	-	-	582.3	356.6	-
Total Recurrent Costs	178.7	85.4	11.8	-	-	739.5	503.0	24.6
Total PROJECT COSTS	3,185.8	475.6	383.2	1,605.3	358.7	1,656.3	1,229.8	61.7
Taxes	-	-	-	-	-	-	-	-
Foreign Exchange	2,939.2	319.9	183.7	802.6	153.0	769.7	718.3	53.5

Burkina Faso

Population and Aids Control Project
Expenditure Accounts by Components
Totals Including Contingencies
(CFAF Million)

	Strengthen the National Capacity to Contain the Spread of HIV/AIDS				Strengthen the National Capacity to Contain the Spread of HIV/AIDS					
	Institutional Strengthening and Capacity Building									
	Strengthening the National AIDS Committee (CNLS)	Improving Epidemiological Surveillance	Improving Blood Safety Capacity	Operational Research	Promoting Information, Education, Communications Program	Promoting condom use	The STDs Program	Strengthening clinical management and community care	Fund for Population and HIV Activities	Total
I. Investment Costs										
A. Civil Works										
Construction	-	-	-	-	-	-	-	-	-	268.2
Rehabilitation	-	20.0	-	-	-	-	-	-	-	70.8
Subtotal Civil Works	-	20.0	-	-	-	-	-	-	-	339.0
B. Goods										
Equipment	15.6	62.3	-	-	-	-	-	-	-	368.2
Material	-	3.0	3.6	-	308.7	-	-	-	-	1,307.7
Furniture	-	-	-	-	-	-	-	-	-	119.4
Vehicles	26.4	61.2	-	-	-	-	-	-	-	451.6
Lab. Materials & Supplies	-	71.4	-	-	-	-	-	-	-	71.4
Medical material and supplies	-	220.9	1,086.6	-	-	-	-	-	-	1,307.4
Subtotal Goods	42.1	418.7	1,090.2	-	308.7	-	-	-	-	3,625.7
C. Drugs	-	-	-	-	-	-	2,213.3	505.9	-	2,719.1
D. Contraceptives	-	-	-	-	-	-	-	-	-	2,501.1
E. Condoms	-	-	-	-	-	1,958.9	-	-	-	1,958.9
F. Specialist services										
1. International	309.8	-	-	-	-	-	-	-	-	768.5
2. National										
Studies, Surveys, and Research	-	-	-	75.7	130.3	-	-	3.5	-	427.6
Pilot Projects	-	-	-	-	-	-	-	-	-	139.6
Capacity-Building	75.4	-	-	-	-	-	-	-	-	261.9
Subtotal National	75.4	-	-	75.7	130.3	-	-	3.5	-	829.0
Subtotal Specialist services	385.3	-	-	75.7	130.3	-	-	3.5	-	1,597.5
G. Training										
Abroad	27.9	21.5	-	1.6	-	-	6.5	19.8	-	448.5
Local	0.1	7.3	-	-	108.9	-	-	35.3	-	944.7
Subtotal Training	28.0	28.7	-	1.6	108.9	-	6.5	55.1	-	1,393.2
H. IEC										
CRESAS	-	-	-	-	44.3	-	-	-	-	78.7
Mass Media	-	-	-	-	856.3	-	-	-	-	1,482.0
Subtotal IEC	-	-	-	-	900.6	-	-	-	-	1,560.6
I. Fund for Population and HIV Activities	-	-	-	-	-	-	-	-	1,120.0	1,120.0
Total Investment Costs	455.3	467.5	1,090.2	77.3	1,448.5	1,958.9	2,219.8	564.5	1,120.0	16,815.3
II. Recurrent Costs										
A. O&M of Equip. & Veh.	25.4	87.4	-	-	-	-	-	-	-	634.3
B. Office and audio-visual supplies	17.2	-	-	-	11.4	-	-	-	-	109.9
C. Personnel										
1. Supervision missions	-	1.8	-	-	-	-	-	-	-	16.6
2. Salaries Ministry staff	154.5	178.3	-	-	-	-	-	-	-	1,056.8
3. Salaries of contractual staff of the Coordinati	-	-	-	-	-	-	-	-	-	199.4
Subtotal Personnel	154.5	180.1	-	-	-	-	-	-	-	1,274.8
Total Recurrent Costs	197.1	267.5	-	-	11.4	-	-	-	-	2,019.1
	652.4	735.0	1,090.2	77.3	1,459.9	1,958.9	2,219.8	564.5	1,120.0	16,834.3
Taxes	-	-	-	-	-	-	-	-	-	-
Foreign Exchange	401.9	491.8	1,090.2	45.6	324.8	1,958.9	2,219.8	540.9	560.0	13,573.9

Burkina Faso
Population and Aids Control Project
Expenditure Accounts by Components
Totals Including Contingencies
(US$ Million)

