AFRICAN DEVELOPMENT FUND

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BURKINA FASO

HEALTH CARE DEVELOPMENT SUPPORT PROJECT

(CENTRE-EAST AND NORTH REGIONS)

APPRAISAL REPORT

NB: This document contains errata or corrigenda (see Annexes)

SOCIAL DEVELOPMENT DEPARTMENT
CENTRAL AND WEST REGIONS

OCSD
MARCH 2005

SCCD: G. G.

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PROJECT INFORMATION SHEET

Date: March 2005

The information given below is intended to provide some guidance to prospective suppliers, contractors, consultants and all persons interested in the procurement of goods and services for projects approved by the Board of Directors of the Bank Group. More details should be obtained from the executing agency of the Borrower.

1. COUNTRY : Burkina Faso

2. NAME OF PROJECT : Health Care development support project – Centre-East and North Regions.

3. LOCATION : Centre-East and North Regions and countrywide for health units and regulatory support.

4. BORROWER : the Government of Burkina Faso

5. EXECUTING AGENCY : Project Implementation Unit
03 P. O. Box 7009 Ouagadougou 03
Fax: (226) 50 36 24 64
Tel: (226) 50 32 41 63

6. PROJECT DESCRIPTION:

The project which will span 5 (five) years comprises the following four components and expenditure categories:

I. Improved access to quality health care: Services, Works, Goods, Operation.
II. Disease control: Services, Goods, Operation.
III. Capacity building: Services, Goods, Operation.
IV. Project management: Services, Goods, Operation.

7. TOTAL PROJECT COST:

i) cost in foreign currency : UA 19.22 million
ii) cost in local currency : UA 8.78 million
iii) total cost : UA 28.00 million

8.	BANK GROUP FINANCING		
	Loan	:	UA 19.00 million
	Grant	:	UA 6.00 million
9.	OTHER FINANCING SOURCES		
	Government	:	UA 3.00 million
10.	LOAN APPROVAL DATE	:	May 2005
11.	ESTIMATED START-UP DATE AND DURATION	:	January 2006 / 5 years

12. PROCUREMENT OF GOODS AND SERVICES:

Under the project, goods, works and services will be procured in accordance with the rules of procedure of the Fund and the following conditions:

Goods: International competitive bidding for biomedical furniture and equipment for the 2 CHR, 2 CMA, 31 CSPS and 4 screening centres.

National competitive bidding for all other furniture, equipment, computer and office automation equipment, vehicles, insecticide treated bednets (ITNs).

Local shopping for PIU furniture and equipment, sensitization material, publication of information leaflets on maintenance and cancer as well as other regulatory documents.

International competitive bidding for drugs and medical consumables. CAMEG-Burkina Faso's central buying office for essential and generic drugs will be responsible for the purchases.

Works: International competitive bidding for construction works on two Regional Hospitals (CHR) in Ouahigouya and Tenkodogo, two CMA in the Centre-East. National competitive bidding for the normalization / rehabilitation of 31 CSPS, the Ouahigouya SIEM, construction of four screening centres and the Tenkodogo SIEM.

Services : Limited shopping following announcements in local or regional newspapers for experts' services (individual consultants) for studies and strategies on regulations concerning the ministry of health and short-term consultants of the PIU.

Shortlisting for the recruitment of: (a) consulting firms to undertake architectural and engineering designs, supervision of construction/ rehabilitation works on health units and control of works; (b) a bio-medical engineer; (c) a procurement expert at the PIU; and (d) auditing firms and accounting firms for the computerized administrative, accounting and financial management system.

Shopping for specialized training institutes in the West African region or abroad, for the training of medical specialists and other senior staff.

Limited shopping following announcements at the national or regional level for the services of training firms and NGO/Associations to undertake all the other training/retraining and sensitization activities.

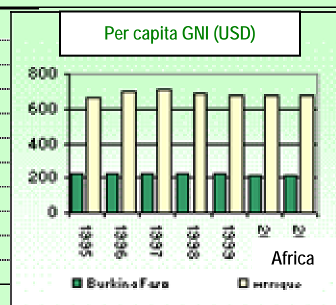
Direct negotiation with training institutes (CREPA and CIFRA), the Faculty of Health Sciences and the Ouagadougou University Teaching Hospital for specialities existing in the country. Agreements will be signed with these institutes.

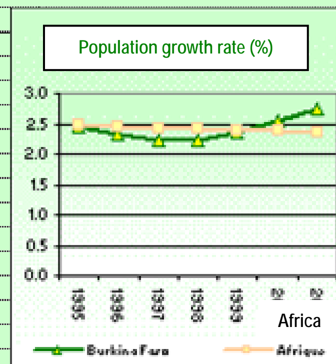
Operation: The 4 (four) senior staff of the PRSS project unit will be reinstated by the Government. The logistics and administrative assistant as well as the support staff of the PIU will be recruited locally according to the country's procedures. National shopping for the procurement of supplies and consumables.

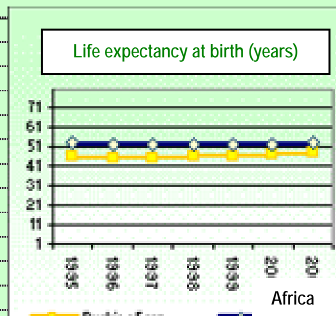
Agreements will be signed with Departments of the Ministry of Health and that of the Environment and Water for health personnel retraining and monitoring of project activities.

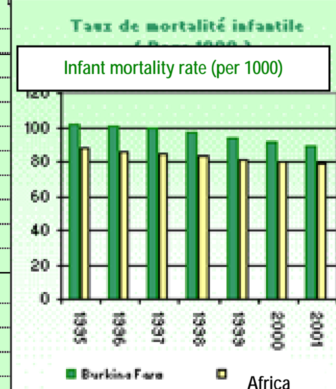
BURKINA FASO
COMPARATIVE SOCIO-ECONOMIC INDICATORS

	Year	Burkina Faso	Africa	Developing countries	Developed countries
Basic indicators					
Area ('000 Km²)		274	30 061	80 976	54 658
Total population (millions)	2003	12.4	811.6	4 940.3	1 193.9
Urban population (% of Total)	2001	19.8	38.0	40.4	76.0
Population density (per Km²)	2003	45.3	27.0	61.0	21.9
GNI per capita (US$)	2002	250	671	1 250	25 890
Labour force participation - Total (%)	2002	47.0	43.3	...	...
Labour force participation – Female (%)	2002	48.4	35.1	...	...
Gender-related development index value	2001	0.317	0.476	0.634	0.916
Human development index (rank among 177 countries)	2004	175	n.a.	n.a.	n.a.
Population living below $ 1 a day (% of population)	1994	61.2	45.0	32.2	...
Demographic indicators					
Population growth rate – Total (%)	2003	2.3	2.4	1.5	0.2
Population growth rate – Urban (%)	2001	6.4	4.1	2.9	0.5
Population aged below 15 years (%)	2003	47.7	42.4	32.4	18.0
Population aged 65 years and above (%)	2003	3.8	3.3	5.1	14.3
Dependency ratio (%)	2001	107.6	85.5	61.1	48.3
Sex ratio (per 100 female)	2003	93.1	99.4	103.3	94.7
Female population of 15 to 49 years (% of total population)	2003	24.0	23.6	26.9	25.4
Life expectancy at birth – Total (years)	2003	53.8	52.5	64.5	75.7
Life expectancy at birth – Female (years)	2001	55.6	53.5	66.3	79.3
Crude birth rate (per 1000)	2003	46.1	37.3	23.4	10.9
Crude death rate per 1000)	2003	14.8	14.0	8.4	10.3
Infant mortality rate (per 1000)	2003	83.0	79.6	57.6	8.9
Child mortality rate(per 1000)	2003	184.0	116.3	79.8	10.2
Maternal mortality rate (per 100000)	2003	484	641	491	13
Total fertility rate (per woman)	2003	6.2	4.9	2.8	1.6
Women using contraception (%)	2003	15.8	40.0	56.0	70.0
Health and nutrition indicators					
Physicians (per 100000 people)	2003	3.3	36.7	78.0	287.0
Nurses (per 100000 people)	2003	26.9	105.8	98.0	782.0
Births attended by trained personnel (%)	2003	30.9	38.0	58.0	99.0
Access to safe water (% of population)	2000	78.0	60.4	72.0	100.0
Access to health services (% of population)	1999	90.0	61.7	80.0	100.0
Access to sanitation (% of population)	2003	35.2	60.5	44.0	100.0
Percentage of adults aged 15-49 living with HIV/AIDS	2001	7.5	5.7	...	...
Incidence of tuberculosis (per 100000)	2000	20.0	105.4	157.0	24.0
Child immunization against tuberculosis (%)	2003	86.3	63.5	82.0	93.0
Child immunization against measles (%)	2003	71.0	58.2	79.0	90.0
Underweight children (% of children under 5 years)	2003	42.2	25.9	31.0	...
Daily calorie supply per capita	2000	2 293	2 408	2 663	3 380
Per capita public spending on health (as a % of GDP)	2003	4.4	3.3	1.8	6.3
Education indicators					
Gross enrollment ratio (%)					
Primary school - Total	2003	42.3	80.7	100.7	102.3
Primary school - Female	2003	38.4	73.4	94.5	101.9
Secondary school - Total	2003	15.5	29.3	50.9	99.5
Secondary school - Female	2003	13.6	25.7	45.8	100.8
Primary school female teaching staff (% of total)	1998	24.4	40.9	51.0	82.0
Adult illiteracy rate - Total (%)	2003	77.7	37.7	26.6	1.2
Adult illiteracy rate – Male (%)	2003	70.6	29.7	19.0	0.8
Adult illiteracy rate – Female (%)	2003	84.8	46.8	34.2	1.6
% of GDP spent on education	1998	1.5	3.5	3.9	5.9
Environmental indicators					
Land use (arable land as % of total land area)	1999	12.4	6.0	9.9	11.6
Annual rate of deforestation (%)	1995	0.7	0.7	0.4	-0.2
Annual rate of reforestation (%)	1990	8.0	4.0	...	...
Per capita CO_2 emissions (metric tons)	2002	0.1	1.1	2.1	12.5









Source : Compiled by the Statistics Division from ADB Data bases, UNAIDS; World Bank Live Database and United Nations Population Division.
Statistical Yearbook and EDS 2003 of the Ministry of Health of Burkina Faso.
Notes : n.a. Not Applicable ; ... Data not Available

CURRENCIES AND MEASURES
(February 2005)

CURRENCIES

Currency unit	=	CFA F
UA 1	=	CFA F 765.154
€1	=	CFA F 655.957
USD 1	=	CFA F 503.229

MEASURES

Metric system

FISCAL YEAR

From 1 January to 31 December

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11. Implementation schedule of project activities

LIST OF ACRONYMS AND ABBREVIATIONS

ADB	African Development Bank
ADF	African Development Fund
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal consultation
BCEAO	Central Bank of West African States
BI	Bamako Initiative
CADSS	Health System decentralization support Unit
CAMEG	Central Buying Office for generic drugs and medical consumables
CHN	National Hospital
CHR	Regional Hospital
CHU	University Teaching Hospital
CHW	Community Health Worker
CIFRA	International Action Research Training Centre
CM	Medical Centre
CMA	Medical Centre with Surgical Unit
CNS	National Health Council
COGES	Management Committee
CSPS	Health and Social Welfare Centre
DAF	Department of Administration and Finance
DEP	Department of Studies and Planning
DES	Department of Health Facilities
DGHSP	Directorate General for Hospitals and supervision of the private sector
DGIEM	Directorate General for Facilities, Equipment and Maintenance
DGPML	Directorate General for Pharmacy, Drugs and Laboratories
DGS	Directorate General for Health
DHMT	District Health Management Team
DHPES	Department of Public Hygiene and Education for Health
DIS	Department of Health Facilities
DL	Department of Laboratories
DLM	Disease Control Department
DML	Department of Maintenance and Logistics
DMPT	Department of Medicine and Traditional Pharmacopoeia
DPM	Department of Pharmacy and Drugs
DRH	Department of Human Resources
DRS	Regional Directorate of Health
DSF	Department of Family Health
HD	Health District
HIV	Human Immunodeficiency Virus.
HU	Health Unit
IEC	Information, Education, Communication
MEDEV	Ministry of the Economy and Development
EGD	Essential generic drugs
MFB	Ministry of Finance and the Budget
MPA	Minimum Package of Activities
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHP	National Health Policy

PADS	Health Development Support Programme
PMU	Project Management Unit
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNDS	National Health Development Plan
PRSS	Health Services Strengthening Project
SIEM	Infrastructure, Equipment and Maintenance Services
SM	Safe Motherhood
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UA	Unit of Account
UNAIDS	United Nations Organization for AIDS Control
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
WFP	World Food Programme
WHO	World Health Organization

BURKINA FASO – HEALTH CARE DEVELOPMENT SUPPORT PROJECT - CENTRE-EAST AND NORTH REGIONS

Project Logical Framework (Loan)

By: R. Y. Coffi and two consultants

Narrative summary	Objectively Verifiable Indicators	Means of verification	Important assumptions
Sector goal Contribute to improved health status and well-being of Burkinabe people by achieving the health-related millennium development goals.	By 2010: 1.1 Reduce mortality rate by 50% (14.8 ‰ in 2003). 1.2 Reduce infant mortality rate by 50% (83 ‰ in 2003). 1.3 Reduce maternal mortality by 50% (484 per 100 000 in 2003).	1.1.1 Surveys to review the poverty reduction strategy paper (PRSP). Demographic and health surveys (DHS) and annual statistics yearbook. 1.2.1 Idem. 1.1.1 Idem.	
Project objectives 1. Improve access to, as well as quality and utilization of health services in the Centre-East and North health regions.	1.1 Increase in utilization of health services from 32.49% in 2003 to 37.7% in 2008 and 40.31% by 2010. 1.2 Increase in health services attendance rate from 34.46% in 2003 to 44.8% in 2008 and 50% in 2010 in the Centre-East, and from 24.47% in 2003 to 35% in 2008 and 40% in 2010 in the North. 1.3 Increase in contraception prevalence from 12.70% in 2003 to about 17.5% in 2008 and 20% in 2010 in the North and from 11.15% in 2003 to about 15.7% in 2008 and 18% in 2010 in the Centre-East. 1.4 Increase in ante-natal consultation coverage from 51.23% in 2003 to about 68% in 2008 and 76.84% in 2010 in the North and from 82.03% in 2003 to about 88.8% in 2008 and 92.28% in the Centre-East by 2010. 1.5 Increase in attended delivery coverage from 39.48% in 2003 to about 46% in 2008 and 49.75% in 2010 in the North and from 45.71% in 2003 to about 53% and to 57.59% in the Centre-East by 2010. 1.6 Useful life of facilities and equipment increased by 20% in 2008 and 25% by 2010.	1.1.1 Statistics yearbook of the Ministry of Health. 1.2.1 Idem. 1.3.1 Idem. 1.4.1 Idem and activity reports of the PNDS monitoring Committee. 1.5.1 Supervision reports of ECD, CMA and hospitals. 1.6.1 Supervision reports of the DGIEM, Statistics yearbook of the Ministry of Health.	1.1.1.1 The State pursues its health policy. The State and other partners continue to finance and implement their activities under the PNDS. 1.2.1.1 Idem. Personnel is available in quality and quantity for the health units and the populations support the different programmes. 1.3.1.1 The populations support the different programmes. 1.4.1.1 The State posts qualified personnel to the health units. 1.5.1.1 Idem. 1.6.1.1 Personnel is available for the health units. Facilities and equipment are maintained.
2. Disease control in the project area.	2.1 Reduction of mortality in the North from 36.62% (2003) to 30% in 2008 and 27.46% in 2010 and in the Centre-East from 43.30% in 2003 to 36% in 2008 and 32.55% in 2010. 2.2 Reduction of rate of malnourished children from 43.50% in 2003 to 36% in 2008 and 32.62% in 2010 in the North and from 52.20% in 2003 to 43% in 2008 and 39.15% in 2010 in the Centre-East. 2.3 Reduction of mother-to-child transmission of HIV (MTCT) from 46.1% in 2003 to 43% in 2008 and 41.4%, by 2010.	2.1.1 Supervision reports of ECD, CMA and hospitals. Reports of the PNDS monitoring committee, Demographic and health surveys. 2.2.1 Idem. 2.3.1 Activity reports of laboratories, screening centres supervision reports of ECD,CMA and hospitals. Demographic and health surveys.	2.1.1.1 The populations support national disease control programmes. 2.2.1.1 Idem. 2.3.1.1 The populations support sensitization campaigns.
(continuation of 2nd objective)	2.4 Reduction of HIV prevalence rate from 2.7% in 2004 to about 2% in 2008 and 1.5% by 2010. 2.5 Reduction by 16% of malaria-related morbidity and mortality, and by 25% by 2010.	2.4.1 Idem. 2.5.1 Statistics yearbook.	2.4.1.1 Idem. Idem.

Narrative summary	Objectively Verifiable Indicators	Means of verification	Important assumptions
Outputs 1. Health units are constructed and / or rehabilitated, equipped, supplied with drugs and operational.	1.1 2 CHR, 2 CMA, 31 CSPS built and/or rehabilitated, normalized and equipped in 2009 at the latest, of which 31 CSPS and 2 CHR and 2 CMA are 60% achieved in 2008. 1.2 The 35 health units and nine district distribution depots are supplied with essential and generic drugs by 2008.	1.1.1 Reports of acceptance of works and delivery of equipment / furniture. 1.2.1 Reports of acceptance of drugs. Activity reports of the Project Management Unit and Bank's supervision reports.	1.1.1.1 The State and other partners continue to finance and implement activities under the PNDS. 1.2.1.1 Idem
2. The provinces of health regions have screening centres.	2.1 Four HIV screening centres are created, equipped by 2009 of which 80% are completed in 2008. 2.2 Training of 100 advisers (at least 1/3 female) in HIV/AIDS management, and 18 physicians in ARVT by 2010, of whom 60 advisers and 10 physicians in 2008. 2.3 Sensitization and patient management in 9 health districts, 80% completed in 2008.	2.1.1 Reports of acceptance of works and delivery of equipment / furniture. 2.2.1 Activity reports of the project management Unit and supervision report of the Bank. 2.3.1 Idem.	2.1.1.1 The State and other partners continue to finance and implement activities under the PNDS. 2.2.1.1 The populations subscribe to the different programmes. 2.3.1.1 Idem.
3. Medical and paramedical personnel of health units are trained and the populations attend health services.	3.1 The medical (at least 1/3 female) and paramedical personnel of the project area is trained by 2010: doctors, nurses, midwives, mobile workers and community health workers, management committee members, 2/3 of them by 2008. The populations are sensitized to the diseases during project implementation.	3.1.1 Activity reports of the project management Unit and supervision report of the Bank.	3.1.1.1 Personnel available in quality and quantity for the health units.
4. The maintenance system is strengthened and operational. Maintenance of facilities and equipment is carried out in the health units of the two regions.	4.1 The Centre-East SIEM is built, the North SIEM is rehabilitated and both are equipped by 2009. In 2008, the works are 80% completed.	4.1.1 Reports of acceptance of works and delivery of equipment / furniture.	4.1.1.1 Supervision and monitoring of works well carried out. Counterpart funds available on time.
5. Medicine and traditional pharmacopoeia are practised in a healthier environment.	5.1 600 traditional doctors (at 1/3 female) are trained in the production of traditional medicine in an appropriate setting, by 2009, of whom 400 in 2008. Two drug production units are acquired, 9 botanic gardens set up in 2008.	5.1.1 Activity reports of the project management Unit and supervision report of the Bank, and of the PNDS monitoring Committee.	5.1.1.1 Traditional and conventional doctors support the programmes.
6. The risk-sharing system is put in place in 9 health districts in the project area.	6.1 About 18000 persons join 400 new mutuals or other alternative health funding mechanisms by 2009; and 80 personnel of those structures are trained, including 9000 members, and 40 managers trained in 2008.	6.1.1 Idem.	6.1.1.1 The populations subscribe to prior contribution.
Activities 1. Architectural and technical studies. Various studies. 2. Training / sensitization 3. Construction/Rehabilitation of health facilities 4. Procurement of furniture, drugs and equipment 5. Audit of project accounts 6. Monitoring / evaluation mission 7. Management / monitoring / evaluation of project.	Project cost by financing source (in million UA) ADF loan UA 19.00 million Government UA 2.52 million Total UA 21.52 million Project cost by category of expenditure (in thousand UA) Total / Loan / Govt Goods 6.76 / 6.56 / 0.20 Works 9.71 / 7.91 / 1.80 Services 1.75 / 1.75 / 0.00 Operating 3.30 / 2.78 / 0.52 Total 21.52 / 19.00 / 2.52	Bank's disbursement documents. Project treasury statements of account. Report of the project management unit. Audit and supervision reports.	The State continues to finance and implement activities under the PNDS.

BURKINA FASO – HEALTH DEVELOPMENT SUPPORT PROJECT - CENTRE-EAST AND NORTH REGIONS

Project Logical Framework (Grant)

By: R. Y. Coffi and two consultants

Narrative summary	Objectively Verifiable Indicators	Means of verification	Important assumptions
Sector goal Contribute to improved health status and well-being of Burkinabe people by achieving the health-related millennium development goals.	By 2010: 1.1 Reduce mortality rate by 50% (14.8 ‰ in 2003). 1.2 Reduce infant mortality rate by 50% (83 ‰ in 2003). 1.3 Reduce maternal mortality by 50% (484 per 100 000 in 2003).	1.1.1 Surveys to review the poverty reduction strategy paper (PRSP). Demographic and health surveys (DHS) and annual statistics yearbook. 1.2.1 Idem. 1.3.2 Idem.	
Project objectives 1. Improve utilization of health services in the Centre-East and North health regions.	1.1 Increase in utilization of health services from 32.49% in 2003 to 37.7% in 2008 and 40.31% by 2010. 1.2 Increase in health services attendance rate from 34.46% in 2003 to 44.8% in 2008 and 50% in 2010 in the Centre-East, and from 24.47% in 2003 to 35% in 2008 and 40% in 2010 in the North. 1.3 Useful life of facilities and equipment increased by 20% in 2008 and 25% by 2010.	1.1.1 Statistics yearbook of the Ministry of Health. 1.2.1 Idem. 1.3.1 Supervision reports of the DGIEM, Statistics yearbook of the Ministry of Health.	1.1.1.1 The State pursues its health policy. The State and other partners continue to finance and implement their activities under the PNDS. 1.2.1.1 Idem. Personnel is available in quality and quantity for the health units and the populations support the different programmes. 1.3.1.1 Personnel is available for the health units. Facilities and equipment are maintained.
2. Disease control in the project area	2.1 Reduction of mortality in the North from 36.62% (2003) to 30% in 2008 and 27.46% in 2010 and in the Centre-East from 43.30% in 2003 to 36% in 2008 and 32.55% in 2010. 2.2 Reduction of rate of malnourished children from 43.50% in 2003 to 36% in 2008 and 32.62% in 2010 in the North and from 52.20% in 2003 to 43% in 2008 and 39.15% in 2010 in the Centre-East. 2.3 Reduction of mother-to-child transmission of HIV (MTCT) from 46.1% in 2003 to 43% in 2008 and 41.4%, by 2010. 2.4 Reduction of HIV prevalence rate from 2.7% in 2004 to about 2% in 2008 and 1.5% by 2010. 2.5 Reduction by 16% of malaria-related morbidity and mortality, and by 25% by 2010.	2.1.1 Supervision reports of ECD, CMA and hospitals. Reports of the PNDS monitoring committee, Demographic and health surveys. 2.2.1 Idem. 2.3.1 Activity reports of laboratories, screening centres supervision reports of ECD, CMA and hospitals. Demographic and health surveys. 2.4.1 Idem. 2.5.1 Statistics yearbook.	2.1.1.1 The populations support national disease control programmes. 2.2.1.1 Idem. 2.3.1.1 The populations support sensitization campaigns. 2.4.1.1 Idem Idem
3. Strengthen health system management.	3.1 All the regulations of the departments in the Ministry of Health are drawn up by 2008. 3.2 Quarterly supervision activities carried out by all the departments of the Ministry by 2008.	3.1.1 Activity report of PNDS monitoring committee. 3.2.1 Idem.	3.1.1.1 Ministry personnel is available and there is proper coordination of health activities at all levels. 3.2.1.1 Idem.
Outputs 1. The provinces of health regions provide counselling in screening centres.	1.1 Training of 100 advisers (at least 1/3 female) in HIV/AIDS management, and 18 physicians in ARVT by 2010, of whom 60 advisers and 10 physicians in 2008.	1.1.1 Activity reports of the project management Unit and supervision report of the Bank.	1.1.1.1 The populations support the different programmes. .
2. Medical and paramedical personnel of health units are trained and the populations attend the health services.	2.1 Medical (at least 1/3 female) and paramedical personnel is trained by 2010: 15 medical specialists, 40 doctors, 25 officers, 27 technicians, 106 ECD members; 2 water sanitation officers, 60 senior technicians, 160 hygiene workers, 80 trainers in disease and hygiene; of whom 2/3	1.2.1 Activity reports of the Project Management Unit and supervision report of the Bank.	2.1.1.1 Personnel available in quality and quantity for the health units.

Narrative summary	Objectively Verifiable Indicators	Means of verification	Important assumptions
	are trained in 2008. The populations are sensitized to all the programmes during the project.		
3. Hospitals play their referral role.	3.1 The plans of action of 12 hospitals are drawn up, implemented and supervised from 2008. 3.2 The rates of charges for services and drugs are available and implemented in hospitals by 2009. In 2008 the rates are prepared.	3.1.1 Activity reports of the Project Management Unit and supervision report of the Bank. And of the PNDS monitoring Committee. 3.2.1 Idem.	3.1.1.1 All hospital personnel subscribe to the programme. Partners' financial contribution is maintained 3.2.1.1 Idem.
4. The maintenance system is strengthened and operational. Maintenance of facilities and equipment is carried out in the health units of the two regions.	4.1 Maintenance personnel is trained: 3 engineers, 22 senior technicians and 27 maintenance technicians, and about 200 users, by 2008 and the total of 405 users in 2009. 4.2 Maintenance and servicing manuals are available in the health units by 2009. In 2008, all manuals are prepared.	4.1.1 Activity reports of the Project Management Unit and supervision report of the Bank. 4.2.1 Idem.	4.1.1.1 Personnel available in quality and quantity for the health units. 4.2.1.1 Idem.
5. Medicine and traditional pharmacopoeia are practised in a healthier environment.	5.1 The populations (about 1 million) are sensitized to traditional medicine in 2008.	5.1.1 Activity reports of the Project Management Unit and supervision report of the Bank.	5.1.1.1 Traditional and conventional doctors and the populations support the programmes.
6. The risk-sharing system is put in place in 9 health districts in the project area.	6.1 The populations (about 1 million) are sensitized throughout the project to health-related risk-sharing systems.	6.1.1 Idem.	6.1.1.1 The populations subscribe to prior contribution.
7. The Directorate General for pharmacy, drugs and laboratories is more operational and plays its role better.	7.1 The drug importation monitoring system is put in place in 2007. 7.2 The location map for pharmacies is drawn up by 2007. 7.3 The laboratory policy and regulatory framework are formulated, as well as all regulations, guides and posters on cancer available in CHR and CMA by 2008. 7.4 The outlines and guidelines on action plans of hospitals are drawn up by 2008. 7.5 Six pharmacists (at least 1/3 female) trained in legislation, quality assurance and public health by 2010, and training will be under way in 2008.	7.1.1 Activity report of DGPML and of the PNDS monitoring committee. 7.2.1 Idem. 7.3.1 Idem. 7.4.1 Idem. 7.5.1 Idem.	7.1.1.1 All stakeholders (pharmacists, laboratories, etc.) subscribe to the activities. 7.2.1.1 Idem. 7.3.1.1 Idem. 7.4.1.1 Idem. 7.5.1.1 Idem.
Activities 1. Various studies 2. Drafting of regulatory texts 3. Training / sensitization 4. Procurement of drugs and equipment 5. Monitoring and supervision missions.	Project cost by financing source (in million UA) ADF grant UA 6.00 million Government UA 0.48 million Total UA 6.48 million Project cost by category of expenditure (in thousand UA) Total / Grant / Govt Goods 0.21 / 0.11 / 0.10 Services 3.84 / 3.84 / 0.00 Operating 2.43 / 2.05 / 0.38 Total 6.48 / 6.00 / 0.48	Bank's disbursement documents. Project treasury statements of account. Report of the project management unit. Audit and supervision reports.	The State continues to finance and implement activities under the PNDS.

