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PROJECT PAPER

UPPER VOLTA

STRENGTHENING HEALTH PLANNING CAPACITY

(686-0251)

Authorized In The Field, September 21, 1982

AGENCY FOR INTERNATIONAL DEVELOPMENT

UNCLASSIFIED

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: A (A ADD, C CHANGE, D DELETE)

PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: Upper Volta

4. DOCUMENT REVISION NUMBER:

5. PROJECT NUMBER (7 digits): 686-0251

6. BUREAU/OFFICE: A. SYMBOL: AFR; B. CODE: 6

7. PROJECT TITLE (Maximum 40 characters): Strengthening Health Planning Capacity

8. ESTIMATED FY OF PROJECT COMPLETION: FY 88

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 82; B. QUARTER 4 (Enter 1, 2, 3, or 4); C. FINAL FY 82

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L/C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L/C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL	3,046	954	4,000	3,046	954	4,000
(GRANT)	(3,046)	(954)	(4,000)	(3,046)	(954)	(4,000)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1. Peace Corps	20		20	40		40
OTHER U.S. 2.						
HOST COUNTRY	–	169	169		824	824
OTHER DONOR(S) WHO	59		59	353		353
TOTALS	3,125	1,123	4,248	3,439	1,778	5,217

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 82 F. GRANT	E. 1ST FY 82 G. LOAN	H. 2ND FY — I. GRANT	H. 2ND FY — J. LOAN	K. 3RD FY — L. GRANT	K. 3RD FY — M. LOAN
(1) SH	580	583		4,000	–				
(2)									
(3)									
(4)									
TOTALS				4,000	–				

A. APPROPRIATION	N. 4TH FY — O. GRANT	N. 4TH FY — P. LOAN	O. 5TH FY — H. GRANT	O. 5TH FY — S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
(1) SH					4,000	–
(2)						
(3)						
(4)						
TOTALS					4,000	–

12. IN-DEPTH EVALUATION SCHEDULED: MM 6 YY 85

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 (1 - NO, 2 - YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Emerson J. Melaven

TITLE: Mission Director, USAID/Upper Volta

DATE SIGNED: MM 09 DD 21 YY 82

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (3-78)

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*/ In order to ensure that this AID-financed project and the proposed assistance of the World Bank to the health sector in Upper Volta are conceptually in harmony with each other, a World Bank consultant joined the AID Project Paper design team for three weeks.

LIST OF COMMONLY USED ACRONYMS

AID	-	Agency for International Development
CDSS	-	Country Development Strategy Statement
CILSS	-	Permanent Inter-State Commission for Drought Control in the Sahel
COP	-	Chief-of-Party
CSPS	-	Centers of Health and Social Advancement
DPOR	-	Directorate of Planning and Operational Research
EPI	-	Expanded Program of Immunization
FX	-	Foreign Exchange
GOUV	-	Government of Upper Volta
HIS	-	Health Information System
HNPHC	-	Higher National Public Health Council
IREE	-	Institut de Recherche sur l'Economie de l'Education
LC	-	Local Currency
MCH	-	Maternal and Child Health
MOH	-	Ministry of Health
MPH	-	Master's in Public Health
NCPR	-	National Commission of Planning and Research
NGO	-	Non-Governmental Organization
PPF	-	Project Preparation Fund
PVO	-	Private Voluntary Organization
RDSS	-	Regional Development Strategy Statement
SDP	-	Sahel Development Program
SHPC	-	Strengthening Health Planning Capacity
TBA	-	Traditional Birth Attendant
USAID	-	U.S. Agency for International Development
WHO	-	World Health Organization