	Support the implementation of the Government's Population Policy							
	Improving the quality of, and access to, MCH/FP services		Promoting IEC Programs			Institutional strengthening		
	Expand FP services through the Public Health System	Establish outreach program	Increasing support for population issues among opinion leaders	Increasing public knowledge of, and demand for, modern contraceptive methods	Enhancing public understanding of women's rights and problems	Strengthening the Permanent Secretariat of CONAPO	Strengthening the Family Planning Directorate (DSF)	Strengthening the Family Promotion Directorate (DPF)
I. Investment Costs								
A. Civil Works								
Construction	-	0.2	-	-	-	-	0.2	-
Rehabilitation	-	-	-	-	-	-	0.1	-
Subtotal Civil Works	-	0.2	-	-	-	-	0.3	-
B. Goods								
Equipment	0.2	0.1	-	-	-	0.1	0.1	0.0
Material	-	-	0.5	0.6	0.6	0.0	-	-
Furniture	-	-	-	-	-	0.1	0.1	0.0
Vehicles	0.3	0.2	-	-	-	0.1	0.1	-
Lab. Materials & Supplies	-	-	-	-	-	-	-	-
Medical material and supplies	-	-	-	-	-	-	-	-
Subtotal Goods	0.5	0.2	0.5	0.6	0.6	0.3	0.3	0.0
C. Drugs	-	-	-	-	-	-	-	-
D. Contraceptives	4.3	-	-	-	-	-	-	-
E. Condoms	-	-	-	-	-	-	-	-
F. Specialist services								
1. International	-	-	-	-	-	0.7	0.1	-
2. National								
Studies, Surveys, and Research	-	-	-	0.1	-	0.5	-	-
Pilot Projects	0.0	0.2	-	0.0	-	-	-	-
Capacity-Building	-	-	-	-	-	0.5	0.0	-
Subtotal National	0.0	0.2	-	0.2	-	1.0	0.0	-
Subtotal Specialist services	0.0	0.2	-	0.2	-	1.6	0.1	-
G. Training								
Abroad	-	-	-	-	-	0.1	0.5	0.0
Local	0.3	-	0.1	0.8	0.0	0.0	0.0	-
Subtotal Training	0.3	-	0.1	0.8	0.0	0.1	0.5	0.0
H. IEC								
CRESAS	-	-	-	0.1	-	-	-	-
Mass Media	-	-	-	1.1	-	-	-	-
Subtotal IEC	-	-	-	1.1	-	-	-	-
I. Fund for Population and HIV Activitie	-	-	-	-	-	-	-	-
Total Investment Costs	5.1	0.7	0.6	2.7	0.6	2.0	1.2	0.1
II. Recurrent Costs								
A. O&M of Equip. & Veh.	0.3	0.1	-	-	-	0.2	0.2	0.0
B. Office and audio-visual supplies	-	-	0.0	-	-	0.1	0.0	0.0
C. Personnel								
1. Supervision missions	-	0.0	-	-	-	0.0	-	-
2. Salaries Ministry staff	-	-	-	-	-	0.6	0.6	-
3. Salaries of contractual staff of the Coordinating Team	-	-	-	-	-	0.3	-	-
Subtotal Personnel	-	0.0	-	-	-	1.0	0.6	-
Total Recurrent Costs	0.3	0.1	0.0	-	-	1.3	0.9	0.0
Total PROJECT COSTS	5.4	0.8	0.7	2.7	0.6	3.2	2.1	0.1
Taxes	-	-	-	-	-	-	-	-
Foreign Exchange	5.0	0.5	0.3	1.4	0.3	1.4	1.2	0.1

Burkina Faso
Population and Aids Control Project
Expenditure Accounts by Components
Totals Including Contingencies
(US$ Million)

	Strengthen the National Capacity to Contain the Spread of HIV/AIDS				Strengthen the National Capacity to Contain the Spread of HIV/AIDS					
	Institutional Strengthening and Capacity Building									
	Strengthening the National AIDS Committee (CNLS)	Improving Epidemiological Surveillance	Improving Blood Safety Capacity	Operational Research	Promoting Information, Education, Communication Program	Promoting condom use	The STDs Program	Strengthening clinical management and community care	Fund for Population and HIV Activities	Total
I. Investment Costs										
A.Civil Works										
Construction	-	-	-	-	-	-	-	-	-	0.5
Rehabilitation	-	0.0	-	-	-	-	-	-	-	0.1
Subtotal Civil Works	-	0.0	-	-	-	-	-	-	-	0.6
B. Goods										
Equipment	0.0	0.1	-	-	-	-	-	-	-	0.6
Material	-	0.0	0.0	-	0.5	-	-	-	-	2.2
Furniture	-	-	-	-	-	-	-	-	-	0.2
Vehicles	0.0	0.1	-	-	-	-	-	-	-	0.8
Lab. Materials & Supplies	-	0.1	-	-	-	-	-	-	-	0.1
Medical material and supplies	-	0.4	1.8	-	-	-	-	-	-	2.2
Subtotal Goods	0.1	0.7	1.9	-	0.5	-	-	-	-	6.2
C. Drugs	-	-	-	-	-	-	3.8	0.9	-	4.6
D. Contraceptives	-	-	-	-	-	-	-	-	-	4.3
E. Condoms	-	-	-	-	-	3.3	-	-	-	3.3
F. Specialist services										
1. International	0.5	-	-	-	-	-	-	-	-	1.3
2. National										
Studies, Surveys, and Research	-	-	-	0.1	0.2	-	-	0.0	-	1.0
Pilot Projects	-	-	-	-	-	-	-	-	-	0.2
Capacity-Building	0.1	-	-	-	-	-	-	-	-	0.6
Subtotal National	0.1	-	-	0.1	0.2	-	-	0.0	-	1.8
Subtotal Specialist services	0.7	-	-	0.1	0.2	-	-	0.0	-	3.1
G. Training										
Abroad	0.0	0.0	-	0.0	-	-	0.0	0.0	-	0.8
Local	0.0	0.0	-	-	0.2	-	-	0.1	-	1.6
Subtotal Training	0.0	0.0	-	0.0	0.2	-	0.0	0.1	-	2.4
H. IEC										
CRESAS	-	-	-	-	0.1	-	-	-	-	0.1
Mass Media	-	-	-	-	1.5	-	-	-	-	2.5
Subtotal IEC	-	-	-	-	1.5	-	-	-	-	2.7
I. Fund for Population and HIV Activities	-	-	-	-	-	-	-	-	4.0	4.0
Total Investment Costs	0.8	0.8	1.9	0.1	2.5	3.3	3.8	1.0	4.0	31.1
II. Recurrent Costs										
A. O&M of Equip. & Veh.	0.0	0.1	-	-	-	-	-	-	-	1.1
B. Office and audio-visual supplies	0.0	-	-	-	0.0	-	-	-	-	0.2
C. Personnel										
1. Supervision missions	-	0.0	-	-	-	-	-	-	-	0.0
2. Salaries Ministry staff	0.3	0.3	-	-	-	-	-	-	-	1.8
3. Salaries of contractual staff of the Coordinating Team	-	-	-	-	-	-	-	-	-	0.3
Subtotal Personnel	0.3	0.3	-	-	-	-	-	-	-	2.2
Total Recurrent Costs	0.3	0.5	-	-	0.0	-	-	-	-	3.4
Total PROJECT COSTS	1.1	1.2	1.9	0.1	2.5	3.3	3.8	1.0	4.0	34.5
Taxes	-	-	-	-	-	-	-	-	-	-
Foreign Exchange	0.7	0.8	1.9	0.1	0.6	3.3	3.8	0.9	2.0	24.3