EXECUTIVE SUMMARY

1. Project Origin and History

Burkina Faso is one of the poorest countries in the world, with a human development index of 0.302 (2004). Poverty affects nearly one half of the population (46%) and is exacerbated in the rural areas (52.3%).The health status is particularly marked by a high mortality and morbidity rate as well as a low rate of access to basic health care for financial, geographical and cultural reasons. This situation is worsened by inadequate staff in terms of quality and quantity. The infant mortality rate of 83 per thousand live births is due mainly to malnutrition and infectious diseases. Malaria represents one of the leading causes of morbidity (on average 600 000 cases per year according to UNICEF), and is endemic along with acute respiratory and diarrheal diseases. Maternal mortality (484 deaths per 100 000 live births) is due to the low rate of ante-natal and obstetric consultation coverage. HIV infection is marked by its stabilisation and affects all segments of the population.

Faced with this situation, the Burkinabe Government prepared a poverty reduction strategy paper in 2000 and in the same year revised its national health policy (NHP). This enabled the Ministry of Health to draw up, in collaboration with health sector, stakeholders and development partners, a national health development plan (PNDS) for the 2001-2010 period. To ensure monitoring of the implementation of the PNDS, a monitoring committee as well as a technical Secretariat have been put in place. The PNDS prioritizes the decentralization of the health system based on the health district model, disease control, promotion of maternal and child health, strengthening of health infrastructure coverage, human resource development, resource mobilization for health.

For the implementation of the PNDS, the Government has approached its partners, including the African Development Bank, to which a request for the financing of this project was submitted. The project concerns the Centre-East and North health regions and is in line with the Government's health policy priorities, as well as the general objectives of the poverty reduction programme.

2. Purposes of the loan and the grant

The ADF loan of UA 19.00 million and the ADF grant of UA 6 million respectively represent 67.86% and 21.43% of total project cost, and will be used to finance 100% of the cost in foreign exchange, that is UA 19.22 million and 65.83% of project cost in local currency, or UA 5.78 million.

3. Project objective

The project's main objective is to contribute to improving the health status and well-being of the Burkinabe populations. The specific objectives of the project are as follows: (i) improve access to and quality utilization of health services in the North and Centre-East health regions; (ii) control diseases in the project area; and (iii) strengthen the health system management through the Ministry of Health.

4. Project description

The project will cover two health regions, viz the Centre-East and North and comprises four components, namely: (i) improved access to quality health care, (ii) disease control, (iii) capacity building, (iv) project management.

5. Project cost

The total cost of the project before taxes and duties is estimated at UA 28 million, of which UA 19.22 million (68.64%) in foreign exchange and UA 8.78 million (31.36%) in local currency.

6. Financing sources

The project will be financed by the ADF (loan and grant) and the Burkinabe Government. The ADF loan, which stands at UA 19 million, will be used to partially finance components 1, 2 and 4. The ADF grant of UA 6 million will finance component 3 and part of component 2. The Government's counterpart funds of UA 3 million represent 10.71% of total project cost, and will finance part of the civil works, equipment and operation.

7. Project implementation

The project will be managed and implemented by the Project Management Unit (PMU) placed under the authority of the Secretary-General of the Ministry of Health and will be located at Ouagadougou. 4 (four) senior staff of the on-going PRSS (Santé II) project in the Bobo-Dioulasso region, whose performance was satisfactory will be maintained and strengthened for this project. The personnel will comprise: a coordinator, an architect, a doctor/ training specialist, a procurement expert, an accountant, an administrative and logistics assistant, a secretary, three drivers, a messenger and two watchmen.

8. Conclusions and recommendations

The project is in line with one of the main thrusts of the poverty reduction strategy paper and with the orientations of the health policy paper and the country's national health development plan. It seeks to strengthen the health system in two health regions, the Centre-East and North, through the strengthening of health districts and CHRs, and building the capacity of departments of the Ministry of Health. Owing to the population's inadequate financial resources and the use of traditional doctors' services, support is provided to set up health mutuals and organize the production of traditional drugs by traditional doctors. Given that the two regions are in border areas, attention is given to HIV/AIDS control and endemic diseases such as malaria, and to improved hygiene and children's malnutrition.

It is recommended that an ADF loan and an ADF grant not exceeding UA 19 million and UA 6 million respectively be extended to the Government of Burkina Faso, for the purpose of implementing the project as described in this report, subject to the conditions specified in the loan agreement.

1. ORIGIN AND HISTORY OF PROJECT

1.1 Burkina Faso's total population is estimated at 12 419 677 inhabitants (2003) with 3 502 340 adult women (28%) and 2 148 604 children aged 0 to 4 years (17.3%). Life expectancy at birth is 53.8 years. With a human development index of 0.302 in 2004 (World human development report), the country is ranked 175th among 177. Poverty which affects nearly half of the population (46.4%) is exacerbated in rural areas (52.3% against 19.9% in urban areas). Population growth was 2.3% in 2003 and there is a resurgence of epidemics. The agriculture and livestock sectors employ 86% of the working population and alone provide 35% of the GDP, while the secondary sector represents 19%. With a per capita GDP of CFA F 182 000 ($ 303.3) and an annual growth rate of 4.90% in 2003, Burkina Faso faces a major challenge which is the eradication of poverty. The low level of education, particularly of girls (33.4%), poverty, malnutrition, limited access to drinking water and basic sanitation are conducive to the spread of diseases.

1.2 The health situation is marked in particular by high morbidity and mortality rates and low access to basic health care (35.2%) for financial, geographical, cultural and health system performance reasons. Malaria represents one of the leading causes of morbidity (an average of 600,000 cases per year according to UNICEF) and is endemic along with acute respiratory and diarrhoeal diseases. The high maternal and infant mortality rates as well as the AIDS pandemic remain critical. These high rates are generally observed among the population affected by malnutrition and where the management of children by health services and households is of poor quality. This health situation is exacerbated by personnel inadequacy in terms of quality and quantity and the epidemiological pattern dominated by communicable and non-communicable diseases.

1.3 Faced with this situation, the Burkina Faso Government prepared a poverty reduction strategy paper in 2000 and in the same year, revised its national health policy (NHP). This enabled the Ministry of Health (MOH) to draw up in 2001, a national health development plan (PNDS) for the period 2001-2010, which represents the operationalization of the NHP. The health policy is based on the strengthening of primary health care through the strategy known as the Bamako Initiative (BI) and it gives priority to the decentralization of the health system. The PNDS for its part has as its main objective to reduce morbidity and mortality among the population. To implement the PNDS, the Government approached all its partners and in 2004, submitted a request to the African Development Bank to finance the strengthening of the two health regions of the Centre-East and North.

1.4 The project was identified and prepared in November 2004 and this report follows an appraisal mission to Burkina Faso from 24 January to 9 February 2004. This project is in keeping with the general objectives of the Government's poverty reduction strategy paper which seeks, among others, access of the poor to basic social services. It is in line with the national health development plan through its objectives and programmes and is based on the plans of health districts (HDs). It is also in conformity with the Bank's Country Strategy Paper (CSP) for Burkina Faso (2002-2004) updated in June and which confirmed that the social sector continues to be one of the sectors with a concentration of Bank Group resources. The project will contribute to the attainment of certain millennium goals such as the reduction of infant mortality, improvement of maternal health and control of malaria and HIV/AIDS. Lastly, it will supplement health sector interventions of the Bank and other partners.

2. THE HEALTH SECTOR

2.1 Health status

2.1.1 The health status in Burkina Faso remains precarious in spite of the Government's efforts in the health domain, a health unit attendance rate rising from 27.11% in 2002 to 32.49% in 2003, and an improvement of certain indicators. The country has one of the highest fertility levels in the region with a total fertility index of 6.2 children, a birth rate of 46.1 per thousand and the overall mortality of 14.8 per thousand (2003). The epidemiological situation is marked by the predominance of communicable diseases, high mortality and morbidity. The infant mortality rate and the likelihood of death between 1 and 5 years are respectively 83 per thousand and 184 per thousand live births (2003, PHS), due mainly to malnutrition and infectious diseases. The maternal mortality rate is 484 per 100 000 live births (2003) and the main causes of death are bleeding, infections, placenta retentions and abortion complications.

2.1.2 Among women, there is an improvement of certain indicators according to the 2003 statistical yearbook. In fact, the national contraception prevalence rate of 15.85% has increased compared to 2002, the obstetric coverage (attended deliveries) recorded an increase of nearly 3% (39.90% in 2002) to reach 43.69% in 2003, the national ante-natal coverage increased from 54.08% in 2002 to 70.87% in 2003, and post-natal coverage recorded an increase from 18.64% in 2002 to 30.85% in 2003. Only the average number of antenatal consultations per pregnancy dropped considerably from 2.6 in 2002 to 1.94 in 2003.

2.1.3 The main reasons for consultations are common malaria (33.02 %) and acute malaria (6.46%), respiratory infections (17.17%), unclassified diseases owing to inaccurate diagnosis (9.76%), diarrhoeal diseases (8.63%) and skin diseases (7.78%). This precarious situation exposes the population to the appearance of potentially epidemic diseases such as cerebro-spinal meningitis, measles, cholera and yellow-fever. Non-communicable diseases, notably chronic diseases (e.g. cancer, diabetes and cardio-vascular diseases) are on the rise. There is also a high prevalence of malnutrition with 15.27% of children consulted showing weights 80% below the normal curve of reference. In fact, about 44.5% of Burkinabe children under 5 years of age show stunted growth and 42.2% are underweight.

2.1.4 While Burkina Faso was one of the West African countries most affected by the AIDS pandemic with 7.17% in 1997, it is agreed that HIV/AIDS which affects all segments of the population is stabilizing and there is a remarkable drop in new infections. In fact, prevalence has decreased from 4.2% in 2002 (statistics yearbook) to 2.7% in 2004 according to surveys conducted on sentinel sites. Prevalence is much higher in urban areas (3.6%) than in rural areas (1.3%) and in terms of regions, the rate ranges from 3.7% in the South-West region to 0.1% in the Sahel. Over the period 2002-2003, the prevalence rate was over 1% among pregnant women on the 5 sentinel sites in the country and the number of women living with AIDS is around 150,000. Highway drivers are the most affected and youth (15 to 40 years) mortality is essentially due to AIDS. The management of PLWHA through ARV treatment under the 3x5 initiative launched by WHO, and other initiatives has improved rising from 1.36% in 2002 to 2.5% in 2003, but is still below the set target of 35%. HIV/AIDS and malaria which remain major public health concerns contribute not only to mortality but also constitute an economic burden for households.

2.2 National health policy

2.2.1 The Government's objective is to eradicate extreme poverty by reducing the incidence of poverty from 45% to 30% by 2015 and increase life expectancy by at least ten years by reducing neonatal, infant and maternal mortality; improving access to drinking water and increasing the literacy rate. To achieve these objectives, the Burkinabe Government has prepared, with support from its partners, a poverty reduction strategy paper (PRSP) which is the reference framework for any development action and is based on 4 main thrusts: (i) promoting sustainable accelerated and equitable growth; (ii) ensuring access of the poor to basic social services; (iii) expanding employment and income-generating opportunities for the poorest; and (iv) promoting good governance. These objectives are also in line with the vision of the millennium development goals (MDGs). For over two decades, Burkina Faso has adopted primary health care as a health development strategy and in 1987 adhered to the Bamako Initiative with emphasis on women and children through the provision of essential drugs, cost recovery and community participation in management.

2.2.2 On the basis of the orientations of the National Health Policy, and in consultation with all stakeholders of the health sector, the Government formulated a National Health Development Plan (PNDS) covering a ten-year period (2001-2010) and which is being operationalized through three-year plans, the first of which covers the period 2003-2005. The PNDS backed by a medium-term reform programme comprises three pro-poor measures, viz: (i) improve health indicators among the poor; (ii) extend the involvement of the neediest communities in decision-making on health; (iii) limit the financial burden of health expenses on poor household incomes. It gives priority to the decentralization of the health system based on the health district model, disease control, promotion of maternal and child health, strengthening of health facilities coverage, human resource development, resource mobilization for health. The PNDS has eight intermediate objectives with corresponding programmes which are detailed in Annex 1. These objectives are consistent with the second main thrust of the PRSP which is "ensuring access of the poor to basic social services", and with those of the HIV/AIDS control strategy framework. They are also in line with the millennium development goals (MDGs) and with those of the New Partnership for Africa's Development (NEPAD) in the domain of health (cf. Annex 2).

2.2.3 A round-table conference on the financing of the PNDS, held in April 2003, brought together health sector representatives, civil society, development partners and other sectors, and permitted: (i) a national consensus on the vision of the sector-wide approach to health development which is a priority of the Burkinabe Government; (ii) a census of external financing estimates for the dual purpose of mobilizing the necessary resources and harmonizing PNDS implementation strategies. The sector-wide approach is defined as a mechanism between the Government and its development partners, permitting the coordination of the Ministry's programmes for greater effectiveness of the utilization of the sector's resources. The objective of the sector-wide approach is to enable the putting in place of a common and sustainable funding mechanism by all sector stakeholders in order to ensure rational management of the funds mobilized, strengthening of decentralized management and increased financing of the PNDS. To that end, all the stakeholders have undertaken to pursue collaboration for the joint implementation of the PNDS and the evaluation of its performance. For the administration of the PNDS implementation, the Government put in place a monitoring and evaluation framework with the creation in 2003 of a Monitoring Committee chaired by the Secretary-General for Health, as well as a permanent technical Secretariat.

2.2.4 Besides this policy, and in a bid to improve the effectiveness of social services as well as service quality, the Government is committed to undertaking actions and measures covering several aspects: (i) application of the new charges for essential generic drugs (EGD) and the publication of the standardised list of basic medical services in health centres, (ii) reduction of the cost of pediatric treatment and attended delivery with free antenatal care, vaccination services and

vitamin distribution, (iii) increase in the votes allocated, and (iv) posting of personnel to regions and districts, (v) normalization of uncompleted facilities from HIPC (Heavily indebted poor countries) funds, and (vi) the application of technical equipment standards for all levels of care. For the implementation of the PNDS, a mechanism for medium-term expenses (CMDT) for the health sector was put in place in 2004; the CMDT is based on the priorities of the PRSP and enables better control of mobilized resources. To that end, civil service reform will strengthen the implementation of public service decentralization and the transfer of budgetary allocations to regions and provinces.

2.3 Organization and functioning of the sector

2.3.1 Administratively, the Burkinabe health system comprises 3 (three) levels: (i) the central level with the Minister's Office and the Secretariat General to which are attached departments, technical services, national and regional hospitals, and most of the health projects; (ii) the intermediate level with 13 regional departments of health (DRS), whose role is to implement government policy at the regional level, support the district health teams (ECD) and control standards; (iii) the peripheral level, represented by provincial departments of health (DPS), comprises 55 health districts which are the most decentralized operational entities in the national health system. This decentralization has enabled an improvement of the functioning of the system and better involvement of persons responsible for health and population.

2.3.2 Concerning care, public care structures are organized in 3 (three) levels. The first level, comprising health districts, each administered by a district health team (ECD) has two sub-levels: the Health and Social Welfare Centre (CSPS), which is the basic structure of the system and the Medical Centre with a surgical unit (CMA) which serves as a referral structure for district health units. Administratively, these structures come under the intermediate and peripheral levels which are Regional Health Departments (DRS) and Provincial Health Departments. The ECD comprising at least four senior staff, carry out the management, planning and technical supervision of public and private health unit personnel and activities in remote areas, clinical care delivery, integration of cross-cutting programmes and health research. The CSPS which covers an average population of 10,000 inhabitants is charged with delivering a Minimum Package of Activities (MPA) which are basic health care, supply of essential and generic drugs, public health and support and management activities. In the villages, two community health workers (CHW) carry out information, education and communication (IEC) and First Aid activities within the communities. CSPS also have management committees (COGES), set up under the Bamako Initiative in order to involve the population in the management of peripheral health units; they are charged with managing health units, but their operationality is not always optimum. CMA cover a population of 150,000 to 200,000 inhabitants each and serve as referral hospitals for all district health units; they provide referral, medical consultation, surgical and laboratory services. There are isolated medical centres (CM), maternities and dispensaries operating and providing care without meeting national norms. For this first level, there were in all 1339 health units in 2003, broken down into 38 CMA, 33 CM, 1147 CSPS, 28 maternities and 93 dispensaries.

2.3.3 The second level, represented by the Regional Hospital (CHR) serves as a referral hospital for CMA, and administratively comes under the central level. Although focusing on access of the populations to primary health care, the health policy recognizes the increased role of hospitals given the level of technical support centres in modern medical patient management. Given their status as public administrative establishments, the CHR are autonomously managed. Their referral hospital role consists in providing diagnoses, care, teaching, training, research and prevention. As such, the CHR must be equipped to plan its activities in order to be able to play its role. Burkina Faso has 9 (nine) CHR distributed in 13 health regions. The Plateau central and Centre-South regions have no CHR as they are close to the University Teaching Hospital of Ouagadougou and other CHR.

2.3.4 The third level consists of the University Teaching Hospital (CHU) which is the highest level of referral for specialized care. It serves as a framework for research and training of different personnel categories and administratively comes under the central level. Burkina Faso has three CHU, of which 2 in Ouagadougou and 1 in Bobo-Dioulasso. There are five specialities in the CHU: pediatrics, surgery, gynaecology, obstetrics, psychiatry and the "Diplôme d'Etude Appliquée" (DEA) in clinical pharmacy. Physicians and paramedics are trained at the Faculty of Health Sciences and at the National School of Public Health (ENSP). The Health System Decentralization Support Unit (CADSS) and the Department of Personnel Training (DFP) are charged with coordinating the training of physicians in district management and essential surgery, as well as in-service training for personnel.

2.3.5 The central buying office for essential generic drugs and medical consumables (CAMEG), an autonomous structure is a key partner in the implementation of the Bamako Initiative (BI). It implements the Government's drug policy by providing EGDs and has a central store at Ouagadougou and three regional depots at Ouagadougou, Bobo-Dioulasso and Fada-N'Gourma. A fourth regional depot is under way in Ouahigouya . Health districts have district distribution depots (DRD) from where health units obtain their supplies. In the first quarter of 2004, there were 56 DRD and 1210 EGD operational depots, that is 98% of existing health units. The high cost of generic drugs in Burkina Faso is not only due to the cost price at the CAMEG, for the DS with its distribution depot applies a 10% margin to the CAMEG selling price and the depots of health units in turn apply a margin of 12% to 20%. In the past three years, the CAMEG has significantly reduced its profit margin bringing about a drop in drug prices. Improved monitoring of the management of health unit depot stocks and observance of the prices are contributing to make EDGs more financially accessible in Burkina Faso. To improve the availability of quality EGDs in urban areas, the CAMEG has been supplying private pharmacies since August 2000.

2.3.6 The private sector is in full expansion and comprises profit and non-profit structures. Apart from drug depots which may be managed by drug non-professionals, private profit-making health structures are operated by health professionals. They play an important role in improving the population's health and are mostly located in Ouagadougou (185) and Bobo-Dioulasso (68) and there are 64 establishments in the other localities in the country. Among these there is a predominance of nursing care units (71%). The main activities are essentially basic health care, specialized care, the supply of drugs and medical and surgical equipment and logistical support (laboratories and medical imagery centres). The private non-profit sector comprises non-governmental organizations (NGOs) and mission establishments which are increasingly opening private health establishments. In a bid to coordinate the activities of NGOs and those of public structures, the Government ratified an agreement with international NGOs and an approval for national NGOs. The private health sub-sector which is an integral part of the health system is not sufficiently taken into account in the Government's health programmes owing to the non-application of legal instruments that are inadequate and ill-adapted, and to the non-existence of a development plan. However, the recent creation of a Directorate General to oversee hospitals and the private health sub-sector will contribute to remedy the situation. A World Bank-financed study on the private sector is under way and will enable the assessment of its role and importance in the health system.

2.3.7 The practice of traditional medicine and pharmacopoeia was recognized by the law of 19/05/1994 on the Public Health Code. In spite of its use by the population and the existence of traditional doctors in all localities, they are not included in health programmes. However, the Ministry has just created a department of medicine and traditional pharmacopoeia (DMPT) within the Directorate General for Pharmacy, Drugs and Laboratories. This department plays a role in the promotion of drugs from the traditional pharmacopoeia.

2.4 Human resources

2.4.1 Burkina Faso has made great efforts to put in place a pyramid system which on the overall is functioning fairly well, but the qualified personnel trained does not yet cover all the needs. Accordingly, a shortage of human resources is one of the main causes of the low coverage of the country's health needs. Furthermore, the distribution of personnel is marked by disparities between urban and rural areas; the majority of personnel of all categories put together is concentrated in urban centres but without meeting the quality standards. According to the country's norms, each CSPS should have at least one nurse, one assistant midwife, a mobile health worker or labourer. The efforts of the Ministry have led to an increase in the number of CSPS with the minimum required personnel, rising from 76.59% in 2002 to 76.8% in 2003, with major disparities between health districts; certain districts having a satisfaction rate of below 50%. Such understaffing jeopardizes the delivery of MPA. Concerning regional and university hospitals acting as referral and counter-referral hospitals, qualified medical staff shortages make them unable to provide all the specialized care; to the extent that nurses and midwives have been trained to provide minimum ENT and ophthalmological care in the CMA.

2.4.2 In public structures, to date there are 134 medical specialists, 180 general practitioners, 33 dental surgeons, 32 pharmacists, 1635 state registered nurses, 1462 certified nurses, 457 midwives, 857 mobile health workers and 1098 assistant midwives. In terms of ratio, there is a downward trend in the number of doctors per inhabitant; in fact, there was 1 doctor per 24,158 inhabitants in 2001 as against 1 doctor per 24,744 inhabitants in 2002 which is well below WHO norms of 1 doctor per 10,000 inhabitants. Concerning nurses, the ratio has improved rising from 1/3,822 in 2001 to 1/3,800 in 2003 and is better than the WHO recommended ratio of 1/5,000. As regards midwives, Burkina Faso is greatly lagging behind compared to the WHO norms of 1/5,000, with a ratio of 1/25,903 in 2001 as against 1/21,050 in 2002.

2.4.3 Considering the policy of decentralization of the health system and the autonomous management granted to referral structures, human resource development, technical qualification of personnel and their incentives are decisive factors in improving the performance of health units. The inadequate supervision and monitoring of health workers makes it impossible to evaluate their performance. The living and working conditions in rural areas (wages, poor accommodation, lack of career opportunities) demotivate personnel, leading to frequent mobility. In urban areas, the personnel rather tends to join the private sub-sector which results in further staff shortages and also lower quality care. A study conducted by the Department of human resources on personnel incentives is under way and solutions such as the institution of allowances for personnel posted to the regions will be soon be discussed between the Government and its partners.

2.5 Financing of the health sector

2.5.1 The health sector is financed by different sources, namely the State, partners (in the form of loans or grants), local authorities and households. The health sector also receives supplementary funding from the Heavily Indebted Poor Countries (HIPC) Initiative. Households contribute to cost recovery through charges paid for medical procedures and EGD sales. For the 2005-2008 period it is estimated that such community participation will reach the amount of CFA F 25,136,980,000, that is 7.84% of the PNDS funding. The funds collected are generally utilized to cover operating costs and to supplement the salaries of personnel under contract, recruited at the regional level. Local authorities intervene through the construction of health units and the payment of salaries of locally recruited staff.

2.5.2 The main financing source for health expenses has always been the budget of the State which has been striving to increase the health sector budget over the past few years. In fact, after a reduction of the amount allocated to the Ministry of Health in 1999 to 2001, budgetary allocations have increased from CFAF 30,700 million in 2001 (6.32% of the national budget) to CFAF 40,100 million in 2003 (7.19%), and showing a drop in 2004 with an amount of 43,000 million (6.25%) while the WHO norm is 10%. The effective contribution of the State is essentially designed for recurrent expenditure (personnel, transfers and equipment) representing 67% of the budget while 33% is for investments. In 2003, salaries represented approximately 40% of the recurrent budget and thus rose from 36% in 2001 to 38% in 2002. The mobilization of financial resources however remains insufficient for equitable, sustainable and overall development.

2.5.3 To improve the effective utilization of public resources and coherence between the State budget and sector-wide policies of beneficiary ministries, HIPC funds are included in the Budget Law of 2002. In 2000, only three ministries benefited from these funds, of which 35% went to health. Considering the decisive impact of their actions on poverty reduction, some ten ministries benefited from the HIPC funds as from 2002, but domains such as education, health and infrastructures / housing remain priorities. The HIPC funds allocated to health even though rising in terms of amount (except in 2002) witnessed a drop in percentage from 35% in 2000 to 22% in 2003. This reduction is due to the fact that other ministries received the funds as from 2002. Table 2.1 below summarizes the trend of the budget of the Ministry of Health and HIPC funds over the last five years.

Table 2.1: Trend of the budget of the Ministry of Health and of HIPC funds

Years	Trend of budget allocated (in million CFAF)					
	National excluding HIPC	MOH	% of budget MOH/National	HIPC	HIPC disbursed to MOH	% disbursed MOH/HIPC
2000	409 495.80	32 902.18	8.03	10 250 000	3 587 500	35
2001	486 383.51	30 754.00	6.32	27 394 552	9 323 838	34
2002	526 299.00	37 296.28	7.09	35 773 651	8 440 000	24
2003	558 128.00	40 134.29	7.19	45 146 118	9 724 000	22
2004	688 371 587	43 066.426	6.25	57 584 521	16 881 673	29

Source: Department of Studies and Planning (2003 Statistics Yearbook, Burkina Faso) and the Department of the Budget and Accounts

2.5.4 In accordance with the implementation of the 2004 HIPC budget of the Ministry of Health, the funds are used to cover expenses relating to: the training of doctors and ministry staff, statistics monitoring and management, remuneration of personnel recruited in the regions, goods procurement (motorcycle ambulances, computer hardware, health district furniture/equipment, drugs, reagents, etc.), normalization of health units, rehabilitation of facilities, repair of materiel and equipment, CSPS office supplies.

2.6 Donor interventions

2.6.1 In accordance with the national health policy, international aid for overall financing of the health sector is designed for primary health care. The main donors are the European Commission, World Bank, African Development Bank (ADB), Islamic Development Bank (IDB), United Nations, bilateral cooperation (Belgium, Canada, China, France, Italy, Japan, Netherlands, Sweden) and the Global Fund. Based on technical support and investments through adhesion to different public health programmes, contributions from partners rose sharply between 2001 and 2002, and were moderate in 2003.

2.6.2 For the period 2003 to 2005, total financing (not including technical assistance and operation) stood at CFAF 67.8 billion. Multilateral cooperation represented 44% of contributions, bilateral cooperation 37%, Global Fund 16% and NGOs 3%. These amounts do not entirely finance PNDS activities because they also include operating costs and technical assistance from certain partners. The project approach represents most of the financing (94.4%) while sector-wide financing represents only 3.1%. For the 2005-2008 period, overall PNDS financing (running costs of public services and supplementary costs of programmes) stand at CFAF 320.3 billion of which CFAF 293.7 billion will be financed by the State and external partners. Internal financing composed of the regular budget, HIPC resources, cost recovery and the special account "Disease Fund" amount to CFA 231.9 billion, while external financing stands at CFAF 61.7 billion for the same period, hence the need to mobilize further resources. This project and the action of certain partners such as UNICEF and the World Bank, which are preparing their future interventions, will contribute to offset this shortfall.

2.6.3 Although all the projects / programmes of the sector are in line with the PNDS objectives and strategies, certain donors channel their resources to specific programmes. Such is the case of the Global Fund and the World Bank whose resources are essentially channeled to the control of communicable and non-communicable diseases as well as the reduction of HIV/AIDS transmission; and the French Cooperation which has strongly supported hospital reform. While all partners agree to lay emphasis on improving care quality (ADB, France, Netherlands, Sweden and WHO), human resource development and the increase of health sector financing lack active partners. As part of the sector-wide approach, the Netherlands (CFAF 2.6 billion), Sweden (CFAF 2.2 billion) and the World Bank have pooled their resources to finance a health development support programme (PADS 2005-2008). The resources from the Netherlands and Sweden for PADS serve essentially to finance health district activities (72%), the remainder being distributed among the other departments, hospitals and the PADS management unit, while the World Bank funds exclusively finance HIV/AIDS control activities. Annex 3 summarizes the financial commitments, the areas and zones of intervention of Burkina Faso's main health sector partners. All these interventions cover the national territory and all PNDS objectives, and are complementary.

2.6.4 At present, all is not set for the implementation of the sector-wide approach. In fact, the process requires the fulfilment of a number of minimum conditions including the following measures: (i) formulation and approval of PNDS financing and implementation modalities, (ii) harmonization of management procedures of all health sector stakeholders; and (iii) strengthening of the management structures of the financial resources of the Ministry of Health. PNDS financing procedures were the subject of a study carried out proposing a minimum consensual procedure for PNDS financing and its implementation plan. The results as amended at the beginning of 2005 by the Government and the country's partners, led to the choice of a consensual financing procedure, its implementation plan and recommendations for the preparation of a procedure manual to ensure effective implementation of the PNDS following the sector-wide approach. As concerns building the capacity of the MOH, the Department of Administration and Finance (DAF) is receiving support from Belgian cooperation. The actions common to all stakeholders are: joint planning of annual activities of all services of the ministry, use of the same indicators; joint field missions, designation of WHO as lead donor institution. Concerning the pooling of resources, all the other partners continue to intervene in the form of projects for the 2005-2008 period. In its desire to move towards a harmonization of interventions in the sector, the Bank through this project, is participating in financing PNDS programmes and will support the gradual implementation of the sector-wide approach on which the Government has embarked.

2.7 Sector constraints

2.7.1 The existence of a political will to make health a priority sector, an EGD policy, a health map, decentralization, a sector-wide approach, community participation and support from multiple development partners are advantages conducive to health development. However, the sector faces constraints which include: (i) a low HU utilization rate; (ii) non-conformity of facilities and equipment; (iii) shortage of qualified staff and poor management of human resources; (iv) difficult economic situation; (v) socio-cultural setbacks; and (vi) the multi-sectoral nature of health.

2.7.2 Existing infrastructures are underused by the population especially in rural areas; in fact, the attendance rate of health services is 32.49%. The MPA (curative, preventive and promotional) is not entirely offered in HUs. The impact of health promotion and prevention activities is diminished by the generally low level of education of the population and the low literacy rate of adult women (15.2% in 2003), given the inaccessibility of the majority of the population to information and to the acquisition of pro-health attitudes. Self-medication and traditional medicine are frequently used by the populations, impacting negatively on the utilization of health services. Whereas, traditional medicine, which is poorly structured is not covered by regulations, causes undesirable side-effects and raises concerns in terms of quality of the products used, therapeutic value for the disease concerned and lack of medical follow-up.

2.7.3 The health facilities and equipment are obsolete owing to a lack of maintenance and are inadequate for delivery of the MPA. The capacity to bear the investment and operating costs are problematic and the financial resources are insufficient to cover maintenance, servicing and new equipment of all health units in particular CHR and CHU. The property management policy (facilities, equipment, maintenance) is not clearly defined, hence the rapid deterioration of facilities and equipment does not enable quality care delivery. Besides, most HUs are not fenced, thus attracting stray animals and making it difficult to keep clean surroundings.

2.7.4 The human resources are marked by inadequacy in quality and quantity, poor distribution and lack of incentives. In fact, medical specialists are lacking in CHR: CMA in urban areas are overstaffed and 26% of CSPS do not meet the minimum staffing norms. The low managerial capacity of decentralized structures during transfer from the State to local authorities constitutes a contributive factor to the slowdown in the on-going process of health sector decentralization in Burkina Faso. The definition of human resource development guidelines which began a few years back is uncompleted and the lack of this document constitutes a problem. Indeed, the formulation of a human resource development policy for the health sector is vital and would enable the identification of measures to be taken on training, specialization, personnel management, career paths, incentives and sanctions.

2.7.5 The country's economic difficulties in a context of poverty and the implementation of cost recovery limit the population's access to health services owing to their low incomes and / or sporadic incomes (farmers) and do not guarantee equity. The poor health and nutritional status coupled with a relatively high fertility rate is a cause and a consequence of poverty in Burkina Faso. This situation aggravates poverty by reducing the productivity and incomes of households while increasing their expenses.

2.7.6 Socio-cultural setbacks translate into traditional practices such as food taboos, excision and domestic violence. This situation which is also a result of illiteracy and poor IEC programmes is an obstacle to health. The high rate of malnutrition among children and pregnant women is also due to prohibition from certain foods necessary for their growth and for boosting their immunity. Female genital mutilation and home abuse are equally deleterious to women's health.

2.7.7 The resolution of health problems is complex and requires a multisectoral approach with the intervention of other development sectors given that many health determinants do not directly come under the MOH (sanitation, drinking water supply, nutrition, etc.). In fact, limited access to basic social services such as sanitation and drinking water (64% in rural areas) and 88.5% in urban areas in 2003) insufficient hospital hygiene; limited access of the population to latrines, inadequate waste water and rainwater drainage facilities resulting in uncleanliness and the proliferation of disease vectors are also poverty-related factors which contribute to a poor health status. Intersector collaboration is inadequate to resolve these along with health problems simultaneously.

3. PROJECT AREAS

Related to the health system constraints are the areas of intervention of this project which cover: (i) availability of health facilities and equipment; (ii) utilization of health services (iii) communicable and non-communicable diseases; (iv) health system management.

3.1 Availability of health facilities

Health district

3.1.1 As part of the decentralization of the health system, the creation of health districts (HD) is one of the most significant changes designed to ensure health care decentralization. Infrastructure coverage has improved markedly in terms of quantity, through the construction of health units. The national CSPS coverage norm is 10,000 inhabitants within a 10 km radius. The average activity radius reduced from 9.07 km in 2002 to 8.68 km in 2003. This apparent reduction belies disparities, for in certain districts the radius exceeds 10 km. Improved health coverage has resulted in the CSPS / number of inhabitants ratios rising from 11,536 in 2002 to 10,828 inhabitants in 2003. However, certain structures are operational without meeting national norms, owing to the lack of dispensary, maternity, technical support centre, drug depot, housing, water, toilets or an incinerator and the insufficiency of medical technology equipment or qualified personnel. Such is the case of maternities (28) and remote dispensaries (93) which do not feature in the classification of care facilities, and 33 medical centres which have no technical support centre and cannot deliver the MPA. The supervision of CSPS through DHMTs is inadequate and ill-targeted. Furthermore, there is a decline in the shortage rate of the 45 essential molecules in the EGD depots, from 10.6% in 2002 to 6% in 2003. The set target in the poverty reduction strategy framework (PRSF) for 2003 being to maintain it at below 5%, more efforts are required. For these different reasons, the country's health units are not sufficiently utilized especially in the rural areas.

3.1.2 In spite of the Government's efforts to supplement the health facilities, there is a need to take measures aimed at normalizing or rehabilitating remote maternities, dispensaries and CMA in order to deliver the MPA. At the national level, the PNDS envisages the transformation of 135 remote dispensaries and 15 remote maternities into CSPS, the rehabilitation of 183 old CSPS and 9 CMA, the construction of 87 EGD depots, 249 houses and 160 boreholes, the construction of 8 CMA, the construction of additional facilities in 18 CMA (hospital rooms, fences, etc.). These measures will enable the ministry to attain the intermediate objectives of the PNDS, namely: (i) increase national health coverage (through the development of health facilities and equipment, operationalization of health districts); and (ii) improve the quality and utilization of health services (availability of quality essential drugs and their accessibility).

The referral system at the regional level

3.1.3 The CHR enjoys autonomous management following the hospital reform financed by French cooperation; however, these reforms have not been able to considerably improve the quality of care delivered by hospital services. To contribute to the strengthening of hospitals, the PADS envisages an allocation of 3% of its resources for the period 2005-2008 and discussions will begin in 2005 to put in place a master plan for hospitals as well as a development plan; these discussions will lead to the adoption of an architectural programme and the standard list of equipment and personnel.

3.1.4 Hospitals are functioning poorly resulting in a poor organization of the referral and counter-referral system, an inadequate organization of emergency hospital services. The corollary is poor patient follow-up and poor quality care delivery owing to the lack of information and coordination. The inadequacy of technical support centres is most often due to obsolete facilities and equipment, a lack of personnel and notably specialists. The patient's circuit is not operational as many of the CHR built in the fifties, were initially CSPS and were transformed into CMA and then into CHR by extension, transformation and the addition of buildings and the care on offer.

3.1.5 All referral hospitals do not play their role fully and to remedy this situation, the PNDS envisages adding 7 CHR (Dédougou, Dori, Fada, Gaoua, Koudougou, Ouahigouya and Tenkodogo) through the creation of new units and the construction of 2 CHR (Banfora and Kaya). The State is able to invest in hospitals with its own resources and with support from some development partners. In fact, certain CHR have already received support for extension and rehabilitation of their installations. Such is the case of: Cascades (Banfora), whose CHR is being financed by the State and the PDSL project, Centre-North (Kaya) being financed by the State, Centre-West (Koudougou) rehabilitated by China, Mohoun (Dédougou) by PRSS/ADB, Sahel (Dori and Djibo) financed by the ADB, South-West (Gaoua) rehabilitated with Kfw funding, East (Fada-N'Gourma) rehabilitated by GTZ, except for a few services added, the CHR of the Centre-East and North have not been rehabilitated to play their new role.

3.1.6 The Ouahigouya CHR which was built in 1954 has been operational since 1955 and most of the buildings are proving inappropriate for the population's health needs, its cramped premises do not provide for the new services warranted by its new legal status and the equipment is dilapidated and incomplete. The hygiene and sanitation system is inappropriate. For these reasons, it is unable to meet the demand for services, which argues for the relocation of the CHR. Moreover, the target population has considerably increased and according to forecasts should reach 1,700,000 inhabitants in some twenty years given its geographical location. The CHR in addition to its population receives patients from the regions of Sourou, Soum and the Republic of Mali.

3.1.7 Tenkodogo CHR is a former medical centre built in 1959 and raised to an "hôpital départemental" in 1980 and supported by an Italian NGO, and in 1991 was granted the status of government administrative hospital with financial autonomy like all hospitals. It faces the same problems as the Ouahigouya CHR and has no technical support centre for resuscitation. Moreover, the Tenkodogo CHR is situated downtown at a major crossroads and close to a busy market; this location is unsuitable for patients and health personnel. As in Ouahigouya, the Tenkodogo DS relies on the CHR and its geographical location makes it the first facility that can be reached by the population. A World Bank-financed study confirms that its premises are cramped and the facilities and equipment and too old; it concludes on the need to relocate the CHR. The lack of financing has made it impossible to implement the recommendations and conclusions of the study. Therefore, the reconstruction of the 2 CHR is necessary, enabling the Ministry to achieve the two intermediate objectives of the PNDS, namely (i) increase national health coverage (through the development of health facilities); and (ii) improve the quality and utilization of health services.

Maintenance system

3.1.8 To ensure closer management of equipment in health units, the MOH in 1999 adopted with GTZ support, a biomedical and hospital maintenance strategy. The project backed by GTZ targeted two regions, Gaoua and Dédougou and will end in December 2005. Through the Health and Nutrition Development Project (PDSN), the MOH has financed the recruitment and training of technical personnel as well as the construction and equipment of 5 regional maintenance workshops (Gaoua, Dédougou, Ouahigouya, Fada N'gourma and Bobo-Dioulasso). The MOH reforms in 2002 led to the creation of the Directorate General for Infrastructure, Equipment and Maintenance (DGIEM) and subsequently, in the context of decentralization, the administrative transformation of former workshops into regional services for Infrastructure, Equipment and Maintenance (SIEM) to carry out preventive and curative maintenance. There is a SIEM in the North which is not very operational, while the Centre-East must refer to that of Fada N'gourma. There is a need to underscore the strengths of the present maintenance strategy such as the creation of the institutional level (DGIEM), creation of awareness, the availability of a biomedical maintenance manual and management tools, the taking into account of the technician's opinion by health units. The inadequacy of technical support centres is also due to the lack of a maintenance expert, insufficient training of senior maintenance technician and poor supervision by the central level. Burkina Faso has 31 maintenance technicians of whom 11 are senior biomedical technicians and 9 contract electrician/mechanics and 11 are financed from HIPC funds. The North has 3 maintenance technicians, while the Centre-East has only one technician.

3.1.9 Certain aspects of maintenance are not yet being taken into account, viz: the lack of a national policy on the maintenance of facilities, the maintenance of buildings, the complexity of medical technology equipment, the inadequacy of financial resources for the systematic acquisition of new equipment and their maintenance; and difficulty of obtaining spare parts. These factors impact negatively on the sustainability of investments. The output of existing SIEM is low as they do not have adequate premises and equipment as well as qualified personnel to fulfil their tasks. Hence, there is a need to put in place a preventive and curative maintenance system for the health sector, through: (a) the formulation and adoption of a national policy on biomedical facilities and equipment and a national strategy document for all health units; (b) the creation of new regional structures and the training of technicians and users. This will permit the achievement of the objective regarding increased national health coverage (through the development of health facilities and equipment).

3.2 Utilization of health services

Human resources

3.2.1 The success of the national health plan largely hinges on the importance accorded to human resource development in its different aspects. Besides the high cost of medical procedures, and under-qualified medical personnel, substandard care delivery, poor patient reception, inadequate medical prescription and personnel mobility are the disadvantages that affect the utilization of health units by the population. Poor qualitative coverage by medical staff is due to a low planning and managerial capacity, inadequate technical capacity, a centralized management of human resources, poor functioning of COGES and inadequate central level regulation and control. Furthermore, the lack of attractive career prospects for doctors trained on the spot and classified and paid as mere general practitioners results in their mobility.

3.2.2 Inadequate facilities, equipment and financial resources make it impossible to provide quality training in hospitals; and administrative procedures to undergo post-doctoral training are ill-adapted. The training of medical specialists which is often done abroad (except for pediatrics,

surgery, gynaecology, psychiatry is due to the lack of structures and qualified personnel capable of providing such training. Besides, there is no planning document for the training of medical specialists and a mismatch between the recruitment policy and the system's needs. There is a need to strengthen the capacity of medical and paramedical personnel through training and sensitization for the ministry to be able to attain the PNDS intermediate goal of developing human resources.

Health mutuals

3.2.3 The low access to health units is also due to low household incomes. To reduce the inequalities and barriers that hinder users from obtaining quality care, the development of a disease risk coverage system is one of the best means in terms of cost, civil society commitment and involvement in the management of the health system. To that end, for a decade now, communities have been setting up mutualist groups on their own and on the initiative of various promoters. Their functioning is generally based on solidarity and mutual assistance. These organizations are autonomous and non-profit making and membership is free and voluntary. However, as they are unable to cope with people's needs, other types of structures are beginning to appear.

3.2.4 The study on alternative funding of health care financed by the World Bank and the Government under the health services strengthening project (PRSS) enabled the identification of different forms of disease risk sharing systems: (i) health mutuals concerning individuals and covering rural and urban areas, (ii) solidarity funds covering groups / associations and public / semi-public services in rural and urban areas, (iii) professional mutuals covering public services, personnel and private enterprises in urban areas, (iv) the system of prepayment covering the population of the CSPS in rural areas, (v) unions of all the COGES in a health district for obstetrical emergencies and covering the populations of a health district's health centres in rural and semi-rural areas, and (vi) the national social security fund which concerns the urban private sector. Certain partners such as WHO, UNICEF, STEP/ILO, Belgium, Denmark, France, the Netherlands and a few national NGOs are providing technical and financial support to the promotion and development of health mutuals.

3.2.5 Given the population (rural and urban) covered by health units and its diversity, two disease risk coverage systems (health mutuals and prepayment) may be adopted. The number of health mutuals has increased since the year 2000, rising from 14 to 81 in 2003; and in 2004, there were 92 mutuals, of which 36 were operational and 34 under way, 4 in difficulty and 17 in the pipeline. The number of members of sickness insurance systems stood at 14580 in 2004, while the number of up-to-date contributors was 8208. The harmonious development of a risk-sharing system requires the formulation of an implementation strategy framework taking into account the social, economic, political contexts and the communities' social dynamics. Hence, certain preconditions are necessary: the conduct of a feasibility study, sensitisation of the population, drafting of instruments, contribution schedule, available care supply and choice of services to be covered, the training of members and establishment of management organs, internal and external evaluation of activities, regional coordination of mutuals in order to strengthen advocacy.

3.2.6 There are several constraints to the system's sustainability: (a) low membership levels among the population (3 to 6%), low collection of contributions (40 to 50% in mutuals); (b) inefficient administrative and financial management due to the insufficient technical capacity of management personnel and organs; (c) lack of training and supervision of COGES members; (d) insufficient collaboration between mutual associations and health services; (e) non-existence of an appropriate legal framework in the development of mutualism in Burkina Faso. The strengthening of health mutuals would contribute to achieving the intermediate objective of improving the population's financial access to health services.

3.3 Communicable and non-communicable diseases

3.3.1 The prevalence of communicable and non-communicable diseases and the fertility index remain high. The morbidity rate is strongly correlated to the living standard, malaria and AIDS remain causes for concern. Vulnerable groups represented by women (maternal mortality, complications of frequent pregnancies) children (mortality and morbidity, malnutrition, communicable diseases), adolescents and youth (risk of unwanted pregnancies, STIs, HIV infections) and a certain category of workers (gold washers, informal sector) are the most affected.

Conventional medicine

3.3.2 Malaria remains the leading cause of consultation and represents 43% of consultations. Children aged 0 to 4 years represent 17.3% of the country's total population, 53.4% of hospitalized children have malaria and 63.5% of hospitalized malaria patients are children aged below 5 years. Certain patients go to health workers and community relays while others resort to traditional medicine. Malaria control is receiving increasing attention from international bodies. Among such initiatives, is the implementation of various programmes, notably: (i) the Malaria Control Acceleration Programme (PALAP), (ii) the integrated management of childhood illness (IMCI); (iii) the global initiative to "Roll Back Malaria". Malaria control problems may be summed up as follows: (i) the financial resources allocated remain inadequate compared to the needs expressed; (ii) the low rate of utilization of health units; and (iii) poor quality patient management.

3.3.3 Maternal health is among the country's priorities; however, the maternal mortality rate remains high. Adult women represent 28% of the country's total population. Few pregnant women (16.5%) undergo ANC in the first quarter and the percentage of at risk pregnancies referred is 14.13%. The rate of births attended by a village birth attendant and health worker is 43.67%, and 30.92% if attended by health personnel. Maternal health problems are due to inadequacies in the following domains: availability of, and access to quality maternal health and neonatal services, management of pregnancy and delivery complications, coordination and monitoring / evaluation of maternal health and neonatal interventions, commitment of leaders and the populations in the fight against maternal and neonatal mortality. These problems are more serious in 9 out of 13 health regions and 39 out of 55 health districts, including the Centre-East and North. The high fertility rate and family planning needs vary according to the socio-demographic characteristics. It is worth noting that the concept of family planning (FP) covers birth spacing and control. Maximum contraception prevalence is between the ages of 20 and 30 years (14%) corresponding to the ages when potential FP demand is highest (44%) and this potential demand is higher in towns (57%) as against 40%). Contraception use is increasing and rose from 8% in 1993 to 14% in 2003, while the level of satisfied demand remained constant at 32%. The proportion of women with unsatisfied demand is higher in rural areas (30%) than in urban areas (23%) and among women of the poorest households. It is realised that the needs identified as unsatisfied in all the regions are more related to child spacing. The involvement of men in FP programmes could be a success factor in the said programmes.

3.3.4 HIV/AIDS is a development problem affecting the 20 to 49 years age bracket which is the most economically productive and women constitute the most vulnerable group. From a prevalence rate of 2.7% in 2004 obtained through surveys conducted in sentinel sites, the situation in Burkina Faso is stabilizing (7.17% in 1997, 4.2% in 2002 and 2.7% in 2004) with a significant drop in new infections. HIV/AIDS control activities are financed by the State budget, the HIPC programme and development partners and cover the 13 most populous provinces, at the rate of one per health region. Chinese cooperation has financed the putting in place of departmental HIV/AIDS control committees; the Global Fund is focusing on access to ARVT for 3600 sick patients, extension of PMTCT in 2 HDs per year and support to associations. The ADF is financing an

HIVAIDS component in the Bobo-Dioulasso, Gaoua and Dedougou regions and also an HIV/AIDS control support project in eleven other provinces. The World Bank for its part is financing a regional programme to accelerate treatment, covering Burkina Faso, Mozambique and Ghana. Increased efforts are needed to achieve the MDGs on HIV/AIDS which is to stop its spread and start reversing the current trend, by extending activities to other provinces of the country and creating screening centres.

3.3.5 There is an emergence of non-communicable diseases and there are no appropriate strategies for the management of these important public health pathologies, notably chronic diseases such as cancer, diabetes and high blood pressure. This is partly due to insufficiency of resources and ignorance of the scope of these diseases. There is insufficient screening for cancer of the female genital apparatus and poor management of the side-effects of female genital mutilation (FGM). Cancer of the uterus and breast cancer are the most common among women and there are no statistics on these. Cancer of the uterus is considered as STI and is a world health problem, and 90% of deaths could be avoided through better prevention and screening. Breast cancer is a common disease related to certain predisposing factors such as age, advanced age of the first pregnancy, early first menstruation, hormonal treatment of menopause and dieting. One out of 11 women develops cancer during her life and one-quarter of cancers among women is breast cancer. Owing to improved education of women and life expectancy in Burkina Faso, they are exposed to all cancer risk factors.

3.3.6 Support to disease control programmes will enable the Government to attain the intermediate objectives of the PNDS, namely to strengthen disease control (promote the health of target groups and reduce the incidence and prevalence of these public health interest diseases) ; and reduce HIV transmission.

Traditional medicine

3.3.7 For cultural and financial reasons, some patients (9% on average with 11% in rural areas) consult traditional doctors first. Traditional medicine plays an important role in the coverage of health needs especially in rural areas (over 70%). It is practised by nearly 30,000 persons with a little over CFAF 10 billion annual turnover (Study by the World Bank in 2003). In spite of its huge potential, certain shortcomings are noted in the organization of its practice. The problem is that of classification and the use of inappropriate techniques for the harvesting and drying of medicinal plants, artisanal production which does not guarantee the required pharmaceutical and therapeutic qualities, inadequate use of recipes and documentation resulting in artisanal drug production, non-mastery of local medicinal plant management and difficulties in validating products. Even if practised commonly, there is a lack of collaboration among practitioners. The Government has embarked on the development of traditional medicine and recently adopted a national policy framework document with two implementing decrees on the practice of traditional medicine and authorization to market drugs derived from the traditional pharmacopoeia.

3.3.8 The Government has embarked on the strengthening of the knowledge and practice of traditional medicine through training sessions and support to the creation of associations. Currently an interface structure consisting in the treatment of certain patients by traditional doctors and their follow-up and check-up by doctors is being tested in order to harmonize and utilize its findings and gains. Certain NGOs such as Doctors without Borders (MSF) help traditional doctors to form associations and produce drugs. Traditional medicine is flourishing in the North and existing associations need support in terms of organization, functioning and supervision, but this domain is affected by the lack of direct partners while in the Centre-East, with the District Health Management Teams initiative, the creation of associations is going well. Strengthening this domain will contribute to the achievement of the intermediate objectives concerning increased national

health coverage (through increased collaboration with the private and traditional health sectors in care delivery).

3.4 Health system management

3.4.1 The MOH started its process of implementation of the sector-wide approach with different health development partners which will enable the harmonization of PNDS interventions while observing equity in the gradual establishment of a mutual fund for financing the plan. All the partners give their agreement in principle on this approach, but it is subject to certain minimum conditions. Being a new option in the country, it needs a common understanding by all stakeholders and the support of all the ministry personnel. Having clearly stated its political will, the Government must embark on measures to ensure knowledge and application of the concept of a sector-wide approach within the MOH at the central level and at the decentralized level, within the other ministries involved in the activities of the MOH, and in grassroots communities participating in the management of health services. This approach if properly conducted will engender true ownership of the strategy.