Burkina Faso
Population and Aids Control Project
Project Cost Summary

	(CFAF Million)					(US$ Million)				
	Local	Foreign	Total	% Foreign Exchange	% Total Base Costs	Local	Foreign	Total	% Foreign Exchange	% Total Base Costs
I. Investment Costs										
A. Civil Works										
Construction	53.8	168.9	222.7	76	1	0.1	0.3	0.4	76	1
Rehabilitation	14.1	44.2	58.3	76	-	0.0	0.1	0.1	76	-
Subtotal Civil Works	67.9	213.1	281.0	76	2	0.1	0.4	0.5	76	2
B. Goods										
Equipment	5.4	331.1	336.5	98	2	0.0	0.6	0.6	98	2
Material	345.3	761.8	1,107.1	69	7	0.6	1.3	1.9	69	6
Furniture	31.3	66.0	97.4	68	1	0.1	0.1	0.2	68	1
Vehicles	16.1	373.9	390.0	96	2	0.0	0.6	0.7	96	2
Lab. Materials & Supplies	-	66.6	66.6	100	-	-	0.1	0.1	100	-
Medical material and supplies	-	1,177.7	1,177.7	100	7	-	2.0	2.0	100	7
Subtotal Goods	398.1	2,777.2	3,175.3	87	20	0.7	4.7	5.4	87	18
C. Drugs	-	2,226.7	2,226.7	100	14	-	3.8	3.8	100	13
D. Contraceptives	-	2,048.2	2,048.2	100	13	-	3.5	3.5	100	12
E. Condoms	-	1,764.6	1,764.6	100	11	-	3.0	3.0	100	10
F. Specialist services										
1. International	-	709.5	709.5	100	4	-	1.2	1.2	100	4
2. National										
Studies, Surveys, and Research	217.5	170.5	388.0	44	2	0.5	0.4	0.9	40	3
Pilot Projects	72.2	52.2	124.4	42	1	0.1	0.1	0.2	42	1
Capacity-Building	147.9	85.2	233.1	37	1	0.4	0.2	0.6	35	2
Subtotal National	437.7	307.8	745.5	41	5	1.0	0.6	1.7	39	6
Subtotal Specialist services	437.7	1,017.4	1,455.1	70	9	1.0	1.9	2.9	64	10
G. Training										
Abroad	-	408.7	408.7	100	3	-	0.7	0.7	100	2
Local	459.1	295.3	754.4	39	5	0.8	0.5	1.3	39	4
Subtotal Training	459.1	704.0	1,163.0	61	7	0.8	1.2	2.0	60	7
H. IEC										
CRESAS	32.3	29.0	61.4	47	-	0.1	0.0	0.1	47	-
Mass Media	897.9	238.2	1,136.1	21	7	1.5	0.4	1.9	21	7
Subtotal IEC	930.3	267.2	1,197.5	22	7	1.6	0.5	2.0	22	7
I. Fund for Population and HIV Activities	560.0	560.0	1,120.0	50	7	2.0	2.0	4.0	50	13
Total Investment Costs	2,853.0	11,578.4	14,431.4	80	90	6.2	20.9	27.1	77	91
II. Recurrent Costs										
A. O&M of Equip. & Veh.	270.0	245.9	515.9	48	3	0.5	0.4	0.9	48	3
B. Office and audio-visual supplies	38.0	53.7	91.7	59	1	0.1	0.1	0.2	59	1
C. Personnel										
1. Supervision missions	5.1	8.8	14.0	63	-	0.0	0.0	0.0	63	-
2. Salaries Ministry staff	791.2	-	791.2	-	5	1.3	-	1.3	-	5
3. Salaries of contractual staff of the Coordinating Team	149.0	-	149.0	-	1	0.3	-	0.3	-	1
Subtotal Personnel	945.3	8.8	954.1	1	6	1.6	0.0	1.6	1	5
Total Recurrent Costs	1,253.3	308.4	1,561.7	20	10	2.1	0.5	2.7	20	9
Total BASELINE COSTS	4,106.3	11,886.8	15,993.1	74	100	8.3	21.4	29.7	72	100
Physical Contingencies	11.6	493.3	504.9	98	3	0.0	0.8	0.9	98	3
Price Contingencies	1,142.5	1,193.7	2,336.3	51	15	1.9	2.0	4.0	51	13
Total PROJECT COSTS	5,260.4	13,573.9	18,834.3	72	118	10.3	24.3	34.5	70	116