3.4.2 Certain departments are affected by the lack or non-enforcement of laws or regulations, for instance, the policy document and texts of the regulatory framework of laboratories, location map of pharmacies and the improvement of their regulations; master plan and legal framework of mutuals outlines of and guidelines on hospital action plans; guides to cancer management, legal, statistical and financial data bank and accounting plan. The institutional strengthening of the MOH by focusing attention on central departments is necessary and is in line with the strategic guidelines of the PNDS.

3.4.3 The implementation of PNDS programmes is monitored on the basis of a table of indicators and enable the assessment of the performance of services charged with the implementation of programmes. The main indicators in conformity with those of the PRSP were drawn up by the PNDS monitoring committee and could be revised on the basis of the evolution of the plan. Each of the health districts hospitals (regional and university) has indicators based on its map and the programmes incumbent on it. Furthermore, health districts draw up their action plans and DRS their health district support plans (coordination, supervision, training) and the objectives for each of the levels concerned (health district or regional hospital) according to mobilizable resources and field realities. Monitoring measures also comprise periodic reports at the operational level, studies which the monitoring committee may deem necessary and internal and external reviews. These measures are not entirely operational and the ministry’s efforts must be supported.

4. THE PROJECT

4.1 Project design and rationale

4.1.1 The foregoing health sector situational analysis has revealed inadequacies in several respects: quality of care delivered in rural areas, inadequacy of facilities and equipment, insufficient human resources in quality and quantity, low attendance of health services. To resolve these problems, one of the priority measures of the PRSP is to promote access of the poor to health services. In the national health policy document, several strategies are implemented in the health domain and integrated multi-sectoral programmes are formulated.

4.1.2 In accordance with the country’s policy, the formulation of the project was based on the programmes being implemented to address the concerns mentioned. The project will contribute to the achievement of PNDS objectives through: the development of health facilities and equipment, support to the execution of health district action plans, reduction of the incidence and prevalence of

diseases, HIV prevention, human resource development, promotion of mutuals, collaboration with traditional medicine and the improvement of the institutional framework of the ministry of health.

4.1.3 The project design was based on the findings of consultations with civil society and the main partners intervening in the sector, and following preparation and appraisal missions to Burkina Faso. The project formulation process is described in Annex 4. Meetings were organized with national and regional representatives of the Government (MOH, MEDEV, MFB), civil society (NGO / Association of mutuals and HIV/AIDS control groups, traditional doctors, beneficiary communities, COGES), as well as development partners intervening in the health sector. Administrative and health authorities of the Centre-East and North regions were consulted and participated in designing the project. These discussions were all carried out in order to understand the functioning, constraints and strengthening needs of these different stakeholders.

4.1.4 The findings of the two missions were discussed with partners, namely WHO, World Bank, UNICEF, UNFPA, UNAIDS, WFP, European Union, French, Italian, Canadian, Swedish, Dutch cooperations. Comments and observations on the project preparation report were received from the main departments of the ministries of health, of the economy and development, of finance and the budget, and from the development partners that were contacted. The project took into account the unanimous position of the Government and partners who wish that all interventions should be in conformity with the PNDS objectives and programmes. In fact, the activities proposed cover all the PNDS objectives and conform to the PRSP as concerns access of the poor to basic health services, millennium development goals (reduction of infant mortality, maternal health, HIV/ADIS control and malaria) and those of NEPAD.

4.1.5 In Burkina Faso, the Bank has financed several projects in all sectors and three projects in the health sector: (i) the health establishments renovation project in Dori and Djibo; (ii) the health services strengthening project (PRSS) approved in 1999, financed from a UA 10 million loan from ADF IV resources, covering three health regions, namely Mohoun, Hauts Bassins and South-West; (iii) the multi- sectoral HIV/AIDS control project in eleven provinces financed from a UA 5 million grant from ADF IX resources which was approved in 2003.

4.1.6 The first project was completed in December 1999. Concerning the PRSS which was launched in 2002, its implementation and disbursement rates are 54.5% and 42% respectively and it will be completed in 2006. The State's contribution is up to 30.37% paid. The first visible outputs are: the training of medical specialists and COGES members, purchase of EGDs, ambulances and supervision vehicles for the health districts and the CHR, the health infrastructure works that are over 50% implemented, sensitization by NGO/Associations on AIDS control, periodic consultation meetings at the health district and health region levels. The furniture and equipment / materiel of health units are in the process of being procured. The implementation of the PRSS is not currently facing any particular problem; the procurement documents are being prepared in accordance with Bank rules; there is an efficient computerized accounting and financial management system; activity and audit reports are drawn up and submitted to the Bank within prescribed time-frames; counterpart funds are disbursed in time for the funding of activities. Despite the delay in project start-up, the implementation schedule will be followed and the project completed within the prescribed time-frame. For these reasons, it may be said that the project coordination unit (PCU) of the PRSS is efficient. The conditions precedent to the first disbursement of the HIV/AIDS control support project were fulfilled by the Government in December 2004 and the activities are starting. This project as concerns HIV control activities will rely on existing provincial and departmental committees and is based on the same approach as the last two financed by the Bank. These activities will be extending those of the HIV/AIDS project to other regions and those of the PRSS through improved access to quality care in the Centre-East and North health regions.

4.1.7 The main lesson learnt from these projects is the late start-up of activities owing to the project officers selection procedures. Given the satisfactory performance of the PCU, it is proposed that the same PRSS unit personnel be maintained for the management of this project. The activities of this project can thus start once the loan is approved and signed, pending the recruitment of supplementary personnel. Furthermore, as regards project implementation in Burkina Faso, the Government procurement approval procedure is considered lengthy. However, with support from the ADB and the World Bank, the Government is reviewing the country's procurement procedures. This project conforms to Bank policy on health, HIV/AIDS control and the control of communicable and non-communicable diseases through malaria and HIV/AIDS control, the improvement of maternal health and access to quality health care.

4.2 Project areas and beneficiaries

4.2.1 The project is located in the vulnerable areas of the Centre-East and North (Annex 5). The choice of the two zones is based on a combination of the following criteria: poverty index and contribution to national poverty, population size, health status, dilapidated state of their facilities and equipment, and the failings of their maintenance system. The North (68.6%) and the Centre-East (55.1%) are among the three regions most affected by poverty. The economic activities of the 2 regions are agriculture (80%), livestock, trade, market gardening, handicraft, gold washing, hotel trade and transport. The proceeds from these activities do not enable the majority of the population to meet their basic needs. The health regions of the Centre-East and North are affected by irregular rainfall, lack of water and unpassable roads. These two regions are located in border areas with a great deal of movement of people which may contribute to the spread of communicable diseases including HIV. Practices around traditional gold washing sites as well as levirate and excision are conducive to the spread of HIV.

4.2.2 The North has 1 112 480 inhabitants, that is 8.95% of the total population and is divided into 5 (five) health districts (Gourcy, Séguénegua, Titao, Yako and Ouahigouya) and comprises 138 CSPS, 2 CM, 2 CMA, 1 CHR, 5 dispensaries, 5 private health units, 2 mission health units, 1 parastatal health unit and 1 Armed forces health unit. One CSPS covers 8061 inhabitants, while one CMA covers 278 120 inhabitants. Although CSPS coverage is good, health centre attendance is very low in this region with a rate of 24.47%. Antenatal coverage is 51.23% and the proportion of women seen in the first quarter of pregnancy is only 10.36%. In 2004, severe malaria caused 369 deaths out of a total of 16869 cases and there were 73543 cases of simple malaria. The sentinel sites of Ouahigouya registered an HIV/AIDS prevalence of 4.2% in 2002/2003, which is among the highest in the country, after Gaoua and Bobo-Dioulasso. Medical personnel (13 doctors) is insufficient and only 43% of CSPS meet staffing norms. The medical personnel ratios are as follows: 1 doctor/85 575 inhabitants, 1 nurse/6 544, 1 midwife/39 731, while the WHO norms are respectively 1/10 000, 1/5 000 and 1/5 000.

4.2.3 The Centre-East region with 1 104 567 inhabitants represents 8.16% of the total population, and comprises four health districts (Tenkodogo, Koupela, Ouargaye and Zabré) and has 83 CSPS, 2 CM, 3 CMA, 1 CHR, 5 private and 2 missionary health units. One CSPS covers 12 224 inhabitants and a CMA 202 913 inhabitants, while the WHO norms are 10 000 and 150 000 inhabitants respectively. While the antenatal coverage is 82.03% in the Centre-East, the proportion of women seen in the first quarter of pregnancy is low at 15.85%. There is a low attendance of health centres with a rate of 34.46%. While the percentage of CSPS meeting the staffing norms of 72.29% may seem significant, in general the medical personnel is insufficient compared to WHO norms. Indeed, the ratios are 1 doctor/67 637 inhabitants, 1 nurse/5 605 inhabitants and 1 midwife /2 273 inhabitants. The health personnel situation in public facilities (physician, nurse and midwife) is shown in table 2.2 below.

Table 2.2: Situation of ratios of personnel categories

Personnel categories	WHO norms	National	Project areas	
			North	Centre-East
Doctors	10 000	37 699	85 575	67 637
Midwives	5 000	25 903	39 731	42 273
Nurses	5 000	3 822	6544	5605

Source: Department of Studies and Planning (2003 Statistical yearbook, Burkina Faso)

4.2.4 The project beneficiaries are the populations (men, women, children, health personnel) in the two health regions of the Centre-East and North, representing 17.12% of the country's total population, of whom about 28% are adult women and 17.3% children aged 0 to 4 years. Activities concerning improved access to quality health care will reach the entire population (men, women and children) through the provision of quality facilities and equipment, as well as health personnel through training. The health mutuals that will be put in place, traditional doctors organized and trained, awareness campaigns on hygiene and HIV/AIDS will also benefit the entire population of the two regions. The women and children of the target regions will be reached by national programmes on safe motherhood (women) and on IMCI (children), while national malaria control programmes will benefit the populations of the two regions. Conversely, institutional support will have a national impact through the preparation, publication and dissemination of policy papers, regulations and directives on maintenance, traditional pharmacopoeia, laboratories, public hygiene and the inclusion of certain diseases such as cancer among women.

4.3 Strategic context

4.3.1 The project comes at a time when the national health development plan (PNDS) is entering its second phase (2006-2010). Following a joint mission by the government, stakeholders and donors undertaken at the end of 2004, satisfactory outcomes have been registered for phase I (2003-2005) such as: the implementation of the planning frameworks and guidelines, the process of participatory planning, improvement of the coverage rate of preventive and curative activities, availability of EGDs in most CSPS, the putting in place of COGES and operational consultative organs, existence of summary tables and progress reports facilitate the calculation of indicators, a commencement of budget making with defined financing sources, there is the commencement of awareness of HIV/AIDS cases and STIs especially in CMA; the technical support centre for surgery is generally of a good level in CMA. However, there are still problems on which all partners must focus their attention. They are notably: the low utilization of health services; the poor distribution of personnel in health regions; the poor state of peripheral health facilities; the lack of waste management; insufficient coordination of activities at various levels of the health pyramid; the non-existence of a management strategy for certain chronic diseases.

4.3.2 The project activities are in conformity with Burkina Faso's national health policy as well as the objectives of the poverty reduction strategy paper (PRSP) which defines health as one of its priority domains. Improving access to care, reduction of infant and maternal mortality, and reduction of HIV/AIDS prevalence which feature in the project are also the key millennium development goals. Indeed Burkina Faso's MDGs for the health sector are (i) to reduce by two-thirds infant and child mortality between 1990 and 2015 and (ii) to reduce by three-quarters the maternal mortality rate between 1990 and 2015, and (iii) to reduce the prevalence rate of HIV/AIDS, malaria and other diseases. Concerning achievement of the MDGs by Burkina Faso, the results are shown in Annex 2.

4.3.3 The project is also consistent with the objectives of the CSP of the Bank Group for Burkina Faso, which lays emphasis on the social sector. Improved access to care and disease control, the strengthening of the maintenance system, the establishment of mutuals and the strengthening of traditional medicine are in line with Bank policy on health and disease control (HIV/AIDS, malaria, etc.) based on primary health care and the improvement and diversification of investments.

4.4 Project objectives

The project's main objective is to contribute to improving the health status and well-being of the people of Burkina Faso. The specific objective of the project is to support the national health development plan through: (i) improved access, quality and utilization of health services in the Centre-East and North health regions; (ii) disease control in the project area; and (iii) strengthening of health system management by the Ministry of Health.

4.5 Description of project outputs

4.5.1 The project will cover 2 (two) levels of the health pyramid: the health district (HD) and the regional hospital (CHR) in the Centre-East and North health regions and the central services of the ministry of health. The project has four components, namely: (i) improved access to quality health care; (ii) disease control; (iii) capacity building; and (iv) project management.

Component No. I: Improving access to quality health care

4.5.2 The activities of this component seek to improve the populations' access to quality health care in general, the functioning of the referral system between the 1st level and the second level of care, through the normalization of CSPS and CMA, the construction of HIV screening centres, the reconstruction and equipment of CHR in the two target regions, support to the implementation of the plans of target health districts and CHR and maintenance in the different health units. Accessibility of quality health care will be strengthened with the putting in place of alternative health financing systems and the organization of traditional doctors for the production of quality drugs. The implementation of all these activities will impact on the increase and attendance of health services.

Improvement of care services

4.5.3 To strengthen the referral and counter-referral system in the two regions of the project, the project will finance : (i) the reconstruction of the 2 CHR of Ouahigouya and Tenkodogo, the CMA of Bittou ; (ii) the normalization of the Pouytenga CMA (Centre-East) through the construction of a surgery unit ; (iii) the normalization of 31 CSPS, of which 8 in the Centre-East and 23 in the North, will be undertaken through the construction of 21 maternities, 10 dispensaries, the construction of pharmaceutical depots, homes, solar energy and lacking boreholes, and the rehabilitation of existing buildings. The CMA of Ourgaye, Titao, Yako and Séguénéga will house screening centres. The council authorities have allotted 2 plots of 15 ha each, from government reserves in new lay-outs, for the construction of the CHR of Ouahigouya and of Tenkodogo, while the plot for the construction of the Bittou CMA is being determined. The Government will have to confirm the allotment of these plots to the project by providing supporting documents and site surveys and geotechnical studies.

4.5.4 Architectural / engineering designs and supervision of construction / rehabilitation works and equipment of facilities will be undertaken by consulting firms. A control firm will also be necessary to undertake the CHR and CMA works. The Ministry of Health has no model plan but has model architectural plans for CMA and CSPS. Concerning CHR, the MOH must confirm their

architectural plans to the consulting firms recruited. The sketches will be discussed with the Burkinabe party at the national and regional levels before transmission to the ADF for approval.

4.5.5 The project will provide the 2 CHR and their interface structures, 2 CMA at Bittou and Pouytengan, the 4 screening centres and 31 normalized CSPS with: (i) furniture and biomedical and non-biomedical equipment, office automation and computer equipment, (ii) vehicles to strengthen referrals between health echelons and levels (six ambulances for 2 CHR and 2 CMA, 2 pick-ups for the CHR, 31 motorcycles and 31 motorcycle ambulances adapted to the tracks for normalized CSPS). An initial allocation of office supplies and consumables will be procured for the health units, interface structures and screening centres targeted by the project.

Preventive and curative maintenance

4.5.6 To improve the maintenance system, the project will finance the construction of a SIEM in the Centre-East (Tenkodogo) which will be attached to the CHR, the rehabilitation of that of the North (Ouahigouya), and training in the domain. The furniture, office automation and computer equipment, two consignments of spare parts and 2 pick-up vehicles will be supplied to the 2 SIEM in order to strengthen their maintenance and supervision activities in the districts. An initial allocation of office supplies and consumables will be procured for the 2 SIEM. The DGIEM will conduct local training of 350 users in the health units (CSPS, CMA and CHR) of the project. Three campaigns to sensitize the population to preventive maintenance will be organized every two years in the health units covered by the project, by technicians of the DGIEM, through audio-visual means and meetings. The sensitization campaigns for men as well as women on hygiene and sanitation will be organized every two years in the health units of the project areas by technicians of the DHPES through audiovisual means and meetings.

Establishment of operational mutuals

4.5.7 For the successful establishment and organization of mutuals the following activities will be implemented: preparation of legal documents, sensitization of the population, setting up of committees and training them, providing management aids, and allocation of resources for the start-up of activities and operation. The services of a consultant (3 staff /months) for the feasibility study and drafting of the statute for the setting up of health mutuals in the two health regions will be financed by the project. This study which will be based on the conclusions and recommendations of the PRSS study on health financing alternatives will enable the determination of available health care supply, the population's financial capacities, the amount of contributions, the payment and reimbursement modalities, etc. The creation of a structure will be decided by the population taking into account their dynamism and commitment, as well as the form the structure will take. Sensitization campaigns to facilitate the population's support will be organized by the DRS and DS, and pursued by managers of the health mutuals. The project will help in the selection and local training of 80 mutual managers by the DRS and DEP. The DRS and DEP will set up and monitor the mutuals and also provide corrective measures concerning management.

Support to traditional medicine

4.5.8 In a bid to foster a healthier environment for the practice of traditional medicine and the production of drugs from plants, the project will support the implementation of the Government's national policy thereon in the two regions through the construction of 2 integrated interface structures in the CHR of Ouahigouya and Tenkodogo, the creation of 9 botanic gardens in the 9 health districts and the provision of two units for the production of drugs from medicinal plants,

comprising an air flow dryer, and a crusher/mixer. The project will finance the training of 6 physicians in the practice of traditional medicine in the two interface centres and 9 district pharmacies in the supervision of traditional medicine activities and drug production.

4.5.9 Supervision and monitoring will be carried out by the DRS for the setting up of associations of traditional doctors and the organization of traditional medicine and pharmacopoeia. Local training will be financed for 600 traditional doctors (at least 1/3 female) to acquire modern nosography (disease classification) techniques, methods of diagnosis, good practices in harvesting, drying, preservation of medicinal plants, production, standardization and labelling of drugs from the traditional pharmacopoeia. This training will be provided locally and by officials of the DRS backed by the DMPT.

Component II: Disease control

4.5.10 This component concerns all care echelons in the two health regions of the project and is designed to strengthen the control of communicable and non-communicable diseases, and the in-service training of health personnel for improved attendance of health units. The activities concern allocation of specific biomedical equipment / materiel for cancer, drugs and consumables designed for normalized and reconstructed CSPS, CMA and CHR, in-service training of medical and paramedical personnel, sensitization of the population, and support to national disease control programmes. The Government must make a commitment to recruit and post all supplementary personnel to strengthen the two CHR and normalized health units to ensure the implementation of the training programmes.

4.5.11 Under prevention, the project will provide specific equipment / materiel such as kits for smears, contraceptives, reagent kits for screening to CMA, CHR and CHU and insecticide treated nets in the project area. These nets will be distributed at low cost to pregnant women coming for consultation in health units, and to children aged under 5 years who are fully immunized. Concerning curative care, an initial allocation of drugs (including essential generic drugs) will be made to 2 CHR, 2 CMA and 31 normalized CSPS; and the nine district depots of the project area will receive supplementary allocations. The project will contribute to production of drugs, natural vitamin complex-base drugs for school children in the two regions.

4.5.12 Improving the efficiency of health care delivery requires in-service training of personnel. Hence, all health personnel categories (doctors, nurses, midwives, health workers) in the two target health regions will undergo training and retraining throughout the project according to the health district and DRS action plans. Most of this training will be local in districts or DRS; some that are more specific (echography, ophthalmology, stomatology, etc.) will be organized in CHR. The personnel will be trained on disease control programmes (malaria, nutrition, PMTCT and safe motherhood), on HIV/AIDS, hygiene, waste management and preventive maintenance. Community health workers (CHW) will be trained in first aid activities, IEC patient management, hygiene, drug management and cost recovery. Elected COGES members and EGD depot managers will be trained in drug management and cost recovery, hygiene and IEC, environmental management and preventive management and in the utilization of maintenance manuals. All the said training will be provided in a chain: at the central level, ministry officials and directors general will be trained by specialized training firms and MOH officials, health region personnel will be trained by central level trainers who will in turn train district health teams who will train peripheral health unit (CSPS and CMA) personnel and CHWs. Agreements will be signed with all national structures charged with providing local training.

4.5.13 The populations of the two regions, men and women alike, will be sensitized to nutrition, malaria, IMCI, safe motherhood, family planning, cancer, HIV/AIDS and STIs, hygiene, sanitation, environment. Three campaigns will take place in the first, second and third year of the project. Through this component, the project will support (i) national disease control programmes

(for malaria, PMTCT, safe motherhood and cancer) partially financed from the ADF grant through the action plans of HDs, DRS and CHR; (ii) NGOs / Associations implementing IEC activities under national HIV/AIDS and disease control programmes; (iii) the operation over a 4-year period of the HIV/AIDS screening centres partially financed from the ADF grant, and that of the two interface structures for traditional medicine in the two target regions.

Component III: Capacity building

4.5.14 Capacity building, entirely financed from the ADF grant and by the Government consists in supporting the measures that help create conditions conducive to significant change in health sector management and delivery of quality care to the population, which will ensure better attendance of health services. Accordingly, the project will intervene at the central and regional level (Centre-East and North) to build capacity in needs analysis, planning and development of programmes and activities and their supervision. This support will reach all the areas through actions targeting central departments of the MOH, and target health regions through the DRS, DS and CHR. This consists of consultants, training courses, workshops for the validation of policy documents, sensitization of medical personnel and populations, preparation and production of policy documents, guidelines and manuals. At least one-third of candidates will be female for the training courses and study trips. Agreements will be signed with national structures providing local training. The Government must give an undertaking to recruit and post all the supplementary personnel to strengthen the two CHR, normalized health units and the two regional maintenance services, in order to enable the implementation of training programmes.

4.5.15 PNDS monitoring committee: To strengthen the process of implementation of the sector-wide approach and the recommendations of the study on the harmonization of procedures, the project will finance short-term consultants' services for 16 staff/months in order to conduct studies and workshops on sector-wide approach themes; these workshops will be organized at the national and regional levels and will bring together the main officials concerned.

4.5.16 Directorate General for Health (DGS): Concerning the improvement of hygiene and sanitation, training will be provided over a 3-year period outside Africa, to 2 officers in water, sanitation, epidemiology and prevention of nosocomial infections; and in the West African sub-region over a three-year period, 60 senior health engineering technicians. The project will finance the training of 60 trainers in disease control programmes by the DLM (IMCI, RH/FP, PMTCT), and 18 doctors on dispensing of ARVT, by the DGHSP. Local training of 160 technicians in hospital hygiene and management of hospital waste and 20 trainers in care waste management will be provided by the PHPES. To foster cancer prevention, the project will produce and disseminate at the national level, 1500 posters on cancer for health units, 350 manuals in CMA and 120 for CHR on cancer prevention. 2 (two) study trips will be organized on hygiene and sanitation at the national level in the regions of the country having this experience; the persons targeted are officials of the DRS and HDs. 1 (one) vehicle will be procured for the DGS to ensure the supervision of activities in the health regions.

4.5.17 Department of Studies and Planning (DEP): Regarding the improved management of 2nd and 3rd level health structures, support will be provided for the formulation, production and dissemination of 360 outlines and guidelines on the preparation of action plans of CHU and CHR. To ensure mastery of the creation of alternative health financing structures, the services of a consultant (2 staff/months) will be needed for the formulation of a master plan on health mutuals. About fifteen workshops will be organized on the theme of alternative forms of financing and run by DRS officials and with the support of a consultant. Three sensitization campaigns will be organized for the population on alternative forms of health financing at the national level every two years by district health teams and the DEP through the audio-visual media and meetings. 2 (two)

study trips will be organized on the structure of alternative forms of health financing at the national level in regions with this experience, for officials of the DEP, DRS and district health teams and associations charged with putting in place this type of structures. 1 (one) vehicle for the DEP will be necessary for the supervision of activities concerning the setting up of mutuals.

4.5.18 Directorate General for the Supervision of Hospitals and the Private Health Sub-sector (DGHSP): As concerns support to hospital reform, the services of 3 (three) consultants will be financed for: (i) the creation of a legal, statistical and financial data bank (1 staff/month); (ii) the establishment of a chart of accounts for public hospitals (2 staff/months); (iii) the institution of a national tariff plan (1 staff/month). Computer and office automation equipment and 1 (one) vehicle will be procured for the DGHSP to enable it to implement its hospital supervision activities.

4.5.19 Directorate General for Pharmacy, Drugs and Laboratories: Three departments will receive support to perform their tasks, namely: the department of laboratories (DL), the department of pharmacy and drugs (DPM), the department of the promotion of medicine and the traditional pharmacopoeia (DMPT). Concerning the DL, in order to improve the situation of regulations and the organization of the biomedical analysis laboratory, the project will support the development of norms and standards. 4 (four) short-term consultants will be recruited for: (i) the preparation of a policy paper on the laboratory sector and the instruments governing the exercise of the bio-medical profession and distribution of laboratory reagents and consumables (2 staff/months); (ii) the study and establishment of a laboratory network (3 staff/months); (iii) the study and establishment of a laboratory quality insurance system (2 staff/months) and (iv) the study of a national laboratories map, and a tariffs framework (2 staff/months). 300 (three hundred) laboratory sector policy documents, regulations and computer and office automation equipment will be procured by the DL for distribution nationwide.

4.5.20 The strengthening of the DPM consists in improving regulatory texts by acquiring the services of three short-term experts for: (i) the study on the improvement of the regulatory framework (2 staff/months), (ii) a study of the location map of pharmacies throughout the territory (2 staff/months); (iii) setting up of a system for monitoring drug imports (2 staff/months). Two pharmacists will be trained in the West African region in public health; and four outside Africa, of whom two in pharmaceutical legislation and two in quality assurance. The training period will be 2 to 3 years. As part of the fight against illicit drugs, the media will be used to support three campaigns to sensitize the populations to illicit drugs, to be organized every two years throughout the territory by the DPM, using audio-visual media and meetings. The project will provide computer and office automation equipment to enable the DPM to implement its administrative activities efficiently.

4.5.21 Concerning the promotion of traditional medicine and pharmacopoeia, a consultant will be recruited for the development of training modules in nosology for a period of 2 months. 2 (two) study trips will be organized on traditional medicine at the national level in regions experienced in this, for the district health teams, DRS, DMPT and associations. Three campaigns to sensitize the populations on traditional medicine at the national level will be organized every two years by the district health team and the DMPT, through audiovisual means and meetings. The project will supply computer and office automation equipment and 1 (one) 4x4 vehicle for the DMPT, and will finance the costs of supervising training activities, associations of traditional doctors, interface structure and the drug production units by the DMPT.

4.5.22 Directorate General for Infrastructure, Equipment and Maintenance (DGIEM): To establish and develop the knowledge and practices necessary for the maintenance and servicing of health facilities and equipment, the following activities will be financed: (i) the services of 2 experts for the study on national policy and the equipment and maintenance strategy (2

staff/months) and the study's report-back workshop. The preparation of 3 preventive and curative maintenance manuals for health units (CHR, CMA and CSPS) in 3 staff/months; (ii) the training abroad for 13 staff/months of 3 engineers and 22 senior technicians in preventive and curative biomedical maintenance; (iii) the training in specialized centres / institutes at the local level of 15 maintenance technicians (masonry, mechanics, electricity, plumbing, carpentry, etc.), and 12 short-term technicians for the DGIEM and SIEM, of 55 users (1 per district) for the DRS. One consignment of specific spare parts and 3700 manuals will be supplied to the DGIEM, as well as 1 (one) vehicle designed for supervision of maintenance activities.

4.5.23 Centre-East and North health regions: The utilization of the new health facilities with a well performing technical support centre requires qualified personnel. To that end, the project will finance medium and long term training at the local level or in the West African region. Candidates for this training will sign with the Ministry of Health, a notarial deed pledging to work in public health services of the project area for at least 5 years when they return. These specialists intended for 2 CHR and 9 CMA of target regions will be trained in universities/institutes of West Africa: 11 medical specialists for 4 years (2 radiology, 2 ENT, 1 internal medicine, 1 anaesthesia-resuscitation, 1 biology, 1 functional rehabilitation, 1 epidemiology and 2 public health); 20 doctors in health services management comprising a training of trainers aspect (9 months); 9 doctors in district management (2 years); 34 laboratory and radiology technicians and 9 pharmaceutical assistants (2 years). At the local level, 4 medical specialists will be trained in 4 years (1 surgery, 1 gynaecology-obstetrics, 2 pediatrics) at the faculty of health sciences in Ouagadougou; and 18 doctors will be trained over a 6-month period, in the Ouagadougou CHU in essential surgery for the 2 CHR and 9 CMA of the project area. Training courses of medium duration on water / sanitation (4 persons) and research / action (13 persons), will be provided in Ouagadougou respectively at the CREPA and at the CIRFA. Specialized training centres will be identified locally for the following 3 to 9 months training courses: 2 doctors in epidemiological surveillance, 4 technicians in computer maintenance, 4 health service management controllers, 6 members of district health teams in health services management and 4 officers in human resource management.

4.5.24 The following activities will be supported by the project: (i) local training of 100 members of district health teams in district management, 100 advisers (at least 1/3 female) for the 4 HIV screening centres by the CNLS, (ii) operational research of CHR, DRS and HD, (iii) formulation of annual plans of HDs, (iv) meeting and supervision activities of DRS and HDs, and (v) district health councils and biennial councils of partners of the region.

Component IV: Project management

4.5.25 This last component will cover human and material resources and the operating expenses of the project management unit (PMU). The furniture, computer and office automation equipment necessary for the proper running of the PMU will be procured. Vehicles will comprise 3 (three) all-terrain vehicles indispensable for the supervision of activities in the two regions; this type of vehicle is adapted to great distances and impassable tracks in the project's target areas. These equipment and material are necessary as those of the PRSS will be fully amortized by 2006.

4.5.26 Consultancies will be financed for: the adjustment and updating of the computerized system of accounting and financial management of the PRSS, annual audits of project accounts, the procurement expert of the PMU. Other short-term consultancies will be required for the following activities: the preparation of a project implementation manual, the drawing up of lists and technical specifications of biomedical equipment, monitoring / evaluation, project completion report, mid-term review, etc.

4.5.27 The project will finance: the operating cost of the PMU (electricity, mail, telephone/fax, publication of bidding documents); the expenses of supervision/monitoring missions of the PMU and central departments to project sites; PMU missions to the Bank; allowances of PMU officials. The counterpart funds will finance the remuneration of support staff and the administrative and logistics assistant, PMU office supplies and consumables, maintenance of office equipment and materiel of the PMU office, expenses on vehicles (fuel, lubricants, insurance, maintenance). Appropriate and sufficient offices will be provided to the PMU by the Government and the works and rental expenses will be covered by counterpart funds.

4.6 Environmental impact

4.6.1 Considering the construction works envisaged, the project is classified under environmental category II. Potential adverse environmental impacts will be mitigated through the application of the necessary measures to be included in the bidding documents and the establishment of an appropriate system of environmental monitoring by the health personnel and the district health team backed by the decentralized services of the Ministry of the Environment and Water. COGES members will be sensitized to environmental rules (tree planting, liquid/solid waste management and treatment, management of toilets), in order to ensure monitoring.

4.6.2 The engineering and architectural designs will also conform to the environmental protection rules in the area of sanitation and treatment of medical liquid and solid wastes. Technical measures will be taken to avoid problems of erosion, gullying and stagnation of rain water and will be included in bidding documents. A specific lay-out of project sites will be envisaged with the personnel of health units and the sites will be restored in order not to disturb and affect care activities and patients. The technical consulting firm in collaboration with the PMU will monitor the implementation by contractors of the corrective measures envisaged in the bidding documents. Quarterly activity reports of the Project Management Unit and supervision reports will include environmental monitoring information.

4.6.3 Certain environmental benefits are expected from the implementation of the project, namely: the site development which will help improve the population’s hygiene conditions; the taking into account of environmental hygiene concerns in training and retraining programmes for CHWs and health committee members. Furthermore, IEC activities undertaken by CHUs will include hygiene and environmental aspects. Training/ sensitization on health and the control of predominant endemic diseases will enable rural populations to protect the environment and create viable settlement areas. Annex 6 summarizes the socio-environmental arrangements of the project.

4.7 Project costs

4.7.1 Total project cost before taxes and customs duties is estimated at UA 28 million, including contingencies and price increases. The taxes which amount to UA 5.04 million will be paid by the governments. The amount was obtained by applying an average of 18% tax on the total project cost. The cost will be financed for up to UA 19.22 million in foreign exchange and UA 8.78 million in local currency including an average provision of 8% for contingencies, an annual inflation rate of 2.6% for foreign exchange and local currency. The cost estimate was made during preparation and appraisal missions on the basis of information gathered from the Ministry of Health, that of Finance and the Budget and consulting firms and the Department of Public Contracts. The detailed costs of the project are described in Annex 7, while Tables 4.1 and 4.2 below respectively summarize the breakdown of project costs by component and by category of expenditure.

Table 4.1: Summary of estimated project costs by component

COMPONENTS	Million CFAF			Million UA			% F.E.
	Foreign exchange	L.C.	Total	F.E.	L.C.	Total	
1. Improved access to quality health care	8 897.25	2 012.93	10 910.18	11.63	2.63	14.26	81.55%
2. Disease control	1 716.63	1 585.80	3 302.43	2.24	2.08	4.32	51.98%
3. Capacity building	1 850.48	1 514.64	3 365.12	2.42	1.98	4.40	54.99%
4. Project management	407.70	765.55	1 173.25	0.53	1.00	1.53	34.75%
Total basic cost	12 87.06	5 878.92	18 750.98	16.82	7.69	24.51	68.64%
Contingencies 8%	1 029.76	470.31	1 500.07	1.35	0.61	1.96	
Price escalation	803.73	367.08	1 170.81	1.05	0.48	1.53	
Total project cost	14 705.55	6 716.31	21 421.86	19.22	8.78	28.00	68.64%

Table 4.2: Summary of estimated project cost by category of expenditure

CATEGORIES OF EXPENDITURE	Million CFAF			Million UA			% F.E.
	Foreign exchange	L.C.	Total	F.E.	L.C.	Total	
Goods	4 432.13	233.27	4 665.40	5.79	0.31	6.10	95.00%
Works	5 203.79	1 300.95	6 504.74	6.80	1.70	8.50	80.00%
Services	2 852.38	890.90	3 743.28	3.73	1.16	4.89	76.20%
Operation	383.76	3 453.80	3 837.56	0.50	4.52	5.02	10.00%
Total basic cost	12 872.06	5 878.92	18 750.98	16.82	7.69	24.51	68.64%
Contingencies 8%	1 029.76	470.31	1 500.07	1.35	0.61	1.96	
Price escalation	803.73	367.08	1 170.81	1.05	0.48	1.53	
Total project cost	14 705.55	6 716.31	21 421.86	19.22	8.78	28.00	68.64%

4.8 Financing sources and expenditure schedule

4.8.1 The project will be jointly financed from an ADF loan and grant, and by the Burkinabe Government. The ADF contribution is a UA 19 million loan and a UA 6 million grant representing respectively 67.86% and 21.43% of total project cost. The national counterpart funds amount to UA 3.00 million, that is 10.71% of total project cost, representing 11.71% of the amount of activities financed from the loan and by the government, and 7.41% of the amount of activities financed from the grant and by the government. The project costs by financing source, by component and by category of expenditure are shown in Tables 4.3, 4.4 and 4.5 below, and the list of goods and services is shown in Annex 8.

Table 4.3: Summary of estimated project cost by financing source
(in million UA)

SOURCES	FOREIGN EXCHANGE	LOCAL CURRENCY	TOTAL	%
ADF (Loan)	15.98	3.02	19.00	67.86%
ADF (Grant)	3.24	2.76	6.00	21.43%
GOVERNMENT	0.00	3.00	3.00	10.71%
TOTAL	19.22	8.78	28.00	100.00%
PERCENTAGE	68.64%	31.36%	100.00%	

Table 4.4: Project cost by financing source and by component
(in million UA)

COMPONENT	ADF (loan)			ADF (grant)			GOVT	TOTAL			% Comp
	F.E.	L.C.	Total	F.E.	L.C.	Total	L.C.	F.E.	L.C.	Total	
1. Improved access to quality health care	13.28	1.14	14.42	0.00	0.00	0.00	1.87	13.28	3.01	16.29	58.18%
2. Disease control	2.05	1.41	3.45	0.56	0.52	1.08	0.40	2.61	2.33	4.94	17.61%
3. Capacity building	0.00	0.00	0.00	2.68	2.24	4.92	0.10	2.68	2.34	5.02	17.95%
4.Project management	0.65	0.47	1.12	0.00	0.00	0.00	0.63	0.65	1.10	1.75	6.26%
Total project cost	15.98	3.02	19.00	3.24	2.76	6.00	3.00	19.22	8.78	28.00	100.00%

Table 4.5: Project cost by financing source and by category of expenditure
(in million UA)

CATEGORIES	ADF (loan)			ADF (grant)			GOVT	TOTAL			% Categ.
	F.E.	L.C.	Total	F.E.	L.C.	Total	L.C.	F.E.	L.C.	Total	
Goods	6.51	0.05	6.56	0.10	0.01	0.11	0.30	6.61	0.36	6.97	24.88%
Works	7.77	0.14	7.91	0.00	0.00	0.00	1.80	7.77	1.94	9.71	34.69%
Services	1.33	0.42	1.75	2.93	0.91	3.84	0.00	4.26	1.33	5.59	19.96%
Operation	0.37	2.41	2.78	0.21	1.84	2.05	0.90	0.58	5.15	5.73	20.47%
Total project cost	15.98	3.02	19.00	3.24	2.76	6.00	3.00	19.22	8.78	28.00	100.00%

4.8.2 ADF resources cover 100% of costs in foreign exchange and 65.83% of costs in local currency. The loan will finance all categories of expenditure of components 1, 2 and 4. The grant will finance component 3 and part of the national disease control programmes, and the operation of component 2 screening centres. The Government's counterpart funds of UA 3 million will cover 34.17% of costs in local currency and will finance part of the works, equipment (vehicles) and operation (salaries of support staff, rents, operating costs/ maintenance of PMU, 25% of mission expenses of component 4, 25% of national disease control programmes, 30% of operation of screening centres and 25% of operation of interface structures in the CHR). The expenditure schedule by component, by category and by financing source is respectively shown in Tables 4.6, 4.7 and 4.8 below

Table 4.6: Schedule of expenditure by component
(in million UA)

COMPOSANTES	2006	2007	2008	2009	2010	Total
1. Improved access to quality health care	0.79	3.83	4.86	4.86	1.95	16.29
2. Disease control	0.24	1.16	1.48	1.47	0.59	4.94
3. Capacity building	0.25	1.18	1.50	1.50	0.59	5.02
4. Project management	0.09	0.41	0.52	0.52	0.21	1.75
Total project cost	1.37	6.58	8.36	8.35	3.34	28.00

Table 4.7: Schedule of expenditure by category
(in million UA)

CATEGORIES OF EXPENDITURE	2006	2007	2008	2009	2010	Total
Goods	0.15	0.71	2.28	2.75	1.08	6.97
Works	0.00	3.40	3.40	2.91	0.00	9.71
Services	0.30	1.41	1.46	1.31	1.11	5.59
Operation	0.92	1.06	1.22	1.38	1.15	5.73
Total project cost	1.37	6.58	8.36	8.35	3.34	28.00

Table 4.8: Schedule of expenses by financing source
(in million UA)

SOURCES	2006	2007	2008	2009	2010	Total
ADF (Loan)	0.93	4.46	5.67	5.67	2.27	19.00
ADF (Grant)	0.29	1.42	1.79	1.79	0.71	6.00
GOVERNMENT	0.15	0.70	0.90	0.89	0.36	3.00
TOTAL	1.37	6.58	8.36	8.35	3.34	28.00

5. PROJECT IMPLEMENTATION

5.1 Executing agency

5.1.1 For the management of this project, it is proposed that the senior staff of the PRSS unit be maintained as follows : the coordinator, the architect, the public health doctor/training expert and the accountant. The performance of the coordination unit of the health services strengthening project (PRSS) which is being implemented in the Bobo – Dioulasso region is deemed satisfactory by the Government and the Bank. The current senior staff will be strengthened with a procurement expert, an administrative and logistics assistant and support staff comprising a secretary, three drivers, two guards and a messenger. New recruitments will be made following the procedures described in chapter 5.4. The Project Management Unit (PMU) composed of this entire staff, will implement this project; it will be located at Ouagadougou and placed under the authority of the Secretary – General of the Ministry of Health (MOH) to which the PNDS monitoring committee is attached. All the PMU personnel will be under contract and their performances will be evaluated every year before the renewal of their contracts which will include evaluation criteria. The contract and the results of the coordinator's annual evaluation will be transmitted to the Bank. The Government must provide evidence of the maintenance in Ouagadougou of the unit and the officials of the PRSS coordination unit and its undertaking to recruit the procurement expert, as a condition for first disbursement.

5.1.2 The main activities of the PMU are: i) planning, coordinating and supervising project implementation, (ii) coordinating with all stakeholders involved in the implementation of the project; (iii) drawing up a schedule of procurements and controlling contract awards; (iv) administrative and financial management of the project; (v) preparing and following up the detailed programme of training; (vi) preparing and transmitting to the ADF through the Ministry of the Economy and the Budget disbursement requests; (vii) coordinating monitoring, mid-term review and audit activities, and; (viii) drawing up and transmitting to the ADF quarterly and annual activity reports and the completion report; (ix) liaising with the African Development Fund and the Government. The furnishing of a schedule of procurements and of a detailed programme of training courses will be conditions to be fulfilled at project start-up. The PMU will see to the establishment of close collaboration with the different partners of the project, and to regular consultation of beneficiaries and grassroots associations. At the start-up of this project, the PRSS coordination unit officials will manage the activities of the new project along with the remaining activities of the PRSS; which will be possible, given that the construction, equipment and training activities of the PRSS will be completed at the beginning of 2006.

5.1.3 In order to facilitate the implementation of specific activities of the project, a procedures manual will be prepared at project start-up by an individual consultant. The manual will specify the terms of reference of all officials and support staff of the PMU, the tasks of the departments involved in the project, relations between the project stakeholders, and all the arrangements

necessary for the PMU to manage and follow up the project. Annex 9 of this report shows the table of contents and the documents to be appended to it.

5.2 Institutional arrangements

5.2.1 For the implementation of the PNDS, a monitoring committee was put in place in May 2003, chaired by the Secretary-General of the Ministry of Health (MOH); it comprised representatives of the MOH, related Ministries and health development partners. The new health development support programme (PADS) for the 2005-2008 period, financed by the Netherlands, Sweden and the World Bank, has put in place two organs for the implementation and monitoring of activities, namely: the Management Unit and the Management Committee. This Management Committee chaired by the Secretary-General meets two times a year, coordinates between the PNDS Monitoring committee, PADS and any other intervention in the sector. Accordingly, in order to facilitate the task of the PNDS monitoring committee, the PADS Management Committee will coordinate the activities of this project. The main departments of the Ministry of Health, the Ministry of Finance and the Budget and the lead donor of the health sector will be represented in the said committee. The Management Committee will ensure that the activities are implemented according to the objectives set in the project document, it will adopt annual activity programmes, quarterly and annual activity reports as well as audit reports and will report progress of this project to the PNDS monitoring committee. It will also be responsible for approving future orientations of the project during the mid-term review. The Government must provide evidence that the PADS Management Committee is also designated as the Monitoring agency of this project.

5.2.2 The project implementation strategy envisages the implementation of training activities by specialized training and institutes and firms, sensitization activities by NGO/ Associations, studies by consulting firms and individual consultants. Contractors and suppliers will be needed for the implementation of works and the delivery of project furniture and equipment. By reason of the different domains covered by the project and considering their usual missions, several departments of the ministry of health will be involved in the implementation and monitoring of training and of works, viz: the Department of studies and planning of the ministry of health, for monitoring the sector-wide approach and mutuals; the Directorate general for infrastructure, equipment and maintenance (works, equipment of health units and training in maintenance for personnel and users); the Directorate general in charge of health for health activities; the Directorate general for public hygiene and education for health of the Ministry of health, for hygiene training; the Directorate general for pharmacy, drugs and laboratories of the ministry of health, for support to this sector; the Department of the environment and water for monitoring works concerning environmental protection measures. The PMU's main role is to manage and coordinate the implementation of project activities by all stakeholders.

5.2.3 The sector-wide approach recommended by the Government and development partners will permit a better utilization and pooling of internal and external resources. Depending on the evolution of the process of the sector-wide approach and the harmonization of PNDS management procedures, the present modalities for the implementation of this project will be discussed during the mid-term review; they may be amended in order to be consistent with the common framework which will be put in place subsequently, following discussions between the government and all donors. The organization chart of the project is shown in Annex 10.

5.3 Implementation and supervision schedules

5.3.1 The project will start at the beginning of 2006, after loan effectiveness and the fulfilment of conditions precedent to the first disbursement and will be implemented over a 5 (five) year period. The implementation and supervision schedules of activities are summarized in Tables 5.1 and 5.2 below and the details are given in Annex 11.

Table 5.1: Schedule of activities

Activities	Dates	Responsibility
Loan effectiveness	December 2005	MOH/ADF
Project launch / Project start-up	January 2006	PMU/ADF/partners
Recruitment of consultant and preparation of procedure manual	January -March 2006	PMU/Consultant
Recruitment of consulting firm / preparation of competitive bidding documents	January 2006- March 2009	MOH/PMU/ Consulting firm /ADF
Supervision of works and equipment	January 2007 – July 2010	Consulting firm /PMU
Training/retraining	September 2006 – July 2010	PMU/MOH/Institutes/Training centres
Services of consultants for studies and institutional support	January 2006 – December 2010	PMU/Consultants
Sensitization	January 2007 - July 2010	PMU/Consultants/NGOs/MOH
Mutuals	January 2007 – November 2010	PMU/DRS
Construction works/Rehabilitation works	January 2007 – July 2009	Contractors/PMU/BF
Preparation of competitive bidding documents for furniture, equipment procurement	January 2006–March 2009	PMU/consultant/ADF
Delivery/installation of furniture and equipment	July 2006–September 2009	Suppliers/PMU
Contract award and delivery of drugs and consumables	January 2007–September 2009	Suppliers/PMU/CAMEG/ADF
Operation/supervision	January 2006 - December 2010	PMU/Government
Audit	February 2007 – February 2011	PMU/Audit firms
Mid-term review	July 2008	MOH/PMU/ADF
Project completion report of the Government	April 2011	PMU/Government
Project completion mission of the Bank	July 2011	ADF

Table 5.2: Schedule of supervision of activities

Period	Activity	Required qualifications	Structures
First quarter 2006	Project launch	Project, disbursement, procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
3rd quarter 2006	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
2nd quarter 2007	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
4th quarter 2007	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
2nd quarter 2008	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
4th quarter 2008	Mid-term review	Project, disbursement, procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
2nd quarter 2009	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
4th quarter 2009	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
2nd quarter 2010	Supervision	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries
4th quarter 2010	Completion	Project and procurement officers	ADF, Government, PMU, COGES, Associations/NGOs, Beneficiaries

5.4 Procurement arrangements

5.4.1 Procurement arrangements for goods, works and services are summarized in Table 5.3 below. Any procurement financed by the Bank will be conducted according to its rules of procedure for the procurement of goods and works or, where applicable, for the utilization of consultancy services, using the appropriate standard bidding documents of the Bank.

Table 5.3: Procurement Arrangements (in million UA)

Categories of expenditure	I.C.B.	N.C.B.	Others*	Shortlisting	Total
A. GOODS					**6.97** [6.67]
- Biomedical furniture and equipment	3.00 [3.00]				3.00
- Non-medical furniture		1.06 [1.06]			1.06
- Computer and office automation equipment, miscellaneous equipment		1.68 [1.55]			1.68
- Vehicles (CHR, CMA and CSPS)		0.39 [0.39]			0.39
- 4x4 vehicles and pick-ups (MOH departments, PMU)		0.17			0.17
- PMU furniture and equipment			0.13(a) [0.13]		0.13
- Maintenance manuals, regulatory instruments, miscellaneous			0.05(a) [0.05]		0.05
- Drugs/Consumables			0.49(b) [0.49]		0.49
B. WORKS					**9.71** [7.91]
- Construction of 2 CHR and 2 CMA	6.81 [5.61]				6.81
- Normalization of 31 CSPS, 2 SIEM and 4 screening centres		2.90 [2.30]			2.90
C. SERVICES					**5.59** [5.59]
- Studies/supervision of works, Bio. Eng. and procurement expert				0.78 [0.78]	0.78
- Audit and accounting system				0.07 [0.07]	0.07
- Various studies (consultants)				0.21(c) [0.21]	0.21
- Consultants for PMU				0.22(c) [0.22]	0.22
- Training abroad (outside Africa)				0.52(d) [0.52]	0.52
- Training abroad (West African region)				1.66(d) [1.66]	1.66
- Local training (Ouagadougou)			0.34(e) [0.34]		0.34
- Local training (Ouagadougou)				0.58(c) [0.58]	0.58
- Sensitization				1.21(c) [1.21]	1.21
D. OPERATION					**5.73** [4.83]
- Retraining/in-service training /workshops for health personnel			1.36(e) [1.36]		1.36
- Logistics and administrative assistant and support personnel			0.11(f)		0.11
- Allowances of PMU officers : Coordinator, architect, doctor, accountant			0.32 (g) [0.32]		0.32
- Office supplies and consumables			0.07(a)		0.07
- Rental and miscellaneous maintenance for PMU (office, equipment, material)			0.19(a)		0.19
- Telephone, mail, electricity			0.09 [0.09]		0.09
- Supervision expenses (disease control, mutual groups, traditional doctors in DS/CMA/CHR, missions, miscellaneous, etc.).			3.59(h) [3.06]		3.59
TOTAL	9.81 [8.61]	6.20 [5.30]	6.74 [5.84]	5.25 [5.25]	28.00 [25.00]

- *Shortlisting applies to the use of consultants' services only.*
- *"Other" :refers to local shopping, private agreement.*

(a) *Local shopping*
(b) *Drugs to be procured directly by CAMEG*
(c) *Short list to be drawn up following notices published in local or regional newspapers*
(d) *Shopping for specialized training institutions in West Africa and outside Africa*
(e) *Private agreement with the Ouagadougou Faculty of Medicine, CREPA and CIFRA specialities*
(e) Private agreement with central and regional departments and DHMTs of the MOH
(f) *Recruitment according to country procedures*
(g) *Reinstatement of 4 PMU officers*
(h) *Directly to MOH personnel: travel expenses, per diem*

[ ] *The figures in brackets are the amounts financed by the ADF.*

5.4.2 The PMU will be responsible for the award of contracts and a procurement expert will be recruited to strengthen it. National procurement laws and regulations in Burkina Faso have been examined and deemed acceptable. The procurements will be conducted according to the modalities described in the paragraphs below.

GOODS

5.4.3 Contracts for the supply of biomedical furniture and equipment for the 2CHR, 2CMA, 31 CSPS and 4 screening centres, evaluated at UA 3 million will be awarded in accordance with the international competitive bidding procedures. Non-medical furniture for an amount of UA 1.06 million, computer/office automation/ miscellaneous equipment and insecticide treated nets for an amount of UA 1.68 million and vehicles for an amount of UA 0.56 million shall be procured through national competitive bidding. Contracts for the supply of PMU furniture and equipment for an amount of UA 1.3 million, the publication of preventive and curative manuals, posters on cancer management, and street medicines, regulatory instruments, sensitization material, evaluated at UA 0.05 million, will be awarded according to local shopping procedures. There are enough local suppliers to ensure competition and the amounts involved are too low to attract external bidders.

5.4.4 Drugs as well as medical consumables evaluated at UA 0.49 million will be procured through international competitive bidding. The essential generic drugs central buying office (CAMEG) of Burkina Faso will play the role of procurement agent and will not be remunerated by the project. CAMEG which is the structure authorized to supply public health units in Burkina Faso is an autonomous structure and observes international competitive bidding procedures acceptable to the Bank and guaranteeing the best value for money.

WORKS

5.4.5 Civil works concerning the construction of the Ouahigouya and Tenkodogo CHR, 2 CMA in the Centre – East, evaluated at UA 6.81 million will be procured according to international competitive bidding procedures in three lots that cannot be handled by one contractor concurrently. The procurement of works for the construction/rehabilitation and normalization of 31 CSPS, the rehabilitation of the Ouahigouya SIEM and construction of that of Tenkodogo, the construction of four screening centres (1 in the Centre-East and 3 in the North) and the rehabilitation of the EPI regional depot in the North, evaluated at UA 2.9 million will be procured through national competitive bidding in 31 (thirty-one) lots, of which no more than three may be concurrent. These works to be executed in 7 health districts are small scale, (each contract is estimated at an average of approximately UA 62735). The dispersal of the sites and the low cost of works may attract very little interest from international contractors. Furthermore, at the national level, there are enough competent contractors to guarantee competition.

SERVICES

5.4.6 Services of specialists. The services of consulting firms in four lots (1 for each CHR, 1 for each region), for architectural and engineering designs, supervision of health unit construction/ rehabilitation works, and the control firm estimated at UA 0.69 million, the procurement expert at the PMU and the biomedical engineer (UA 0.09 million) will be procured through shortlisting and the selection procedure based on the analysis of technical bids with price consideration. The services of audit and accounting firms for the computerized administrative, accounting and financial management (UA 0.07 million) will be engaged through shortlisting. The services of individual consultants for specific tasks (various studies for the MOH, drafting of policy documents, the sector-wide approach, etc is estimated at UA 0.21 million) and the consultants for the PMU (procedures manual of the project, monitoring /evaluation, completion etc), evaluated at

UA 0.22 million will be procured through shortlisting and selected on the lowest-bidder basis. The short lists will be drawn up following notices for expression of interest to be published in local or regional newspapers. However, an eligible consultant whether regional or not may express his interest in being shortlisted.