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Burkina Faso
Population and Aids Control Project
Project Components by Year
(US$ Million)

	Totals Including Contingencies					
	1995	1996	1997	1998	1999	Total
A. Support the Implementation of the Government's Population Policy						
1. Improving the quality of, and access to, MCH/FP services						
Expand FP services through the Public Health System	1.2	1.1	1.1	1.0	1.0	5.4
Establish outreach program	0.6	0.2	0.0	0.0	0.0	0.8
Subtotal Improving the quality of, and access to, MCH/FP services	1.8	1.2	1.1	1.1	1.0	6.2
2. Promoting IEC Programs						
Increasing support for population issues among opinion leaders	0.1	0.1	0.1	0.1	0.1	0.7
Increasing public knowledge of, and demand for, modern contraceptive methods	0.3	0.5	0.6	0.6	0.7	2.7
Enhancing public understanding of women's rights and problems	0.1	0.1	0.1	0.1	0.1	0.6
Subtotal Promoting IEC Programs	0.5	0.8	0.8	0.9	0.9	4.0
3. Institutional strengthening						
Strengthening the Permanent Secretariat of CONAPO	1.0	0.8	0.8	0.4	0.4	3.2
Strengthening the Family Planning Directorate (DSF)	0.4	0.7	0.4	0.3	0.3	2.1
Strengthening the Family Promotion Directorate (DPF)	0.1	0.0	0.0	0.0	0.0	0.1
Subtotal Institutional strengthening	1.5	1.5	1.2	0.6	0.6	5.4
Subtotal Support the Implementation of the Government's Population Policy	3.8	3.5	3.2	2.6	2.6	15.6
B. Strengthen the National Capacity to Contain the Spread of HIV/AIDS						
1. Institutional Strengthening and Capacity Building						
a. Strengthening the National AIDS Committee (CNLS)	0.3	0.3	0.3	0.2	0.1	1.1
b. Improving Epidemiological Surveillance	0.5	0.2	0.2	0.2	0.2	1.2
c. Improving Blood Safety Capacity	0.4	0.4	0.4	0.4	0.4	1.9
d. Operational Research	0.1	0.0	0.0	-	-	0.1
Subtotal Institutional Strengthening and Capacity Building	1.2	0.9	0.8	0.8	0.7	4.3
2. Promoting Information, Education, Communications Program	0.3	0.5	0.6	0.5	0.6	2.5
3. Promoting condom use	0.6	0.6	0.7	0.7	0.7	3.3
4. The STDs Program	0.7	0.7	0.8	0.8	0.8	3.8
5. Strengthening clinical management and community care	0.2	0.2	0.2	0.2	0.2	1.0
Subtotal Strengthen the National Capacity to Contain the Spread of HIV/AIDS	3.1	2.9	3.0	3.0	2.9	14.9
C. Fund for Population and HIV Activities	0.8	0.8	0.8	0.8	0.8	4.0
Total PROJECT COSTS	7.7	7.2	7.0	6.3	6.3	34.5

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Burkina Faso
Population and Aids Control Project
Components by Financiers
(US$ Million)