5.4.7 *Training* : Shopping for training institutes and / or centres abroad (outside Africa) for the training of pharmacists (quality assurance, drug legislation), maintenance officers and technicians, health engineering officers, estimated at UA 0.52 million. Shopping for specialized training institutes and centres in West Africa for the training of medical specialists (ENT, internal medicine, radiology, biology, anaesthesia, functional rehabilitation, epidemiology, public health), pharmacists (public health), doctors (health service management and district management), senior health engineering technicians, laboratory and radiology technicians, pharmaceutical assistants, estimated at UA 1.66 million. Long-term training of medical specialists (pediatrics, surgery, gynaecology- obstetrics) of an amount of UA 0.24 million will be conducted at the faculty of health sciences in Ouagadougou; medium-term training on water/ sanitation and in action research estimated at UA 0.10 million will be done in Ouagadougou respectively at CREPA and at CIFRA: these specialities exist in the faculties and institutes in Burkina Faso.

5.4.8 *Training* : Shopping for specialized training institutes and centres for the following courses : doctors (epidemiological surveillance), officers (control of health services management ; human resource management, health services management), health engineering and maintenance technicians, district maintenance users, computer maintenance technicians estimated at UA 0.58 million, based on short lists drawn up following a notice at the national or regional level; each training course not exceeding UA 350 000. Sensitization campaigns for health personnel and the population (national disease control programmes, HIV/AIDS, hygiene and sanitation, mutuals, traditional medicine and pharmacopoeia, illicit drugs, etc.), estimated at UA 1.21 million will be conducted by training firms, NGOs and associations on the basis of short lists drawn up following a notice at the national or regional level. The country has enough associations to guarantee competition; each of the training courses not exceeding UA 350 000.

OPERATION

5.4.9 The training of screening centre advisers, sensitization on maintenance of users of Health Districts, CSPC, CMA and CHR, in –service training and health personnel retraining, estimated at UA 1.36 million excluding any workers' salaries, will be conducted by officers of the departments of the ministry of health, these tasks forming part of their usual tasks. The same will apply to workshops on maintenance policy, sector-wide approach, mutualization, also conducted by the central departments of the MOH and comprising travel expenses, per diem, hiring of halls and minor supplies, excluding any worker's salaries.

5.4.10 Support staff and the administrative and logistics assistant, who are local counterpart (UA 0.11 million) staff will be recruited according to the country's procedures. The operating costs also concern allowances, estimated at UA 0.32 million, of the four PMU offices recruited by the government, coordinator, architect, public health doctor/ specialists in training, accountant). Procurements under the project as concerns the maintenance and servicing expenses of equipment, office supplies and consumables, estimated at 0.26 million will be made through national shopping. The rental of the PMU office in Ouagadougou and water expenses will be financed by the government. Agreements will be drawn up between the project management unit and these structures and submitted to the Bank for review. The other expenses concerning supervision missions (per diem and travel) by the PMU and regional departments and central departments estimated at UA 3.68 million will be procured directly and financed from project funds.

General procurement notice

5.4.11 The text of the general procurement notice will be discussed with the Government of Burkina Faso, during negotiations and issued for publication in “Development Business”, once the loan is approved by the Bank’s Board of Directors.

Review procedures

5.4.12 Given that there are many small contracts to be concluded and the need to implement the project at a steady pace, contracts of a maximum amount of UA 30,000 will be awarded by the PMU without prior appraisal by the ADF, as well as individual consultants for a maximum period of two months, who will be recruited directly by the PMU according to Bank rules of procedure. Documents on such contracts, notably competitive bidding and/or shopping documents, contract award reports and contract awards will be kept by the PMU for periodic examination by ADF supervision missions and the annual audit of procurements by a specialized firm. This procedure may be applied, since the PMU has the required capacities and has acquired sufficient experience and expertise in Bank rules and procedures as indicated in paragraph 4.1.6. Furthermore, a procurement expert with a sound knowledge of national procedures and practices and Bank rules of procedure will be recruited at the PMU.

5.4.13 For contracts exceeding UA 30,000, the following documents will be submitted for examination and approval by the ADF prior to publication: (i) all specific procurement notices; (ii) standard prequalification documents (where necessary); (iii) standard bidding documents and invitations to consultants to submit proposals; (iv) reports on analysis of bids from contractors, suppliers and service providers, containing contract award recommendations; (v) draft contracts, if those included in the competitive bidding documents have been modified.

5.5 Disbursement arrangements

5.5.1 The loan and grant funds will be disbursed according to a schedule of expenditure by component and by category as presented in Tables 4.6 and 4.7. All the disbursements will be released according to relevant Bank Group rules and procedures. The disbursement methods adopted are: (i) the special account method; (ii) the direct payment method; and (iii) the repayment method. For the operation of the PMU, the Government will open two special accounts at the BCEAO one to receive the loan funds, and the other to receive grant funds. To facilitate the implementation of day-to-day activities, two sub-accounts will be opened in the name of the project in a commercial bank acceptable to the Fund. These sub-accounts will be provisioned from the special accounts according to needs. Furthermore, the Government will open an account at the Treasury to receive the national counterpart funds for financing the project.

5.5.2 The disbursement for the operation of the PMU will be released on the basis of a 4-month programme of activities, previously approved by the ADF. The funds will be replenished on the same basis, after satisfactory justification of at least 50% of the preceding payment. The request for revolving fund which will be prepared by the project Coordinator will be transmitted to the ADF by the Ministry of Finance and the Budget. Disbursements concerning contracts for works, vehicles, furniture and equipment will be released directly to contractors and suppliers by direct payment. The same method will be used for contracts concerning specialized services, short-term consultants and training under agreements.

5.6 Monitoring and evaluation

5.6.1 To facilitate project impact monitoring and evaluation, a situational analysis will be conducted at project start-up and pursued each year. The PNDS monitoring indicators will be used in relation to the millennium development goals. Data will be collected yearly through surveys by the monitoring/evaluation consultant. All structures involved in project implementation will prepare and transmit to the PMU quarterly and annual activity implementation reports. Launch, supervision, mid-term review and completion missions will be undertaken by the Government party and the Bank. The reports and findings of these missions will be communicated to the management committee so that it can take appropriate steps to resolve the problems identified during project implementation. Furthermore, in the course of project implementation, the coordinator and main officials of the PMU will undertake missions to the Bank to acquaint themselves with Bank procedures for project management. The performance of the PMU Coordinator must be evaluated; the results will be transmitted to the Bank each year and will be used to renew his contract. The installation in 2006 of a national office of the Bank in Burkina Faso will facilitate monitoring of the implementation of project activities.

Activity reports

5.6.2 The project management unit will prepare and submit to the Bank within 30 days of the end of each quarter, quarterly and annual activity reports on the project implementation status according to the Bank format. These reports will be based on the trend of the indicators defined in the project matrix and those of the PNDS, and on the outputs of the different partners, involved in implementing the project. These reports must contain in their annexes, the reports of meetings of the management committee of the project and will be distributed to the management committee. The PMU must also draft and submit to the Bank, a completion report at the end of project implementation, in accordance with Bank standards.

Supervision

5.6.3 The PMU will conduct regular missions to the project area. It will see to the regular collection of statistics and monitoring of project indicators in relation to the logical framework of the project (utilization of the project facilities, reduction of self-referral, increased cost recovery). The choice of indicators at the start, will permit the monitoring of trends at mid-term and end of the project. A workshop will be organized annually bringing together the stakeholders in the field and beneficiaries in order to enable proper monitoring of activities and seek their opinions.

5.6.4 The Bank Group will in collaboration with the Government, conduct a project launch mission, two supervision missions on average per year and a project completion mission; the latter mission will be undertaken after the drafting by the Government of its project completion report. The launch mission will comprise PMU officials, central and decentralized representatives of the ministries involved in the project, COGES members, and development partners. The supervision missions will also involve beneficiaries and structures charged with project implementation. Meetings in the form of workshops will be held in order to foster the participatory approach. The findings of annual studies by the monitoring / evaluation consultants will be used to prepare for supervision meetings.

Mid-term review

5.6.5 In the third year of the project, a mid-term review will be conducted, in the form of a workshop. The findings of the study of the 3rd year by the monitoring / evaluation expert will be used to prepare the mid-term review. The comparative analysis of indicators will be conducted at the review and at the end of the project. During the said review, the progress recorded by the

project will be evaluated, implementation problems and appropriate solutions examined, the project implementation modalities discussed afresh. The review will concern all parties involved in implementing the project, including representatives of beneficiaries, civil society organizations and development partners. The indicators to be considered during the mid-term review are summarized in the table below.

Table 5.4: Monitoring indicators of the mid-term review

Activities	Intermediate indicators 2008	Indicators at end of project 2010
Health units	31 CSPS and four HIV screening centres built and equipped CHR and SIEM works 60% implemented	CHR, 2 CMA, 31 CSPS and 4 screening centres are constructed and / or rehabilitated, normalized and equipped.
Disease control	Procurement of furniture, drugs and equipment. The 35 health units and nine district distribution depots are allocated essential generic drugs. Districts are allocated kits for CHWs. 2 sensitization sessions on hygiene in HUs, 80 hygiene workers, Action plans of hospitals and tariffs prepared, The training of 80 trainers is conducted.	Hospitals play their referral role. The action plans of 12 hospitals are prepared, implemented and supervised. 2 officers (water/sanitation), 60 senior technicians, 160 hygiene workers trained, 80 trainers. Sensitization and management of patients in 9 health districts. 3 national campaigns on illicit drugs conducted.
Human Resource capacities	Training of 60 advisers in HIV/AIDS management and of 10 doctors in ARVT, Medical and paramedical personnel of CSPS is trained (30 doctors, 106 DHMT members), Members of management committees, all medium and long-term training courses have been started.	Training of 100 advisers in HIV/AIDS management and 18 doctors in ARVT, Medical and paramedical personnel trained/retrained: 15 medical specialists, 40 doctors, 25 officers, 27 technicians, all nurses, midwives, mobile workers and community health workers, 106 DHMT members.
Maintenance	The study, workshops on maintenance policy and strategy conducted, Maintenance manuals prepared, 2 sessions for sensitization to maintenance in HUs, 3 engineers, 22 senior technicians, 15 technicians, 200 users trained.	A national policy and strategy on equipment and maintenance exists, The maintenance is strengthened and operational. The 2 SIEM constructed / rehabilitated and equipped, Maintenance personnel is trained: 3 engineers, 22 senior technicians and 27 technicians and 405 users. Maintenance and servicing manuals are available in health units.
Traditional medicine	Nosology training modules prepared Associations of traditional doctors set up, 400 traditional doctors trained, 2 production units installed, 9 botanic gardens created, Sensitization of the population on traditional medicine.	Medicine and traditional pharmacopoeia are practised in a healthier environment and traditional drugs production in an appropriate context. Associations of traditional doctors and 9 botanic gardens exist. 2 drug production units are procured. 600 traditional doctors are trained. 9 pharmacists trained in the supervision of production. 6 doctors collaborate in two interface structures.
Mutuals	The master plan on mutuals drawn up and disseminated, Feasibility studies conducted in the two regions, 20 mutuals put in place with 9000 members and 40 officials trained, The system of risk-sharing is put in place in 9 health districts in the project area.	The master plan on mutuals exists. The 15 workshops held. 40 health mutuals put in place. 80 officials of these structures trained. 3 national sensitization campaigns conducted.
Regulations	The drug imports monitoring system put in place and the location map of pharmacies drawn, The policy paper and the regulatory framework for laboratories prepared, All regulatory instruments formulated, manuals and posters on cancer available in CHR and CMA, Outlines of and guidelines on hospital action plans prepared.	15 workshops on sector-wide approach held. The Directorate General for pharmacy, drugs and laboratories is more operational and plays its role better. Six pharmacists trained in legislation, quality assurance and public health. Drug and service charges are available and applied in hospitals.

5.7 Financial reporting

Accounting

5.7.1 Once the project activities commence, a chartered accounting firm will be engaged to assist the project management unit to put in place an accounting system tailored to the needs and taking into account the specificities of the project. The firm will also be charged with preparing a manual of administrative, accounting and financial procedures. The accounting system put in place should enable separate management by financing source as well as monitoring of expenditure by component and by category.

Audit

5.7.2 An external audit shall be conducted to audit the accounts at the end of each fiscal year. Corresponding audit reports will be transmitted to the Bank, no later than six months following the close of the fiscal year failing which disbursement will be suspended. Among the auditor's terms of reference, there shall be an aspect concerning procurements enabling it to check conformity with Bank rules of procedure on procurement.

5.8 Aid coordination

5.8.1 The Directorate General for cooperation of the Ministry of the Economy and Development coordinates external aid. The DEP of the MOH coordinates the interventions of various health sector donors. Given the diversity of partners, consultations on cooperation are carried out at the central level through the donors' annual conference and at the peripheral level through the regional technical health committees, the district health boards and the partners' conference held every three months. However, these consultation forums do not function satisfactorily.

5.8.2 The implementation of the PNDS is monitored at the central level by two organs, namely the steering committee and the monitoring committee, at the intermediate level by the regional health directorates and by the district health teams at the peripheral level. The steering committee is autonomous and attached to the Secretariat General. It reports on the status of implementation of the PNDS, monitors and evaluates the plans and programmes, coordinates at the national level and prepares the adoption of triennial and annual plans and programmes by the monitoring committee. The monitoring committee put in place in 2003 and chaired by the Secretary-General of the MOH comprises representatives of the MOH, related ministries, health sector development partners, NGOs and associations. It is charged with arbitrating resource allocations, adopting the different annual and triennial plans, giving guidelines to the steering committee, assessing reports from the steering committee and validating the findings of internal and external evaluations. A half-yearly meeting is held by the monitoring committee with the steering committee providing secretarial services. Six thematic commissions specialized in different topics (human resources, decentralization, private sub-sector, institutional strengthening of the MOH, sector-wide approach and health financing, and PNDS monitoring indicators) were put in place and proposals are made to the monitoring committee for approval before submission to the Government. Furthermore, the monitoring committee organizes joint mission to sites with donors and its other members. Besides, the activities of all central and decentralized services and health districts are planned each year and are discussed with all donors.

5.8.3 In spite of the progress made in the implementation of the PNDS in a coherent environment and the improvement of certain indicators, on the one hand, some efforts are still required for instance to improve the quality of annual PNDS monitoring reports and to build the capacity of the MOH in order for it to play its role of managing, coordinating and monitoring the system. On the other hand, the commissions' discussions on health financing have shown the need to harmonize the management and financing modalities of all donors and programming of joint missions. The corresponding study made the following main recommendations: the sensitization/training of all stakeholders on the PNDS and the sector-wide approach; the establishment of a forum for consultation, dialogue and reflexion; the strengthening of the technical services of the DEP and the DAF, and the pursuit of negotiations for the putting in place of a mutual fund. The gradual implementation of the sector-wide approach will permit improved coordination of interventions in the sector both at the central level and at the decentralized level. Concerning the strengthening of coordination and harmonization of intervention modalities, the project provides institutional support to the PNDS monitoring committee for the implementation of the recommendations of this study.

5.8.4 The management committee of the project in its relations with the PNDS monitoring committee will have an impact on aid coordination in Burkina Faso. The Bank Group during these preparation, appraisal and supervision missions to new projects, favoured consultation with partners to ensure complementarity of interventions. Furthermore, with the installation of its national office in 2006, the Bank will be able to strengthen dialogue and coordination with the

Government and bilateral and multilateral partners as part of the harmonization of PNDS interventions and procedures.

6. PROJECT SUSTAINABILITY AND RISKS

6.1 Recurrent expenses

6.1.1 Health structures and most of the activities included in the project already exist. Furthermore, the reconstruction of 2 CHR and the normalization of health units will generate additional recurrent expenses concerning: the salaries of supplementary personnel, operating expenses of the additional services, maintenance and servicing of new facilities and equipment. The annual amount of these expenses is estimated at CFAF 624 million (UA 0.82 million), of which CFAF 336.67 million will be paid by the State in the form of salaries (the personnel of the Tenkodogo SIEM, and the supplementary personnel of 2 CHR, 2 CMA, 31 normalized CSPS, Ouahigouya SIEM). The difference of CFAF 287.33 million (UA 0.38 million), representing the maintenance cost of the facilities (CFAF 97.53 million) and equipment (CFAF 189.80 million) is jointly financed by the State from its budget, and the health units (CSPS, CMA and CHR) through cost recovery. The total cost of recurrent expenses represented 1.55% of the budget allocated to the Ministry of health in 2003 and 0.11% of that of the State in the same year, which is not substantial and can thus be borne by the Government considering, on the one hand, the trend of the State budget and of the MOH over the past four years, and on the other hand, of the HIPC initiative funds allocated to the MOH and which have been increasing yearly since year 2000, from CFAF 3 587 500 000 to CFAF 16 881 673 326 in 2004.

6.1.2 In Burkina Faso, local authorities contribute to certain recurrent expenses such as operating costs of health units managed by them. Through cost recovery (total estimate for 2005: CFAF 25 136 980 000) COGES contribute slightly to the funding of the maintenance of facilities and equipment and the recruitment of certain contract employees. As such, the regular supply of drugs to health units and the training of depot managers will strengthen cost recovery and decentralization. Improved utilization of health units should increase revenue and enable better coverage of operating costs. Furthermore, the Bank and all partners will promote dialogue with the Burkinabe authorities to ensure that the resources necessary for maintenance activities are earmarked in budgets in order to perpetuate the gains of the intervention. A Bank Group-financed study is under way to determine measures to be taken by all countries of the West African economic and monetary union (UEMOA) to achieve sustainable management of social sector investments.

6.2 Project sustainability

6.2.1 Project actions consist in strengthening and improving existing activities, and the populations will be sensitized and involved in the implementation of activities through their associations, thus ensuring ownership of the gains and their continuity after the end of the project. The involvement of health committees in project monitoring and evaluation and the participation of health committees in project coordination meetings are measures which will contribute to project ownership and sustainability. The training and retraining of COGES members will permit greater involvement of the populations. The training and retraining of medical and paramedical personnel and CHWs will permit them to acquire skills, provide quality services and properly manage health units and reassure; they may then pursue the training of other workers and their activities of sensitizing the populations on diseases, hygiene/sanitation, mutuals, etc. Support to the implementation of health district action plans will strengthen the decentralization of health system management.

6.2.2 Once the training is acquired, the maintenance manuals and supplementary equipment are made available to regional maintenance services, the maintenance technicians and trained users will be able to maintain the facilities and equipment and extend their useful life while reducing health structure maintenance costs. COGES members and trained drug depot managers will improve the management and cost recovery system for a more rational use of available resources to guarantee the sustainability of project gains. The funds allocated to the MOH under the HIPC have been regular since year 2000 (CFAF 16 881 673 in 2004) and are used to normalize health units and recruit medical and paramedical personnel. These funds will help the ministry to pursue its actions when the project ends.

6.2.3 Concerning alternative forms of health financing, notably mutuals, the sensitization of the population, the training of mutual managers and sound management of the structures, increased membership and contributions, the assurance of quality care in health services are factors conducive to the autonomy of mutuals and their sustainability. As part of their duties, managers will pursue the sensitization of the population to increase membership. Concerning traditional doctors, additional incomes acquired thanks to the sale of their drugs will partly be used to cover the maintenance and operating expenses of botanic gardens and production units acquired under the project.

6.3 Critical risks and mitigative measures

6.3.1 The main identified assumptions concerning the project are: (i) pursuit of the implementation of the national health development plan and partners' contribution to its financing ; (ii) posting of the qualified staff required to the health facilities constructed to provide quality care; (iii) coverage of maintenance and servicing of the facilities built and of the equipment/furniture acquired; (iv) population's subscription to the system of health sector risk-sharing for a better utilization of health facilities; (v) involvement and support of the population, traditional doctors, medical and paramedical personnel in project activities.

6.3.2 Regarding the first two risks, on the one hand, the Government is showing its political will to implement its health development plan, recruit more health personnel and increase the health budget, as reflected in the constantly rising trend of the MOH budget boosted with HIPC funds; and on the other hand, it continues to mobilize partners for the PNDS. However, the training envisaged under the project will contribute to offset qualified staff shortages. Concerning the third risk, it is mitigated by the fact that all the parties acknowledge the inadequacy of the maintenance system which has led the State to put in place a Directorate general for facilities, equipment and maintenance (DGIEM) and five regional maintenance services out of the thirteen envisaged. Furthermore, the project is providing support in order to strengthen and supplement the regional maintenance services, train qualified personnel at all levels (including the COGES), and sensitize users and the population. These activities and the increase of health unit resources will help mitigate this risk.

6.3.3 Cost recovery as practised in the country's peripheral health units helps to partially cover operating costs. One of the expected outcomes of the project being the increase in quantity and quality of the care provided, an increase in revenue as a result of increased utilization of health services is expected. Improved management of the system should lead to a more rational utilization of resources and sustainability of project activities. Moreover, by the end of the project, councils will be more operational and will finance a greater share of health structure costs.

6.3.4 As concerns health sector financing alternatives, the State has initiated a study of mutuals which will serve as a basis for reflection on regulations on this domain, limiting the number of fake structures. Furthermore, the project will support the establishment of health mutuals

according to requests from the populations, the training of managers of mutuals and the provision of management tools to improve the performance of the mutuals. These activities will enable the populations to understand the functioning of mutuals, participate in their management and subscribe to the risk-sharing system. Sensitization campaigns will be conducted for all stakeholders (populations, health personnel, traditional doctors, etc.) to explain the benefits of the activities identified with the stakeholders and proposed in this project.

7 PROJECT BENEFITS

The project has definite benefits for the populations of the two target regions and for the central level in several respects: economic through poverty reduction, and social by improving health services through disease control.

7.1 Economic Impact

7.1.1 The implementation of project activities (studies, construction of 2 CHR, 2 CMA, 31 CSPS, goods, sensitization campaigns) will require the use of civil society skills, thus creating jobs in the country and notably in the target regions and increasing the income of the service providers. This will help increase job opportunities and income-generating activities, which constitute the third priority action of the Government's poverty reduction strategy paper. In fact, on the one hand, consultants and consulting firms are required to provide services, contractors and suppliers to undertake construction / rehabilitation works and procure goods. On the other hand, local community-based associations will be able to conduct sensitization campaigns and treat mosquito nets with insecticide.

7.1.2 The early detection of certain diseases in primary health units will generate savings on hospital costs. The quantitative and qualitative improvement of care through the training of health personnel in disease management will reduce morbidity of the populations who will be able to pursue their activities and contribute to the country's economic development. Indeed, malaria reduces the population's ability to work and AIDS affects the most active segment of the population. As Burkina Faso is an agricultural country, certain endemic diseases such as malaria which occur in the farming season decrease productivity if they are not contained. As concerns children, with the sensitization campaigns on hygiene and nutrition, their health status will improve, thus reducing the burden of health care expenses on households.

7.1.3 As the Government's objective is to improve health care accessibility and quality, restructuring measures as well as a sector strategy will bring down the unit costs of basic health care without increasing the resources allocated to this sector. The building of the ministry's capacity will impact on the rational use of resources in a sector whose needs are substantial.

7.2 Social Impact

7.2.1 The achievement of the project's objectives with improved accessibility, increased services offer, better organization of services, the putting in place of mutuals and IEC, will increase attendance of health services leading to an improvement of the health status of the population notably women and children. Sensitization campaigns on personal and environmental hygiene will bring about better living and health conditions for the populations. The training of 15 medical specialists, 40 doctors, 25 officers, all categories of health personnel in the two target regions (doctors, nurses, midwives, community health workers, etc) the strengthening of the activities of community health workers, and the intensification of outreach strategy activities will increase accessibility in order to cater for the most disadvantaged not only by bringing them closer to care geographically, but also through the care quality provided. The training of 100 advisers in

screening centres and sensitization of the populations to the risks of communicable diseases such as HIV/AIDS will contribute to improve voluntary screening especially among youth and women. In general, the following indicators will improve: reduction of mortality by 50%, morbidity and HIV/AIDS prevalence which will drop from 2.7% in 2004 to 1.5% in 2010.

7.2.2 The training of 3 engineers, 49 technicians, 405 users in the maintenance and servicing of health facilities and equipment, the training of 2 officers, 60 senior technicians and 160 hygiene and sanitation workers, the construction / rehabilitation / normalization and the equipment of CHR, CMA, CSPS and SIEM will have a real impact on the state of these structures and create a healthy environment for the practice of health care for the benefit of the populations of the two regions of the Centre-East and North.

7.2.3 The putting in place of 40 health mutuals with about 18,000 members (that is over 100,000 beneficiaries) and the training of 80 managers of the structures, will bring about increased utilization of health services by disadvantaged populations resulting in an improvement of their health status. As concerns the organization and training of 600 traditional doctors and the acquisition of drug production units, they will permit the proper treatment of the populations that use these types of curative practices.

7.3 Impact on Women

The fertility, infant and maternal mortality rates in Burkina Faso are still high. The project through its new facilities and equipment, its sensitization, training and IEC activities will help to significantly reduce the said rates. The PCIME (integrated management of childhood diseases programme) will contribute to the reduction of the infant mortality rate by 50% in 2010. IEC campaigns will give women better knowledge of HIV and better protection, similarly a better knowledge of women’s cancers will enable earlier prevention, diagnosis and management. In general, the impact on women will translate into better information resulting in increased birth control. The training of doctors in the domains of surgery and gynaeco-obstetrics, the normalization and equipment of CSPS and CMA, the construction and equipment of CHR will significantly improve local management of gynaeco-obstetric infections and cancer. Furthermore, increased access to care, will increase pregnancy follow-up, and improve delivery conditions, all of which will lead to a decrease in maternal mortality. In fact, the maternal mortality rate could be reduced by 50% by 2010; while the ante-natal consultation coverage will increase by 50% by 2010. The reduction of waiting time owing to increased and closer care opportunities will enable women to have more time to engage in income-generating activities, thereby contributing to poverty reduction. Improved care accessibility and quality will reduce disease frequency and consequently the decline in women’s income-generating activities which has adverse effects on entire households and on children in particular.

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

The project is in line with the poverty reduction strategy paper (PRSP) and with the orientations of the health policy paper and the country’s national health development plan (PNDS). It seeks to strengthen the health care system in the health districts of the two regions of Centre-East and North, through the strengthening of health districts, CHR and building the capacities of departments of the MOH. Owing to the population’s lack of financial resources and the utilization of the traditional doctors’ services, support is provided to put in place health mutuals and organize

the production of traditional drugs by traditional doctors. As the two zones are located in border areas, attention is being paid to the control of HIV/AIDS and endemic diseases such as malaria and to the improvement of hygiene and children's nutrition.