	IDA Amount	Norway Amount	Denmark Amount	The Government Amount	Total Amount
A. Support the Implementation of the Government's Population Policy					
1. Improving the quality of, and access to, MCH/FP services					
Expand FP services through the Public Health System	5.3	-	-	0.1	5.4
Establish outreach program	0.7	-	-	0.1	0.8
Subtotal Improving the quality of, and access to, MCH/FP services	6.0	-	-	0.2	6.2
2. Promoting IEC Programs					
Increasing support for population issues among opinion leaders	0.7	-	-	-	0.7
Increasing public knowledge of, and demand for, modern contraceptive methods	2.7	-	-	-	2.7
Enhancing public understanding of women's rights and problems	0.6	-	-	-	0.6
Subtotal Promoting IEC Programs	4.0	-	-	-	4.0
3. Institutional strengthening					
Strengthening the Permanent Secretariat of CONAPO	2.6	-	-	0.7	3.2
Strengthening the Family Planning Directorate (DSF)	1.4	-	-	0.7	2.1
Strengthening the Family Promotion Directorate (DPF)	0.1	-	-	0.0	0.1
Subtotal Institutional strengthening	4.1	-	-	1.4	5.4
Subtotal Support the Implementation of the Government's Population Policy	14.1	-	-	1.5	15.6
B. Strengthen the National Capacity to Contain the Spread of HIV/AIDS					
1. Institutional Strengthening and Capacity Building					
a. Strengthening the National AIDS Committee (CNLS)	0.8	-	-	0.3	1.1
b. Improving Epidemiological Surveillance	0.9	-	-	0.4	1.2
c. Improving Blood Safety Capacity	1.9	-	-	-	1.9
d. Operational Research	0.1	-	-	-	0.1
Subtotal Institutional Strengthening and Capacity Building	3.7	-	-	0.6	4.3
2. Promoting Information, Education, Communications Program	2.5	-	-	-	2.5
3. Promoting condom use	3.3	-	-	-	3.3
4. The STDs Program	1.8	1.0	1.0	-	3.8
5. Strengthening clinical management and community care	1.0	-	-	-	1.0
Subtotal Strengthen the National Capacity to Contain the Spread of HIV/AIDS	12.2	1.0	1.0	0.6	14.9
C. Fund for Population and HIV Activities	-	2.0	2.0	-	4.0
Total Disbursement	26.3	3.0	3.0	2.2	34.5

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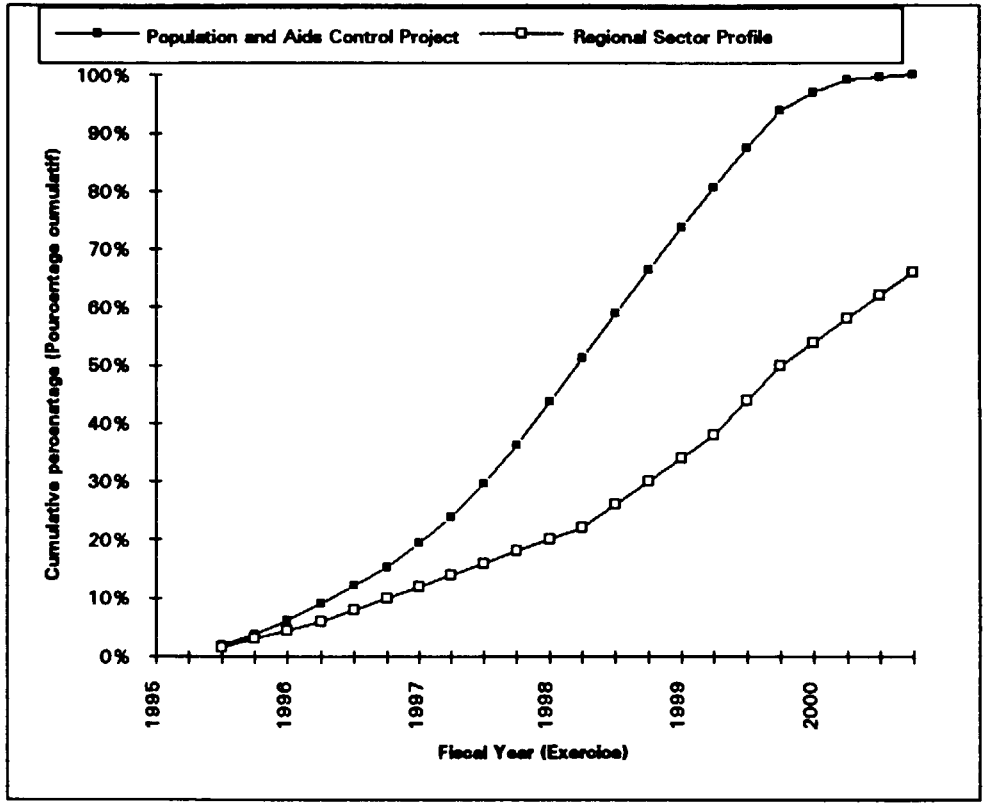
BURKINA FASO
POPULATION AND AIDS CONTROL PROJECT

Disbursement Profile/Profil de Debourements

IDA fiscal years and quarters		Disbursements/ *Debourements*		Profile/ *Profil*	
		By Quarter	Cumulative	Credit	Regional Sector
Annees budgetaires IDA et trimestres		*Par trimestre*	*Cumulatif*	*Credit*	*Secteur a l'echelle regionale*
		(US$ million)	(US$ million)	(%)	(%)
1995	1	-	-		
	2	-	-		
	3	0.5	0.5	2%	2%
1.0	4	0.5	1.0	4%	3%
1996	1	0.6	1.6	6%	5%
	2	0.8	2.4	9%	6%
	3	0.8	3.2	12%	8%
3.0	4	0.8	4.0	15%	10%
1997	1	1.1	5.1	19%	12%
	2	1.2	6.3	24%	14%
	3	1.5	7.8	30%	16%
5.5	4	1.7	9.5	36%	18%
1998	1	2.0	11.5	44%	20%
	2	2.0	13.5	51%	22%
	3	2.0	15.5	59%	26%
8.0	4	2.0	17.5	67%	30%
1999	1	1.9	19.4	74%	34%
	2	1.8	21.2	81%	38%
	3	1.8	23.0	87%	44%
7.2	4	1.7	24.7	94%	50%
2000	1	0.8	25.5	97%	54%
	2	0.6	26.1	99%	58%
	3	0.1	26.2	100%	62%
1.6	4	0.1	26.3	100%	66%



BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Supervision Plan

1. Borrower's Contribution to Supervision

(a) The project coordinating team in the Permanent Secretariat (PS) of CONAPO will submit semi-annual reports of project monitoring data to IDA in March and September each year.

(b) The project coordinating team will maintain up-to date project accounts and present summary accounts to IDA every six months.

(c) The audits of project accounts by indipendent auditors acceptable to IDA will be made to the Bank within six months of the close of each fiscal year.

(d) Each implementing unit will report semi-annually to the project coordinating team on implementation, including progress and delays.

(e) By January 15, 1997, the PS of CONAPO will prepare and provide to IDA for its approval a plan for carrying out a mid-term project review. The PS will, with the assistance of the implementing units, carry out a mid-term review in accordance with the agreed plan. Thereafter, Government will promptly take all actions recommended as a result of the review that are required to achieve project objectives.

(f) The project coordinating team will be responsible for coordinating arrangements for Bank supervision missions and for providing information required by missions.

(g) Mission briefing meetings on arrival and wrap-up meetings before departure will be normally chaired by the Minister in charge of Planning in the Ministry of Plan and Finance.

2. Cofinanciers' Contribution to Supervision. Cofinanciers will be consulted on, and invited to, participate in supervision activities, and will be kept fully informed regarding TORs, aide-mémoires, and results of IDA supervision missions. It is expected that cofinanciers will participate in annual joint review missions and bring complementary skills to supervision missions.

Bank Supervision Inputs into Key Activities

Approx. Dates	Skill Requirements	Activity	Staff-weeks
July 1994	Mission Leader Epidemiologist Procurement Spec. Inst. Strength. Spec. IEC Specialist	Project Launch	9
January 1995	Mission Leader Epidemiologist Demographer	Supervision	6
July 1995	Mission Leader Epidemiologist Procurement Spec. Inst. Strength. Spec.	Supervision	8
March 1996	Mission Leader Epidemiologist M&E Specialist	Supervision	6
September 1996	Mission Leader Epidemiologist	Supervision	4
March 1997	Mission Leader Epidemiologist IEC Specialist Management Spec.	Mid-Term Review	12
September 1997	Mission Leader Epidemiologist Demographer	Supervision	6
March 1998	Mission Leader Epidemiologist IEC Specialist	Supervision	6
October 1998	Mission Leader Epidemiologist	Supervision	4
March 1999	Mission Leader Epidemiologist Demographer	Supervision	6
November 1999	Mission Leader IEC Specialist Epidemiologist Management Spec.	Project Completion	8

PROCUREMENT ARRANGEMENTS

IMPLEMENTATION SCHEDULE

	Pre-project	Project Year					Total	Procure	# of
	1994	1995	1996	1997	1998	1999	Payment	-ment	Packages
Quarters	..1.1.2.1.3.1.4..	..1.1.2.1.3.1.4..	..1.1.2.1.3.1.4..	..1.1.2.1.3.1.4..	..1.1.2.1.3.1.4..	..1.1.2.1.3.1.4..	(US$'000)	Method	Contracts
Board	x								
Signature/Effectiveness/Closing	x x					x			
A. WORKS							676		
1. Health Infrastructures							293		
1.1 Construction extension ABBEF clinic		ddAbbeAcmmwww	wwwwww				249	LCB	1
1.2. Rehabilitation cold storage room		dbeww					34	LCB	1
2. Other Infrastructures							293		
2.1. Construction DSF offices		ddAbbeAcmmwww	wwwwww				207	LCB	1
2.2 Rehab. regional training centers		dbeww ww	ww ww ww				86	LCB	5
B. GOODS							6,184		
1. Medical Equipment							2,345		
1.1 Medical materials & supplies		ddAbbeAcmmwww	www ddAbbe	eAcmmmww			2,223	ICB	6
1.2. Lab. materials & supplies		ddAbbeAcmmwww	www ddAbbe	eAcmmmww			122	OTH	3
2. Office Equipement & Supplies							3,052		
2.1. Office equipment & supplies		ddAbbeAcmmwww	www				626	ICB/LCB	6
2.2. Furniture		ddAbbeAcmmwww	www				203	LCB	2
2.3. Materials		www	www	www	www	www	2,223	ICB/LCB	30
3. Vehicles/Motorcycles							767		
3.1. Vehicles/motorcycles		ddabbeAcmmmww	www ddabbeA	cmmww			657	ICB	4
3.2. Carts							110	LCB	3
C. DRUGS							4,823		
1. STDs Drugs		ddabbeAcmm	www	www ddabbeA	cmmww	www	3,763	ICB	2
2. Other drugs		ddabbeAcmm	www	www ddabbeA	cmmww	www	860	ICB	2
D. CONTRACEPTIVES		ddabbeAcmm	www	www ddabbeA	cmmww	www	4,252	ICB	4
E. CONDOMS		ddabbeAcmm	www	www ddabbeA	cmmww	www	3,330	ICB	4

d: bid docs - b: bidding periods - e: evaluation - A: Bank/Govt approval - c: contract signature - w: execution of works/delivery