8.2 Recommendations

8.2.1 It is recommended that the Burkina Faso Government be granted an ADF loan not exceeding UA 19 million and an ADF grant not exceeding UA 6 million for the implementation of the project described in this report. This loan will be subject to the general conditions of the Bank for its effectiveness and to the following special conditions:

A. Conditions precedent to loan and grant effectiveness

8.2.2 Loan effectiveness is subject to fulfilment by the Borrower to the satisfaction of ADF of the provisions of Section 5.01 of the General Conditions applicable to loan agreements and to guarantee agreements of the Fund. The grant memorandum of understanding shall enter into force upon its signature by the different parties.

B. Undertaking prior to any disbursement

8.2.3 Before any disbursement of the loan and the grant, the Government shall give an undertaking to post the competent personnel required to the CHR built, the CMA and CSPS normalized and the regional maintenance services (paragraphs 4.5.10/14).

C. Conditions precedent to first disbursement of the loan and of the grant

8.2.4 Besides the undertaking and the effectiveness of the loan agreement and the grant memorandum of understanding, ADF shall release the first disbursement of the loan and the grant funds only upon fulfilment by the Borrower to the satisfaction of ADF of the following specific conditions precedent:

i) Provide to the Fund evidence of having maintained in Ouagadougou the coordination unit of the PRSS and its senior staff, namely: the coordinator, the architect, the public health physician / training expert and the accountant (paragraph 5.1.1);

ii) Provide to the Fund evidence that the management committee of PADS will also be designated as a monitoring organ of this project (paragraph 5.2.1);

iii) Provide to the Fund evidence of having allotted to the project plots designed for the new buildings of the two CHR in Ouahigouya and Tenkodogo and the CMA at Bittou, as well as the topographical surveys and geotechnical studies (paragraph 4.5.3);

iv) Provide to the Fund evidence of having opened two accounts at BCEAO, one for receiving the loan funds and the other for the funds of the grant, the two accounts being in a commercial bank acceptable to the ADF, as well as an account at the Treasury for receiving the counterpart funds (paragraph 5.5.1).

D. Other conditions

8.2.5 In the course of project implementation, the Borrower shall fulfil the following other conditions:

i) Provide to the Fund, no later than three years following project start-up, the integrated list of care services provided in hospitals (paragraph 2.2.4);

ii) Provide to the Fund, three months following loan effectiveness, the performance contract of the coordinator whose terms shall have been deemed acceptable by the ADF. The results of his/her evaluation will be transmitted annually to the ADF before renewal of contract (paragraph 5.1.1);

iii) Provide to the Fund, no later then three months before delivery of works and equipment, the list of required personnel posted to built/rehabilitated health units and regional maintenance services (paragraphs 4.5.10/14);

iv) Provide to the Fund, three months following the first disbursement a detailed plan of all the training and retraining courses specifying the choice of establishments, candidates selected, training schedule and duration, as well as a detailed plan of project procurements (paragraph 5.1.2);

v) Provide to the Fund, no later than three months before start-up of corresponding activities, all agreements concluded with the Ouagadougou Faculty of Health Sciences, CREPA, CIRFA, departments of the ministry of health in charge of local training (DGHSP, DHPES, DPM, DGIEM, CHU, CHR, DRS, ECD, CNLS), whose terms shall have been deemed acceptable by the Fund (paragraphs 4.5.12 and 4.5.14);

vi) Provide to the Fund before health personnel leave for medium or long-term training, evidence of an undertaking by the personnel to serve in public health structures in the project area for at least five years after their training (paragraph 4.5.23).

ANNEX 1

BURKINA FASO
HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

PNDS objectives and programmes

Intermediate objectives (8)	Specific objectives or programmes (22)
1. Increase national health coverage.	-develop health facilities and equipment, -operationalize health districts, -develop community-based services, -strengthen collaboration with the private and traditional sectors in the health care supply.
2. Improve the quality and utilization of health services	-develop a national service quality assurance strategy ; -improve the availability of essential drugs and their accessibility; -strengthen health support and promotion activities.
3. Strengthen the control of communicable diseases and non-communicable diseases	-promote the health of target groups, -reduce the incidence and prevalence of public health interest diseases.
4. Reduce HIV transmission	-strengthen preventive measures for STI and HIV transmission, -improve quality of medical management and counselling of PLWHA.
5. Develop human resources in the health sector	-define national guidelines on health sector human resource development, -satisfy the health system's human resource needs.
6. Improve population's financial access to health services	-improve the efficiency of health services, -promote health risk-sharing mechanisms.
7. Increase health sector financing	-mobilize supplementary financial resources for the health sector, -improve cost recovery.
8. Build the institutional capacity of the Ministry of Health	-improve the organizational framework of the MOH, -strengthen the legal framework of the MOH, -increase the administrative, managerial and technical support capacities of the MOH, -improve the coordination of health sector interventions, -strengthen intersectoral collaboration.

Source: National Health Development Plan 2001-2010, Ministry of Health.

ANNEX 2

BURKINA FASO

HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Burkina Faso : Millennium Development Goals

Objectives	Objectives and measures initiated for their achievement	Bank's role
1. Reduce by 50% the proportion of the population living in poverty between 1990 and 2015.	The incidence of poverty was estimated at 45.3% in 1998 and the Government's objective is to reduce it to less than 30% in 2015, notably by utilizing HIPC resources in a targeted manner. In 2003, the index was 46.4%. The objective is achievable if real GDP growth is above 7 to 8% over the period concerned and if the conditions (of internal and external resource mobilization) are met	Bank's support in the implementation of the PRSP, Bank participation in coordination with the other partners in the HIPC initiative in favour of Burkina Faso.
2. Ensure primary school education for all by 2015	Burkina Faso has drawn up a ten-year development plan for basic education (PDDEB) for the 2000-2009 period in a bid to considerably increase access to education. However, with the enrolment rate which was estimated at 43% in 2000-2001 and 42.3% in 2003, it is unlikely that the objective will be achieved.	Financing of the Education V Project
3. Promote gender equality and empower women by eliminating gender disparities in primary and secondary education by 2015	The girls/boys ratio in primary school education was 0.76 in 2001 and 0.83 in 2003. The literacy rate for adult women was 15.2% and 29.4% for men in 2003. Accordingly, in spite of the implementation of the PDDEB, it is unlikely that parity will be achieved in 2015.	Financing of the Education V Project
4. Reduce by two-thirds the infant and child mortality rates between 1990 and 2015	The Government's objective is to reduce the infant mortality rate by 210‰ in 1990 to 70‰ In 2015. The infant mortality rate being 83‰ in2003, this objective is achievable.	Financing of the infectious diseases support programme and the social security support programme
5. Reduce by three-quarters maternal mortality between 1990 and 2015	The Government's objective is to reduce maternal mortality from 556 per 100,000 in 1993 to 139 per 100,000 in 2015. This rate of 484 per 100,000 in 1998 can be improved if ongoing efforts are pursued.	Idem
6. Reduce the prevalence of HIV/AIDS, malaria and the other diseases	The AIDS prevalence rate was 4.2% in 2002 and 2.7% in 2004 and malaria incidence was 29.2 per 100,000. The control of HIV/AIDS and malaria as well as other diseases is among the Government's priorities. Many donors are supporting this measure. The objective will probably be achieved.	AIDS and malaria control are components of the infectious diseases support programme financed by the Bank
7. Ensure environmental sustainability, notably by ensuring access to potable water for 50% of the population.	Access to drinking water notably in rural areas and environmental protection (notably under the PNGT) are among the Government's priorities. The proportion of forest zones dropped from 26.5% in 1990 to 25.9% in 2000, while in 2003, the percentage of limited access to drinking water in urban areas was estimated at 88.5% and 64.2% in rural areas. This objective will be difficult to attain.	Contribution through the small dams project, the agricultural project and studies on the regional development plan.
8. Put in place a global partnership for development.	Partnership has been put in place in various domains notably in the area of poverty reduction and reform programmes. The process is underway and needs to be supported.	The Bank by joining other donors is contributing to Burkina Faso's economic and social development.

Source: DSP Burkina 2002-2004, EDS 2003 and PRSP of Burkina 2003

ANNEX 3

BURKINA FASO

HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Donors' contribution

Partners	Areas of intervention	Intervention zones	Period	Financing
French Cooperation	Aquassou Project Hospital reform. HIV/AIDS control. PRE MTSS Maternal and child health and AIDS	Sub-regional National National Cascades and Hauts Bassins	2002-2006 2005 2005-2008 2003-2006	Euros 400 000 CFA F 800 000 000 Euros 12 500 000 Euros 1 372 000
Dutch cooperation	PNALAT Health mutuals PADS (phase II)	National, Region, District, FS Kaya National	2005 2005 2005-2008	CFA F 765 000 000 CFA F 615 000 000 CFA F 2 600 000 000
Swedish cooperation	PADS (phase II)	National	2005-2008	CFA F 2 200 000 000
MSF	Support to management of PLWHA, Community support	DS Sindou, CMA Pissy, Ouagadougou National	2005	CFA F 102 000 000 /year CFA F 151 000 000 /year
Plan Burkina Faso	HIV/AIDS Childcare and safe motherhood	Kaya,Tenkodogo, Gaoua, Koupéla, Boulsakaya,Kougoussi, Barsalogo, Dèdougou	2006 2006	CFA F 2 310 000 000 CFA F 4 550 000 000
UNFPA	Communication for change of attitude, Support to RH activities in the region HIV/AIDS control	Central Dori, Fada, Tenkodogo National	2005 2005 2005	CFA F 438 000 000 CFA F 8 000 000 CFA F 467 086 000
WFP	Assistance to vulnerable groups	National (11 poorest provinces of the country: North, North-West and East	2005	CFA F 5 557 799 800
Unicef	Support to decentralized health system HIV/AIDS, EPI, malaria, ARI, Measles, maternal health	National, DRS Fada, Tenkodogo, Dor National	2005 2006-2010	CFA F 7 665 000 000 $ 20 000 000
European Commission	EC-Burkina cooperation strategy	National	2004	CFA 98 billion
World Bank	PMLS, capacity building programme	National	2005	16.5 billion
Japanese cooperation	Japanese Grant: poverty reduction	National	2005	$ 357 010
ADB	PRSS AIDS	Hauts bassins, Mouhoun Loop, South-West and central level National	2006 2007	CFA F 8 291 620 000 UA 5 million (grant)
IDB	Health centres construction project	Nouma HD, Toma, Solenzo, Dori, Dédougou, Gorom	2010	CFA F 10 870 060 000
China	CSPS construction project	National	2006	CFA F 615 000 000
CIDA (Canada)	AIDS control support Project	Ouahigouya, Pissy, Banfora	2010	CFA F 2 109 936 000
Canadian cooperation	PASEI 2 AIDS 3	DRS/DS National DRS/DS	2003-2007 2001-2006	Canadian $ 1 730 154 Canadian $ 2 850 000
ASDI (Sweden)	Support to action plans and DRS	National	2005	CFA F 4 400 000 000
GTZ	Family planning AIDS control Promotion of a maintenance system	South-West, Mouhoun Loop.	2005 2005 2005	 CFA F 617 000 000
Global Fund	Malaria control AIDS control	National National	2010 2010	CFA F 7 472 500 000 CFA F 27 755 000 000
Italian cooperation	Support to implementation of PNDS Support to decentralization	DS Sector 30, CNRFP, ENSP, DGSP	2005	CFA F 1 812 279 541
Belgian cooperation	Support to the development of HDs Phase 2 Support to the National HIV / AIDS control Plan Institutional support to DAF of the MOH	Plateau Central Health region National National	2004-2008 2004-2009 2004-2007	CFA F 2 951 681 396 CFA F 3 279 787 004 CFA F 341 947 641

ANNEX 4

BURKINA FASO
HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Appraisal report preparation process

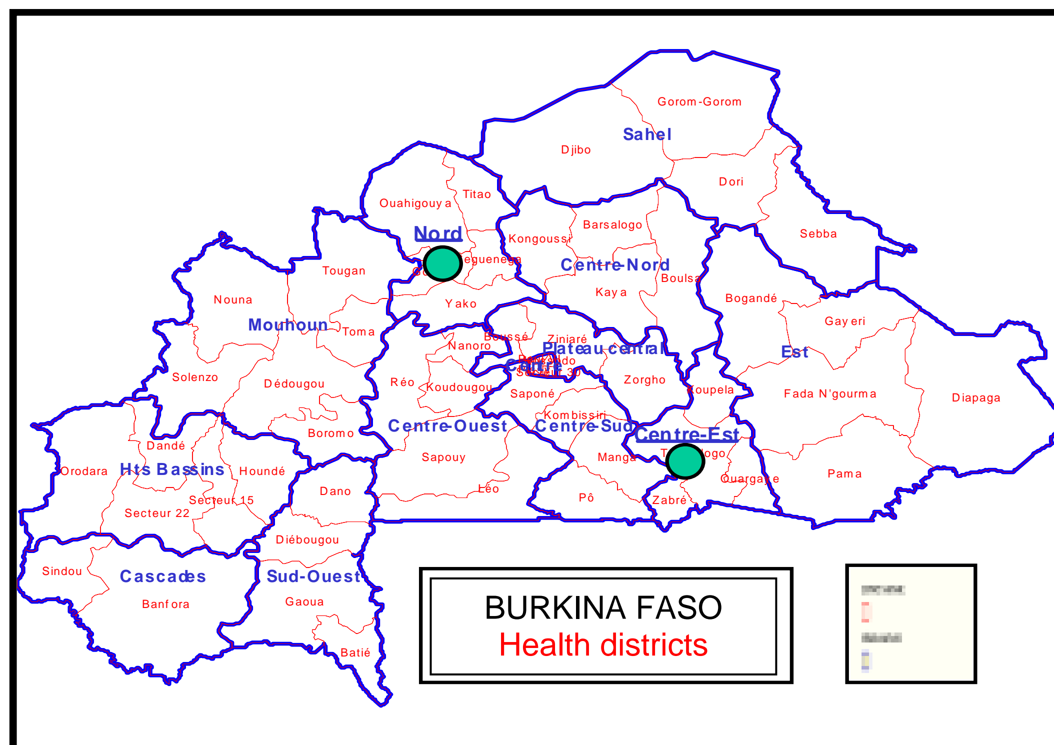
Main activities	**Implementation date**	**Remarks**
Identification/preparation mission	21 October – 08 November 2004	The mission met with the Authorities of the country at the central and regional levels as well as development partners and civil society. Project formulation took into account the PNDS programmes and findings from consultations.
Appraisal mission	24 January – 09 February 2005	The mission met with the Authorities of the country at the central and regional levels as well as development partners and civil society. A final agreement was reached on Project objectives, components and areas of intervention.
Drafting of mission report and appraisal report	11 February – 2 March 2005	The findings of the mission were communicated to the Burkinabe Government and to other donors
Meeting of internal working group	07 March 2005	Comments of the meeting included in the report sent to the interdepartmental working group.
Meeting of interdepartmental working group	18 March 2005	The comments of the interdepartmental meeting have been included in the report submitted to the higher management committee.
Meeting of the senior management committee	31 March 2005	The report was amended to reflect the comments of the meetings and the re-allocation of resources (grant and loan).
Forwarding of report to the Secretariat General	14 April 2005	The amended report was sent for translation and distribution to the Board of Directors.

ANNEX 5

BURKINA FASO

HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

PROJECT AREAS



This map was drawn by staff of the African Development Bank Group for exclusive use by readers of this report. The names and boundaries shown on this MAP do not imply on the part of the ADB Group and its members, any opinion concerning the legal status of a territory or any approval or acceptance of its boundaries whatsoever.

: Project areas

ANNEX 6

BURKINA FASO

HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Summary of socio-environmental arrangements of the project

Description of the main socio-environmental components of the project
To increase and improve access to quality health services, the project envisages, among other activities, the construction and extension of health facilities (2 regional hospitals – (CHR), 2 medical centres with a surgical unit – (CMA), 31 Health and Social Welfare centres (CSPS), including the construction of latrines, boreholes, lighting by solar energy and incinerators.

Main socio-environmental impacts
The project is classified under Environmental Category II given that it has minor environmental impacts.

Protection programme and mitigative measures
Engineering and architectural designs will conform to the environmental protection rules as regards sanitation and treatment of liquid and solid medical waste. Waste generated by health activities will be treated using adequate means such as incinerators or others. Technical measures will be taken to avoid erosion problems, gullying, rainwater stagnation and will be included in the bidding documents.

Monitoring programme and supplementary initiatives
The technical consulting firm in collaboration with the PMU will monitor implementation by contractors of the corrective measures envisaged in the competitive bidding documents. Environmental monitoring of these measures will be directly undertaken by health personnel and the ECD with the support of the decentralized services of the Ministry of the Environment and Water.

Institutional arrangements and capacity building
COGES members and the public will be sensitized to environmental rules (tree planting, management and treatment of liquid/solid wastes, management of toilets) in order to monitor them. The project will finance campaigns to sensitize the population to hygiene and health personnel to hospital hygiene.

Public consultations and access to information
Beneficiaries will be consulted on project design activities through discussions prior to project start-up, as well as on household waste management and improvement of their environment. Activity reports including information on environmental protection-related activities will be accessible to the different partners involved in the implementation of the project.

Implementation schedule and reporting
After the architectural and engineering designs which will be conducted at the end of 2006, environmental monitoring will be undertaken during the works, from 2007 to 2009, by the Ministry of the Environment and Water, the consulting firms and the PMU, and subsequently on a permanent basis by the population and COGES, even when the project ends. Quarterly activity reports of the Project Management Unit and supervision reports will include information on environmental monitoring throughout the project from 2007 to 2010.

BURKINA FASO

HEALTH CARE DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Summary of detailed project costs

	Total Million CFA F	Total Million UA
COMPONENT I : IMPROVED ACCESS TO QUALITY HEALTH CARE		
- Equipment and furniture for 2 CHR, 2 CMA, 31 CSPS, 2 SIEM, 4 screening Centres and 2 Interfaces	*2 474.00*	
- Miscellaneous equipment for CSPS and Traditional doctors	*381.40*	
- Computer and office automation equipment for 2 CHR, 2 CMA, and 2 SIEM	*309.20*	
- Vehicles for 2 CHR, 2 CMA, 31 CSPS and 2 SIEM	*260.05*	
- Pick up vehicle for 2 SIEM, CHR	*49.70*	
- Construction works on 2 CHR and 2 CMA	*4 562.23*	
- Construction works on 31 CSPS, 2 SIEM, 4 CDD and 9 botanic gardens	*1 942.51*	
Studies and supervision of 2 CHR, 2 CMA, 31 CSPS , 4 CDD and 9 botanic gardens	*520.38*	
Studies on mutuals	*10.00*	
Sensitization	*45.00*	
- Allocation of office supplies for 2 CHR, 2 CMA, 31 CSPS, 2 SIEM and 4 CDD	*21.75*	
Local training by MOH	*133.96*	
- Support to the functioning of associations of traditional doctors and mutuals	*200.00*	
TOTAL BASIC COST COMPONENT I	10 910.18	14.26
Contingencies 8%	872.81	1.14
Sub-total	11 782.99	15.40
2.6% inflation per year	681.23	0.89
TOTAL COMPONENT I	**12 464.22**	**16.29**
COMPONENT II : DISEASE CONTROL		
- Specific equipment for non-communicable diseases	*228.25*	
- Miscellaneous allocations	*402.00*	
- Biomedical drugs and consumables for 2 CHR, 2 CMA, 31 CSPS and 9 district depots	*331.25*	
- Consultancy for studies	*8.25*	
- - Workshops	*1.75*	
- Sensitization seminars for populations	*364.50*	
- Training / retraining of medical personnel of the two regions	*671.43*	
- Support to national disease control programmes	*1 295.00*	
TOTAL BASIC COST COMPONENT II	3 302.43	4.32
Contingencies 8%	264.19	0.35
Total including contingencies	3 566.62	4.66
2.6% inflation per year	206.20	0.27
TOTAL COMPONENT II	**3 772.83**	**4.93**

	Total Million CFA F	Total Million UA
COMPONENT III : CAPACITY BUILDING		
- Provision of documents, guides and posters	*31.75*	
- Provision of computer equipment and office automation equipment	*30.00*	
- Provision of consignment of specific spare parts for DGIEM	*15.00*	
- Provision of 4x4 vehicles	*64.25*	
- Consultancies	*124.50*	
- Workshops	*236.50*	
- Training abroad	*347.14*	
- Training in West Africa	***1 110.88***	
- Local training in institutes and the university	*616.18*	
- Sensitization of populations	*135.00*	
- Local training by the MOH	*104.95*	
- Supervision missions	*537.97*	
- Study trips	*11.00*	
TOTAL BASIC COST COMPONENT III	3 365.12	4.40
Contingencies 8%	269.21	0.35
Total including contingencies	3 634.33	4.75
2.6% inflation per year	210.12	0.27
TOTAL COMPONENT III	**3 844.45**	**5.02**
COMPONENT IV : PROJECT MANAGEMENT		
- Equipment and furniture of the PMU	*13.50*	
- Computer and office automation equipment of the PMU	*36.50*	
- 4x4 vehicles of the PMU	*38.55*	
- Consultancies	*147.45*	
- Audit of project accounts (5 missions)	*47.50*	
- Workshop	*28.25*	
- Wages of support staff	*72.00*	
- Allowances of managerial staff	*216.00*	
- Office supplies and consumables of the PMU	*26.00*	
- Recurrent expenses of the PMU (rent, maintenance)	*128.00*	
- Other recurrent expenses of the PMU (telephone, mail, electricity)	*60.00*	
- Mission expenses of the PMU	*160.00*	
- Mission expenses of central departments and consultants	*199.50*	
TOTAL BASIC COST COMPONENT IV	1 173.25	1.53
Contingencies 8%	93.86	0.12
Total including contingencies	1 267.11	1.66
2.6% inflation per year	73.26	0.10
TOTAL COMPONENT IV	**1 340.37**	**1.75**
TOTAL BASIC COST OF PROJECT	18 750.98	24.51
Total Contingencies 8%	1 500.07	1.96
Total including contingencies	20 251.05	26.47
2.6% inflation per year	1 170.81	1.53
TOTAL PROJECT COST	**21 421.86**	**28.00**

ANNEX 8

BURKINA FASO

HEALTH DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Provisional list of goods and services

UA 1 = 765.154 CFA F

FINANCING SOURCES		Million CFAF			Million UA			Cofinanciers		
CATEGORIES OF EXPENDITURE		Foreign currency	Local currency	Total	F.C	L.C.	Total	ADF (Loan)	ADF (Grant)	Gvt
GOODS	Basic total cost	4 432.13	233.27	4 665.40	5.79	0.30	6.10	5.74	0.10	0.26
	Contingencies	354.57	18.66	373.23	0.46	0.02	0.49	0.46	0.01	0.02
	Price escalation	276.74	14.57	291.31	0.36	0.02	0.38	0.36	0.01	0.02
	Total cost of goods	**5 063.44**	**266.50**	**5 329.94**	**6.62**	**0.35**	**6.97**	**6.56**	**0.11**	**0.30**
WORKS	Basic total cost	5 203.79	1 300.95	6 504.74	6.80	1.70	8.50	6.93	0.00	1.58
	Contingencies	416.30	104.08	520.38	0.54	0.14	0.68	0.55	0.00	0.12
	Price escalation	324.92	81.23	406.15	0.42	0.11	0.53	0.43	0.00	0.10
	Total cost of works	**5 945.02**	**1 486.25**	**7 431.27**	**7.77**	**1.94**	**9.71**	**7.91**	**0.00**	**1.80**
SERVICES	Basic total cost	2 852.38	890.90	3 743.28	3.73	1.16	4.89	1.53	3.36	0.00
	Contingencies	228.19	71.27	299.46	0.30	0.09	0.39	0.12	0.27	0.00
	Price escalation	178.10	55.63	233.73	0.23	0.07	0.31	0.10	0.21	0.00
	Total cost of services	**3 258.67**	**1 017.80**	**4 276.47**	**4.26**	**1.33**	**5.59**	**1.75**	**3.84**	**0.00**
OPERATION	Basic total cost	383.76	3 453.80	3 837.56	0.50	4.51	5.02	2.44	1.79	0.79
	Contingencies	30.70	276.30	307.00	0.04	0.36	0.40	0.19	0.14	0.06
	Price escalation	23.96	215.65	239.62	0.03	0.28	0.31	0.15	0.12	0.05
	Total operating cost	**438.42**	**3 945.76**	**4 384.18**	**0.57**	**5.16**	**5.73**	**2.78**	**2.05**	**0.90**
PROJECT	Basic total cost	12 872.06	5 878.92	18 750.98	16.82	7.68	24.51	16.63	5.25	2.63
	Contingencies	1 029.76	470.31	1 500.07	1.35	0.61	1.96	1.33	0.42	0.21
	Price escalation	803.73	367.08	1 170.81	1.05	0.48	1.53	1.04	0.33	0.16
	Total cost of project	**14 705.55**	**6 716.31**	**21 421.86**	**19.22**	**8.78**	**28.00**	**19.00**	**6.00**	**3.00**

ANNEX 9

BURKINA FASO

HEALTH DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Table of contents of the project implementation manual and annexes

1. Introduction

2. Presentation of the project
   Objectives
   Beneficiaries of the project
   Summary description of project outputs

3. Project costs

4. Implementation of components
   Formulation, approval and implementation of activities by component

5. Project implementation modalities
   The Management Committee (composition, mission, monitoring/evaluation, etc)
   The Project Management Unit (composition, operation, missions of each member, performance criteria of each member, evaluation of each member, etc.)
   Departments of the Ministry of Health (missions, monitoring/evaluation, etc.)
   The other stakeholders (missions, monitoring/evaluation, etc.)
   Activity report to be drawn up by each stakeholder in the project,
   Financial reporting,
   Mid-term review,
   System of monitoring important risks and mitigative measures,
   Environmental impact monitoring system.