	Pre-project	Project Year					Total	Procure	# of
	1994	1995	1996	1997	1998	1999	Payment	-ment	Packages
Quarters	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	US$'000	Method	Contracts
F. SPECIALISTS SERVICES/STUDIES							3,127		
LOI/TORs/Sh. L. for Approval		ddb	ddb	ddb	ddb	ddb			
Award/Contact review by IDA		eac	eac	eac	eac	eac			
International Services							1,307		
A. POPULATION POLICY									
1. Institutional Strengthening									
a) CONAPO									
- Demographic program		www					40	OTH	n.a.
- CONAPO strengthening		www					40	OTH	n.a.
- Fund Management		ww	w				41	OTH	n.a.
- Project mid-term evaluation				wwww			40	OTH	n.a.
- IEC		wwwww	wwwww	wwwww	wwwww	wwwww	486	OTH	n.a.
b) DSF									
- FP/MCH/EPI program		wwww	wwww				120	OTH	n.a.
- Training of regional trainers			w				14	OTH	n.a.
B. HIV/AIDS/STDs									
1. Institutional Strengthening									
- Organizational workshop for AIDS prog.		w					17	OTH	n.a.
- AIDS program preparation			w	w	w		17	OTH	n.a.
- Twinning arrangement		wwwwww	wwwwww	wwwwww	wwwwww	wwwwww	493	OTH	n.a.
Local Services							1,820		
A. POPULATION POLICY									
1. Improving FP/MCH Services							207		
- Pilot project use of carts/ evaluation of CP surveys		w	w		w		9	OTH	n.a.
- Pilot project contraceptive distribution		w				w	198	OTH	n.a.
2. Promoting IEC Programs							167		
- Pilot project IEC in health centers		w	w				30	OTH	n.a.
- IEC Research		www	www	www	www	www	93	OTH	n.a.
- Effectiveness of FP material distribution		www				www	14	OTH	n.a.
- KAP survey		www				www	30	OTH	n.a.
3. Institutional Strengthening							962		
a) CONAPO									
- Programming of demographic research		wwwwww					12	OTH	n.a.
- Demographic research		www	www	www	www		491	OTH	n.a.
- CONAPO strengthening		wwwwww					12	OTH	n.a.
- Programming of CONAPO's meetings		ww	ww	ww	ww	ww	18	OTH	n.a.
- NGOs		ww	ww	ww	ww	ww	295	OTH	n.a.
- Procurement		ww	ww	ww			8	OTH	n.a.
- Accounting system		ww					8	OTH	n.a.
- Audit		w	w	w	w	w	107	OTH	n.a.
b) DSF									
- Strengthening DSF's mgmt. system		www	www				12	OTH	n.a.
B. HIV/AIDS/STDs									
1. Institutional Strengthening							484		
- CNLS's management system		w					2	OTH	n.a.
- AIDS program		w	w	w			3	OTH	n.a.
- IEC		wwwwwwwwww	wwwwwwwwww	wwwwwwwwww	wwwwwwwwww	wwwwwwwwww	123	OTH	n.a.
- Study on economic impact of AIDS/ surveys		ww	ww	ww	ww		43	OTH	n.a.
							85	OTH	n.a.
2. Promoting IEC Programs									
- IEC research		www	www	www	www	www	150	OTH	n.a.
- Mass media impact				www			30	OTH	n.a.
- KAP surveys		www				www	30	OTH	n.a.
- AIDS-IEC curriculum development				wwwwww			12	OTH	n.a.
3. Clinical Management									
- Guide on medico-psychol. assistance		www					6	OTH	n.a.

d: bid docs - b: bidding periods - e: evaluation - A: Bank/Govt approval - c: contract signature - w: execution of works

	Pre-project	Project Year					Total	Procure	# of
	1994	1995	1996	1997	1998	1999	Payment	-ment	Packages
Quarters	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	..1.I..2..I..3..I.4..	US$'000	Method	Contracts
G. TRAINING							2,377		
Abroad							763		
A. POPULATION POLICY							631		
1. Institutional Strengthening							631		
a) CONAPO							67		
- Advanced IEC techniques		1 participant					67	OTH	n.a.
b) DGF							547		
- MPH fellowships			2 fellowships	2 fellowships			213	OTH	n.a.
- Advanced IEC techniques		1 participant					9	OTH	n.a.
- IEC program management		1 participant					11	OTH	n.a.
- Study tours to observe FP-IEC prog.			4 participants				18	OTH	n.a.
- Regional fellowships in health mgmt.			3 participants	3 participants	3 participants	3 participants	296	OTH	n.a.
c) DPF							18		
- Basic IEC		2 participants					18	OTH	n.a.
B. HIV/AIDS/STDs							131		
1. Institutional Strengthening									
- Basic IEC		2 participants					18	OTH	n.a.
- IEC program management		2 participants					11	OTH	n.a.
- Regional study tours			6 participants		2 participants		19	OTH	n.a.
- International conference on AIDS		2 participants	2 participants	2 participants	2 participants	2 participants	37	OTH	n.a.
- Research method		30 participants					3	OTH	n.a.
C. Case Management									
- Regional seminars/study tours		12 participants					45	OTH	n.a.
Local							1,615		
A. POPULATION POLICY							1,360		
1. Improving FP/MCH Services							331		
- FP/MCH/IEC for health personnel		1,310 participants	1,310 participants	1,310 participants	1,310 participants		331	OTH	n.a.
2. Promoting IEC Programs							999		
- Seminars opinion leaders		300 particip.	300 particip.	300 particip.	300 particip.	300 particip.	247	OTH	n.a.
- Mass media meetings							16	OTH	n.a.
- FP-IEC for health workers				250 particip.	250 particip.	250 particip.	143	OTH	n.a.
- Population dynamics for teachers			250 particip.	250 particip.	250 particip.	250 particip.	565	OTH	n.a.
- FP-IEC for the CRESAS		20 particip.	20 particip.	20 particip.	20 particip.	20 particip.	13	OTH	n.a.
- FP for social workers		10 participants	20 particip.	20 particip.	20 particip.	20 particip.	24	OTH	n.a.
3. Institutional Strengthening							30		
- Computer training for CONAPO staff		7 participants					29	OTH	n.a.
- Delivery services for regional trainers			15 particip.				1	OTH	n.a.
B. HIV/AIDS/STDs							255		
1. Institutional Strengthening							10		
- Workshops on National AIDS program		20 particip.					0.2	OTH	n.a.
- Epid. surveillance		122 particip.					8.5	OTH	n.a.
- Maintenance of hospital equipment		1 participant					1.2	OTH	n.a.
2. Promoting IEC Programs							185		
- AIDS-STDs for social workers		10 participants	20 particip.	20 particip.	20 particip.	20 particip.	24	OTH	n.a.
- AIDS-IEC for CRESAS		20 particip.	20 particip.	20 particip.	20 particip.	20 particip.	9	OTH	n.a.
- Teacher training AIDS-IEC							2	OTH	n.a.
- Seminars opinion leaders		300 particip.	300 particip.	300 particip.	300 particip.	300 particip.	151	OTH	n.a.
3. Clinical Management							60		
- Counseling/community care		982 particip.	820 particip.				60	OTH	n.a.
H. IEC							2,853		
Mass Media/CRESAS Activities		wwwww	wwwww	wwwww	wwwww	wwwww	2,853	OTH	n.a.
I. FUND							4,000	NBF/H&N	
J. OPERATING COSTS							3,433		
IDA		wwwwwwwww	wwwwwwwww	wwwwwwwww	wwwwwwwww	wwwwwwwww	1,239	OTH	n.a.
GOVT		wwwwwwwww	wwwwwwwww	wwwwwwwww	wwwwwwwww	wwwwwwwww	2,194	NBF/G	
TOTAL IDA							26,342		
Not Bank-financed							8,194	Govt +	Norway + Holland
TOTAL COST							34,536		

Prior Review Threshold, Contract Profile by Value/Number

Range of Contracts Values (incl. Conting.) (US$ '000)	Estimated Value (No.) of Contracts within Range (US$ million)		Cumulative Value (No.) above Threshold (US$ million)		Percentage of Total Value (No.) above Threshold	
Goods	**Value**	**Number**	**Value**	**Number**	**Value**	**Number**
500 and above	12.7	25	12.7	25	69%	45%
200 to 499	2.7	8	15.4	33	83%	59%
Threshold						
50 to 199	3.0	20	18.4	53	99%	95%
0 to 49	0.1	3	18.5	56	100%	100%

Duration of procurement is about five years

W O R K S	**Value**	**Number**	**Value**	**Number**	**Value**	**Number**
200 and above	0.45	2	0.45	2	80%	25%
Threshold						
30 to 199	0.03	1	0.48	3	85%	38%
0 to 29	0.09	5	0.57	8	100%	100%

Duration of procurement is about five years

Threshold selection corresponds to a desirable percentage coverage of contract value (around 83% for Goods and 80% of Works).

* Includes 2 million of cofinancing by Norway and Denmark (US$1 million each), managed by IDA.

BURKINA FASO

POPULATION AND AIDS CONTROL PROJECT

Documents in Project File

1. Brenzel, Logan. Burkina Faso - The Economic Impact of AIDS. February 1994.

2. Ciardi, P. Qualitative Survey of Utilization of Health Services, Participation and Health Needs in Burkina Faso's Rural Communities. March 1993.

3. Ciardi, P. Women, AIDS, and Reproductive Health in Burkina Faso. February 1994.

4. Comité National de la Lutte contre l'Excision. Note d'Informations Complémentaires au Plan d'Action National du Comité de la Lutte contre la Pratique de l'Excision. March 1993.

5. Direction de la Santé Familiale. Politique et Standard de SMI/PF. July 1993.

6. Direction de la Santé Familiale. Programme National de Planification Familiale. November 1992.

7. Kamenga, Claudes. Burkina Faso - Sexually Transmitted Diseases, January 1994.

8. Manuel des Procédures du Fonds de Population et du Sida, February 1994.

9. Ministère du Plan et des Finances. Conseil National de Population. Programme d'Action en Matière de Population, 1991-1995. April 1991.

10. PAF-CPF. Programme d'Appui à la Famille: Volet Code des Personnes et de la Famille, February 1993.

11. Population and Human Resources Division. Sahelian Department. Africa Region. Burkina Faso - Women-in-Development Assessment, June 25, 1993.

DECEMBER 1993

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