Annexes

1. Project appraisal report
2. Terms of reference of personnel of the PMU
3. PMU personnel performance evaluation criteria
4. Model application documents for the recruitment of consultants
5. Model competitive bidding documents for goods and works
6. Bank disbursement manual
7. Detailed project costs
8. List of localities where CSPS will be normalized

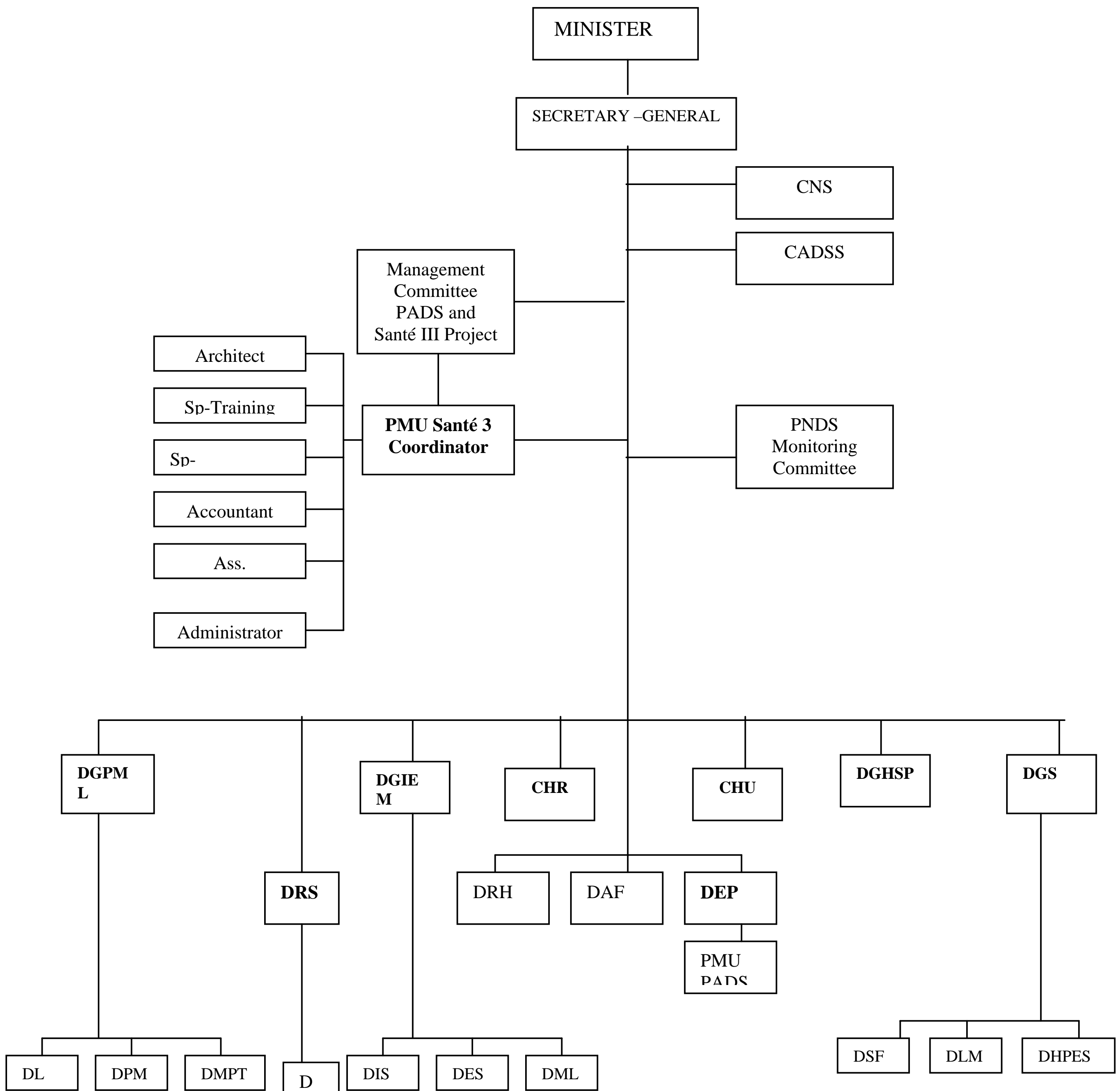
ETC.

ANNEX 10

BURKINA FASO

HEALTH DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Project organization chart



ANNEX 11

BURKINA FASO

HEALTH DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Project implementation schedule

	2005		2006				2007				2008				2009				2010				2011	
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2

Board presentation
Loan effectiveness
Project start-up
Recruitment of supplementary staff
Project launch
Project supervision
Mid-term review
Government's completion report
ADF's completion report
Recruitment of consulting firms
Architect. studies, competit. bidding doc. & supervis°
Supervision of works and equipment
Competitive bidding and contracts
Construction of CHR, CMA, CSPS and SIEM
Provisional acceptance of works
Final acceptance of works
Shopping equip/furniture of the PMU
Order, delivery and installation
Competit. bidding for vehicles and contracts
Acceptance and distribution of vehicles

Drawing up of lists of biomedical equipment
Competit. bidding for biomed. equip. & contracts
Order, delivery and installation
Prep. competitive bidding for equip/furniture
Competit. bidding equip/furnit. & contracts.
Order, delivery, installation

Drawing up of lists of drugs and consumables
Approval and contract with CAMEG
Delivery/distribut° of drugs & consumables

Recruitment of short-term consultants
Conduct of studies
Report-back workshops
Training abroad
Local training
Training/Retraining in Health Units
Sensitization of populations
Recruitment of system management consultant
Management system update mission
Recruitment of audit firm
Audit missions

Operation
Supervision of health activities by DGS
Supervision of activities of mutuals
Supervision of trad. medicine activities
Supervision of hyg. & sanitation activities
Supervision of activities of the PMU by the management committee
Operation of the PMU

Annex

THE HEALTH CARE DEVELOPMENT SUPPORT PROJECT (CENTRE-EAST AND NORTH REGIONS)

CORRIGENDUM

I. INTRODUCTION

1.1 The Health Care Development Support Project in the Center-East and North regions of Burkina Faso was appraised by the Bank in February 2005 and sent for translation on 14 April 2005. This project was to be financed with a UA 19 million loan as well as a UA 6 million grant from ADF IX resources. It was subsequently determined that the resources available under ADF IX would not be sufficient to meet the project costs. According to the policy governing ADF X, Burkina Faso is not eligible for grant resources; the project will thus be entirely financed using a loan of UA 25 million from ADF X resources, as well as the Government counterpart of UA 3 Million. The project is in line with the Bank's Country Strategy Paper for Burkina Faso.

1.2 This corrigendum has thus been prepared owing to the changes to the initial appraisal report, specifically that all the activities initially financed under the grant will now be financed under the ADF loan, while the counterpart amount remains the unchanged.

II. CORRECTIONS

The modified paragraph and tables are replacing the existing text of the appraisal report as follows:

Table of Contents

Preliminary pages: (i) – (xii)

Project Information Sheet

- 8 – Bank Group financing:
  Loan: UA 25 million
  The grant has been cancelled

- 10: Loan Approval Date:
  July 2005

Project Logical Framework

- The grant logical framework has been cancelled
- The loan logical framework is replaced as follows:

BURKINA FASO – HEALTH CARE DEVELOPMENT SUPPORT PROJECT - CENTRE-EAST AND NORTH REGIONS

Project Logical Framework

By: R. Y. Coffi and two consultants

Narrative summary	Objectively Verifiable Indicators	Means of verification	Major assumptions
Sector goal Contribute to improved health status and well-being of Burkinabe people by achieving the health-related millennium development goals.	By 2010: 1.1 Reduce mortality rate by 50% (14.8 ‰ in 2003). 1.2 Reduce infant mortality rate by 50% (83 ‰ in 2003). 1.3 Reduce maternal mortality by 50% (484 per 100 000 in 2003).	1.1.1 Surveys to review the poverty reduction strategy paper (PRSP). Demographic and health surveys (DHS) and annual statistics yearbook. 1.2.1 Idem. 1.1.1 Idem.	
Project objectives 1. Improve access to, as well as quality and utilization of health services in the Centre-East and North health regions.	1.1 Increase in utilization of health services from 32.49% in 2003 to 37.7% in 2008 and 40.31% by 2010. 1.2 Increase in health services attendance rate from 34.46% in 2003 to 44.8% in 2008 and 50% in 2010 in the Centre-East, and from 24.47% in 2003 to 35% in 2008 and 40% in 2010 in the North. 1.3 Increase in contraception prevalence from 12.70% in 2003 to about 17.5% in 2008 and 20% in 2010 in the North and from 11.15% in 2003 to about 15.7% in 2008 and 18% in 2010 in the Centre-East. 1.4 Increase in ante-natal consultation coverage from 51.23% in 2003 to about 68% in 2008 and 76.84% in 2010 in the North and from 82.03% in 2003 to about 88.8% in 2008 and 92.28% in the Centre-East by 2010. 1.5 Increase in attended delivery coverage from 39.48% in 2003 to about 46% in 2008 and 49.75% in 2010 in the North and from 45.71% in 2003 to about 53% and to 57.59% in the Centre-East by 2010. 1.6 Useful life of facilities and equipment increased by 20% in 2008 and 25% by 2010.	1.1.1 Statistics yearbook of the Ministry of Health. 1.2.1 Idem. 1.3.1 Idem. 1.4.1 Idem and activity reports of the PNDS monitoring Committee. 1.5.1 Supervision reports of ECD, CMA and hospitals. 1.6.1 Supervision reports of the DGIEM, Statistics yearbook of the Ministry of Health.	1.1.1.1 The State pursues its health policy. The Government and other partners continue to finance and implement their activities under the PNDS. 1.2.1.1 Idem. Personnel is available in terms of quality and quantity for the health units and the populations support the different programmes. 1.3.1.1 The populations support the different programmes. 1.4.1.1 The Government posts qualified personnel to the health units. 1.5.1.1 Idem. 1.6.1.1 Personnel is available for the health units. Facilities and equipment are maintained.
2. Disease control in the project area.	2.1 Reduction of mortality in the North from 36.62% (2003) to 30% in 2008 and 27.46% in 2010 and in the Centre-East from 43.30% in 2003 to 36% in 2008 and 32.55% in 2010. 2.2 Reduction of rate of malnourished children from 43.50% in 2003 to 36% in 2008 and 32.62% in 2010 in the North and from 52.20% in 2003 to 43% in 2008 and 39.15% in 2010 in the Centre-East. 2.3 Reduction of mother-to-child transmission of HIV (MTCT) from 46.1% in 2003 to 43% in 2008 and 41.4% by 2010.	2.1.1 Supervision reports of ECD, CMA and hospitals. Reports of the PNDS monitoring committee, Demographic and health surveys. 2.2.1 Idem. 2.3.1 Activity reports of laboratories, screening centres supervision reports of ECD, CMA and hospitals. Demographic and health surveys.	2.1.1.1 The populations support national disease control programmes. 2.2.1.1 Idem. 2.3.1.1 The populations support sensitization campaigns.

Narrative summary	Objectively Verifiable Indicators	Means of verification	Major assumptions
	2.4 Reduction of HIV prevalence rate from 2.7% in 2004 to about 2% in 2008 and 1.5% by 2010. 2.5 Reduction by 16% of malaria-related morbidity and mortality, and by 25% by 2010.	2.4.1 Idem. 2.5.1 Statistics yearbook.	2.4.1.1 Idem. Idem.
3. Strengthen health system management.	3.1 All the regulations of the departments in the Ministry of Health are drawn up by 2008. 3.2 Quarterly supervision activities carried out by all the departments of the Ministry by 2008.	3.1.1 Activity report of PNDS monitoring committee. 3.2.1 Idem.	3.1.1.1 Ministry personnel is available and there is proper coordination of health activities at all levels. 3.2.1.1 Idem.
Outputs 1. Health units are constructed and / or rehabilitated, equipped, supplied with drugs and operational.	1.1 2 CHR, 2 CMA, 31 CSPS built and/or rehabilitated, normalized and equipped in 2009 at the latest, of which 31 CSPS and 2 CHR and 2 CMA are 60% achieved in 2008. 1.2 The 35 health units and nine district distribution depots are supplied with essential and generic drugs by 2008.	1.1.1 Reports of acceptance of works and delivery of equipment / furniture. 1.2.1 Reports of acceptance of drugs. Activity reports of the Project Management Unit and Bank's supervision reports.	1.1.1.1 The State and other partners continue to finance and implement activities under the PNDS. 1.2.1.1 Idem
2. The provinces of health regions have screening centers and provide HIV/AIDS control counseling.	2.1 Four HIV screening centers are created, equipped by 2009 of which 80% are completed in 2008. 2.2 Training of 100 advisers (at least 1/3 female) in HIV/AIDS management, and 18 physicians in ARVT by 2010, of whom 60 advisers and 10 physicians in 2008. 2.3 Sensitization and patient management in 9 health districts, 80% completed in 2008.	2.1.1 Reports of acceptance of works and delivery of equipment / furniture. 2.2.1 Activity reports of the project management Unit and supervision report of the Bank. 2.3.1 Idem.	2.1.1.1 The State and other partners continue to finance and implement activities under the PNDS. 2.2.1.1 The populations subscribe to the different programmes. 2.3.1.1 Idem.
3. Medical and paramedical personnel of health units are trained and the populations attend the health facilities.	3.1. Medical (at least 1/3 female) and paramedical personnel is trained by 2010: 15 medical specialists, 40 doctors, 25 officers, 27 technicians, 106 ECD members; 2 water sanitation officers, 60 senior technicians, 160 hygiene workers, 80 trainers in disease and hygiene; of whom 2/3 are trained in 2008. The populations are sensitized to all the programmes during the project. 3.2. The medical staff (at least 1/3 women) and paramedicals trained by 2010:15 specialist doctors 3.3. The populations are sensitized on disease during the project implementation.	3.3.1 Activity reports of the Project Management Unit and supervision report of the Bank. 3.2.1 Idem 3.3.1 Idem	2.1.1.1 Personnel available in quality and quantity for the health units. 3.2.1. Idem. 3.3.1.1. The populations support the various programmes
4. Hospitals play their referral role.	4.1 The plans of action of 12 hospitals are drawn up, implemented and supervised from 2008. 4.2. The rates of charges for services and drugs are available and implemented in hospitals by 2009. In 2008 the rates are prepared.	4.1.1 Activity reports of the Project Management Unit and supervision report of the Bank. And of the PNDS monitoring Committee. 4.2.1 Idem.	4.1.1.1 All hospital personnel subscribe to the programme. Partners' financial contribution is maintained 4.2.1.1 Idem.
5. The maintenance system is strengthened and operational. Maintenance of facilities and equipment is carried out in the health units of the two regions.	5.1 The Centre-east SIEM constructed, that of the north rehabilitated and both equipped by 2009. Works 80% completed in 2008. 5.2 Maintenance personnel is trained: 3 engineers, 22 senior technicians and 27 maintenance technicians, and about 200 users, by 2008 and the total of 405 users in 2009.	5.1.1 Works acceptance and equipment/furniture delivery records 5.2.1 Activity reports of the Project Management Unit and supervision report of the Bank. 53.1 Idem.	5.1.1.1 Works supervision and monitoring actually underway. Timely release of counterpart funds 5.2.1.1.Required numbers of appropriate personnel available for the health units. 5.3.1.1 Idem

Narrative summary	Objectively Verifiable Indicators	Means of verification	Major assumptions
	5.3 Maintenance and servicing manuals are available in the health units by 2009. In 2008, all manuals prepared.		
6. Medicine and traditional pharmacopoeia are practiced in a healthier environment.	6.1 600 traditional doctors (at 1/3 female) are trained in the production of traditional medicine in an appropriate setting, by 2009, of whom 400 in 2008. Two drug production units are acquired, 9 botanical gardens set up in 2008. 6.2 The populations (approximately 1 million people) sensitized on traditional medicine in 2008.	6.1.1 Activity reports of the project management Unit and supervision report of the Bank, and of the PNDS monitoring Committee. 6.2.1 Activity reports of the project management Unit and supervision report of the Bank,	6.1.1.1 Traditional practitioners and conventional doctors support the programmes. 6.2.1.1 Traditional practitioners, conventional doctors and populations support the programmes.
7. The risk-sharing system is put in place in 9 health districts in the project area.	7.1 About 18000 persons join 40 new mutuals or other alternative health funding mechanisms by 2009; and 80 personnel of those structures are trained, including 9000 members, and 40 managers trained in 2008. 7.2 The populations (approximately 1 million) sensitized throughout the project concerning the health risk sharing system.	7.1.1 Project Management Units'' Activity report and the Bank's supervision report 7.2.1 Idem.	7.1.1.1 The populations subscribe to prior contribution. 7.2.1.1 Idem
8. The Directorate General for pharmacy, drugs and laboratories is more operational and plays its role better.	8.1 The drug importation monitoring system is put in place in 2007. 8.2 The location map for pharmacies is drawn up by 2007. 8.3 The laboratory policy and regulatory framework are formulated, as well as all regulations, guides and posters on cancer available in CHR and CMA by 2008. 8.4 The outlines and guidelines on action plans of hospitals are drawn up by 2008. 8.5 Six pharmacists (at least 1/3 female) trained in legislation, quality assurance and public health by 2010, and training will be underway in 2008.	8.1.1 Activity report of DGPML and of the PNDS Monitoring Committee. 82.1 Idem. 8.3.1 Idem. 8.4.1 Idem. 8.5.1 Idem.	8.1.1.1 All stakeholders (pharmacists, laboratories, etc.) subscribe to the activities. 8.2.1.1 Idem. 8.3.1.1 Idem. 8.4.1.1 Idem. 8.5.1.1 Idem.
Activities 1. Architectural and Technical Studies Various studies 2. Drafting regulatory texts 3.Training / sensitization 4. Construction/Rehabilitation of health infrastructure 5.Procurement of furniture, drugs and equipment 6.Project audit and accounts 7.Supervision missions. 8.Project management, monitoring/evaluation.	Project cost by financing source (in million UA) ADF Loan UA 25.00 million Government UA 3.00 million Total UA 28.00 million Project cost by category of expenditure (in thousand UA) — Total / Loan / Govt Goods 6.97 / 6.67 / 0.30 Works 9.71 / 7.91 / 1.80 Services 5.59 / 5.59 / 0.00 Operating 5.73 / 4.83 / 0.90 Total 28.00 / 25.00 / 3.00	Bank's disbursement documents. Project treasury statements of account. Report of the project management unit. Audit and supervision reports.	The State continues to finance and implement activities under the PNDS.

Executive Summary

- Page xii –2:

Purpose of the loan

The ADF loan of UA 25.00 million representing 89.29% of the total project cost, and will be used to finance 100% of the cost in foreign exchange, that is UA 19.22 million, and 65.83% of project cost in local currency, or UA 5.78 million.

- Page xiii –6:

The project will be financed by an ADF loan and the Burkinabe Government. The ADF loan of UA 25.00 million will be used to partially finance the four components. The Government counterpart funds of UA 3 million represent 10.71% of total project cost and will finance part of the civil works, equipment and operation.

- Page xiii –8, second paragraph:

It is recommended that an ADF loan not exceeding UA 25.00 million be extended to the Government of Burkina Faso for the purpose of implementing the project as described in this report, subject to the conditions specified in the loan agreement.

Project Origin and Background

- Page 1- 1.4, fourth sentence:

It is also in conformity with the Bank's Country Strategy Paper (CSP) for Burkina Faso (2002-2009), which lays emphasis on improving living conditions, particularly for the vulnerable segments, and providing the poor populations easier access to basic social services and especially health sector services.

Strategic Context

- Page 21 - 4.3.3, first sentence:

The project is also consistent with the objectives of the Bank Group 2005-2009 CSP for Burkina Faso, which underlines the need to improve living conditions, particularly for vulnerable groups, by enabling the poor segments to have access to basic social services.

Description of Project Outputs

- Page 24- 4.5.13, last sentence:

Through this component, the project will support (i) national disease control programmes (for malaria, PMTCT, safe motherhood and cancer) based on the action plans of HDs, DRS and CHR; (ii) NGOs/Associations implementing IEC activities under national HIV/AIDS and disease control programmes; (iii) the operation over a 4-year period of the HIV/AIDS screening centers and that of the two traditional medicine interface structures in the two target regions.

- Page 25- 4.5.14, first sentence:

Capacity building consists in supporting the measures that help create conditions conducive to significant change in health sector management and delivery of quality care to the population, which will ensure better attendance of health facilities.

Financing Sources and Expenditure Schedule

- Page 29- 4.8.1:

The project will be jointly financed by an ADF loan and the Burkinabe Government contribution. The ADF contribution is UA 25 million and that of the government is UA 3.00 million, representing respectively 89.29% and 10.71% of the total project cost. The project costs by financing source, by component and by category of expenditure are shown in Tables 4.3, 4.4 and 4.5 below, and the list of goods and services is Annex 8.

Table 4.3: Summary of estimated project cost by financing source
(in million UA)

SOURCES	F.C.	L.C.	TOTAL	%
ADF	19.22	5.78	25.00	89.29%
GOVERNMENT	0.00	3.00	3.00	10.71%
TOTAL	19.22	8.78	28.00	100.00%
PERCENTAGE	68.64%	31.36%	100.00%	

Table 4.4: Project cost by financing source and by component
(in million UA)

COMPONENT	ADF			GOVT	TOTAL			%
	F.C	L.C.	Total	L.C	F.C.	L.C.	Total	Comp
1. Improved access to quality health care	13.28	1.14	14.42	1.87	13.28	3.01	16.29	58.18%
2. Disease control	2.61	1.93	4.54	0.40	2.61	2.33	4.94	17.64%
3. Capacity building	2.68	2.24	4.92	0.10	2.68	2.34	5.02	17.93%
4.Project management	0.65	0.47	1.12	0.63	0.65	1.10	1.75	6.25%
Total project cost	19.22	5.78	25.00	3.00	19.22	8.78	28.00	100.00%

Table 4.5: Project cost by financing source and by category of expenditure
(in million UA)

CATEGORIES	ADF			GOVT	TOTAL			%
	F.C	L.C.	Total	L.C	F.C.	L.C.	Total	Categ.
Goods	6,61	0,06	6,67	0,30	6,61	0,36	6,97	24,89%
Works	7,77	0,14	7,91	1,80	7,77	1,94	9,71	34,68%
Services	4,26	1,33	5,59	0,00	4,26	1,33	5,59	19,96%
Operation	0,58	4,25	4,83	0,90	0,58	5,15	5,73	20,47%
Total project cost	19,22	5,78	25,00	3,00	19,22	8,78	28,00	100,00%

- Page 30- 4.8.2:

The ADF resources cover 100% of the foreign exchange costs and 65.83% of the local currency costs. The loan will finance all the categories of expenditure of the four components. The Government's counterpart funds of UA 3 million will cover 34.17% of the local currency costs in and will finance part of the works, equipment (vehicles) and operation (salaries of support staff, rents, operating costs/maintenance of PMU, 25% of mission expenses of component 4. 25% of national disease control programmes, 30% of operation of screening centers and 25% of operation of interface structures in the CHR). The expenditure schedules by component, by category and by financing source are shown in Tables 4.6, 4.7 and 4.8 respectively.

- Page 31:

Table 4.8: Schedule of expenses by financing source
(in million UA)

SOURCES	2006	2007	2008	2009	2010	Total
ADF	1.22	5.88	7.46	7.46	2.98	25.00
GUVERNMENT	0.15	0.70	0.90	0.89	0.36	3.00
TOTAL	1.37	6.58	8.36	8.35	3.34	28.00

Disbursement arrangements

- Page 38 - 5.5.1:

5.1.1 The loan funds will be disbursed according to the schedules of expenditure by component and by category as presented in Tables 4.6 and 4.7. All the disbursements will be released in accordance with the relevant Bank Group rules and procedures. The disbursement methods adopted are: (i) the special account method; (ii) the direct payment method; and (iii) the repayment method. For the operation of the PMU, the Government will open a special account at the BCEAO to receive the loan funds. To facilitate the implementation of day-to-day activities, a sub-account will be opened in the name of the project in a commercial bank acceptable to the Fund. This sub-account will be provisioned from the special accounts according to needs. Furthermore, the Government will open an account at the Treasury to receive the national counterpart funds for financing the project.

Recommendations

- Page 47- 8.2.1:

It is recommended that the Burkina Faso Government be granted an ADF loan not exceeding UA 25 million for the implementation of the project described in this report. This loan will be subject to the general conditions of the Bank concerning its effectiveness and to the following special conditions:

A. Conditions Precedent to Loan Effectiveness

- Page 47-8.2.2:

Loan effectiveness is subject to fulfilment by the Borrower, to the satisfaction of ADF, of the provisions of Section 5.01 of the General Conditions Applicable to Loan and Guarantee Agreements of the Fund.

B. Undertaking prior to any disbursement

- Page 47-8.2.3:

Before any disbursement of the loan, the Government shall undertake to assign the competent personnel required to the CHR built, the CMA and CSPS normalized and the regional maintenance services (paragraphs 4.5.10/14).

C. Conditions precedent to first disbursement of the loan and of the grant

- Page 47

8.2.4 Besides the undertaking and the effectiveness of the loan agreement, ADF shall release the first disbursement of the loan funds only upon the Borrower's fulfillment to the satisfaction of ADF of the following specific conditions precedent:

- Page 47: Condition n° iv) now reads:

iv) Provide to the Fund evidence of having opened a BCEAO account to receive the loan funds, an account in a commercial bank acceptable to ADF, as well as an account at the Treasury for receiving the counterpart funds (paragraph 5.5.1).

- Annex 8

BURKINA FASO

HEALTH DEVELOPMENT SUPPORT PROJECT – CENTRE-EAST AND NORTH REGIONS

Provisional List of Goods and Services

1 UA = 765.154 FCFA

FINANCING SOURCES		Million CFAF			Million UA			Cofinanciers	
CATEGORIES OF EXPENDITURE		F.C	L.C.	Total	F.C	L.C.	Total	ADF	Gvt
GOODS	Basic total cost	4 432.13	233.27	4 665.40	5.79	0.30	6.10	5.84	0.26
	Contingencies	354.57	18.66	373.23	0.46	0.02	0.49	0.47	0.02
	Price escalation	276.74	14.57	291.31	0.36	0.02	0.38	0.37	0.02
	Total cost of goods	**5 063.44**	**266.50**	**5 329.94**	**6.62**	**0.35**	**6.97**	**6.67**	**0.30**
WORKS	Basic total cost	5 203.79	1 300.95	6 504.74	6.80	1.70	8.50	6.93	1.58
	Contingencies	416.30	104.08	520.38	0.54	0.14	0.68	0.55	0.12
	Price escalation	324.92	81.23	406.15	0.42	0.11	0.53	0.43	0.10
	Total cost of works	**5 945.02**	**1 486.25**	**7 431.27**	**7.77**	**1.94**	**9.71**	**7.91**	**1.80**
SERVICES	Basic total cost	2 852.38	890.90	3 743.28	3.73	1.16	4.89	4.89	0.00
	Contingencies	228.19	71.27	299.46	0.30	0.09	0.39	0.39	0.00
	Price escalation	178.10	55.63	233.73	0.23	0.07	0.31	0.31	0.00
	Total cost of services	**3 258.67**	**1 017.80**	**4 276.47**	**4.26**	**1.33**	**5.59**	**5.59**	**0.00**
OPERATION	Basic total cost	383.76	3 453.80	3 837.56	0.50	4.51	5.02	4.23	0.79
	Contingencies	30.70	276.30	307.00	0.04	0.36	0.40	0.33	0.06
	Price escalation	23.96	215.65	239.62	0.03	0.28	0.31	0.27	0.05
	Total operating cost	**438.42**	**3 945.76**	**4 384.18**	**0.57**	**5.16**	**5.73**	**4.83**	**0.90**
PROJECT	Basic total cost	12 872.06	5 878.92	18 750.98	16.82	7.68	24.51	21.88	2.63
	Contingencies	1 029.76	470.31	1 500.07	1.35	0.61	1.96	1.75	0.21
	Price escalation	803.73	367.08	1 170.81	1.05	0.48	1.53	1.37	0.16
	Total cost of project	**14 705.55**	**6 716.31**	**21 421.86**	**19.22**	**8.78**	**28.00**	**25.00**	**3.00**