UPPER VOLTA

BASIC POPULATION AND HEALTH INDICATORS

Area:	274,122 km^2
Resident population:	5,638,203 (1975 census) 6,200,000 (mid-1981: World Bank projection)
Population density:	22 inhabitants per sq.km. (1981)
Percent urban:	9.1% (1975 census)
Percent under 15 years:	45.3% (1975 census)
Rate of natural increase:	2.4% (1980-85: World Bank projection)
Intercensal population growth rate, 1960-1975:	1.7% (includes effect of net emigratio
Total fertility rate:	6.5 live births per woman (1980-85 Wor Bank projection)
Crude birth rate:	48 per 1,000 population (1980-85 World Bank projection)
Life expectancy at birth:	35-40 years (1976 Post Enumeration Survey)
Infant mortality rate:	161 per 1,000 (1976 Post Enumeration Survey)
Proportion of children dying before age 5:	270 per 1,000 (1976 Post Enumeration Survey)
Crude death rate:	24 per 1,000 population (1980-85 World Bank projection)
Literacy rate:	7.5% (1975 census)
Percent enrollment in primary school:	17%
Percent of population with access to safe water:	25%
Population per physician:	50,000
Population per nurse:	3,650
Population per midwife:	27,200
Population per hospital bed:	1,625
Daily per capita calorie supply:	1,900-2,000 (over 90% of required standard)
Daily per capita protein consumption:	56 grams (as of late 1970's)
Daily per capita animal protein consumption:	4 grams (as of late 1970's)
GNP per capita (updated by 1982 World Bank economic mission):	US$ 210 (1980)
Government per capita expenditures in health:	US$ 3.2 (1981)
Overall per capita expenditures in health:	US$ 6.0 (1981)

Source: World Bank Statistics, Upper Volta Health and Nutrition Sector Review July 30, 1982.

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ACTION MEMORANDUM FOR THE MISSION DIRECTOR, USAID/UPPER VOLTA

FROM: Patricia J. Lerner, Project Development Officer

THROUGH: Michael A. Rugh, Acting Assistant Director (draft)

I. Problem: Your approval is required to execute a grant of four million dollars ($4,000,000) from the Sahel Development Program appropriation (SH) to the Government of Upper Volta (GOUV) for the Strengthening Health Planning Capacity Project (686-0251). It is planned that the $4,000,000 will be fully obligated in FY 1982.

II. Discussion: Along with other A.I.D. initiatives in the health sector in Upper Volta, this project contributes to the overall goal of improving the health status of the Voltaic population by increasing delivery of health services to rural areas. The project is designed to meet the purpose of strengthening the planning capacity of the Directorate of Planning and Operational Research (DPOR) of the Ministry of Health (MOH) for the systematic analysis of health needs and resources, the development of health strategies and programs, and to provide a more effective MOH contribution to national planning efforts. The specific objective of making the DPOR operational entails training MOH personnel in the areas of health management, health planning, program evaluation, statistical analysis and planning/programming/documentation (through both on-the-job and formal training). At least five MOH staff members will receive professional training under this project. Another element necessary for making the DPOR operational is the establishment of a Health Information System to comprehensively gather data on vital statistics, health status, health service activities, donor and PVO activities in health, etc., to be periodically updated to constitute a central data bank. In addition, the project will construct and equip a building to house the DPOR, as well as provide a portion of its operating costs during the life of the project. Finally, project staff (technical assistance and MOH counterparts) will carry out several operational research studies and produce a variety of sector analyses, systems development, project development, sectoral planning and national planning documents for use by the MOH and the donor community.

An operational DPOR will possess more precise knowledge of the health needs and services in Upper Volta, will be better able to recommend policy options attuned to the realities of the country, and will have a better chance of allocating resources to the actual needs. Once the DPOR is operational there will be improved possiblities for evaluating health interventions, there will be a stronger possibility of channeling foreign aid funds for health to cost-effective projects and, lastly, the DPOR will be better able to present MOH priorities and concerns at the national planning level.

By strengthening the health planning capacity of the GOUV, the project responds directly to CILSS, GOUV, Sahel Development Program and A.I.D. priorities in the health sector. The initial direct beneficiaries of the project are the employees of the DPOR and other GOUV personnel who interface with the DPOR, employees of the MOH who work in towns and villages outside the capital city,

and rural residents participating in workshops funded by the project. Longer-term benefits will accrue to rural residents who receive drugs and other medicines in a more efficient and consistent manner as a result of improved distribution logistics, and rural residents who participate in the test activities through which the DPOR will gather data during the project. Ultimately, the entire country will benefit directly from having the health needs of its people met more efficiently and comprehensively through better application of both internal and external resources.

It is anticipated that full life-of-project funding, $4,000,000, will be obligated in the first year (FY 1982) of this six-year project. The breakdown by input is as follows:

($ 000)

Project Inputs	A.I.D.	GOUV	Total
Technical Assistance	1,881	--	1,881
Training	75	--	75
Commodities	259	--	259
Construction	289	--	289
Evaluations	87	--	87
Operation, maintenance, salaries	279	579	858
Compounded inflation	844	188	1,032
Contingencies	286	57	343
TOTAL	4,000	824	4,824

The local currency financed by A.I.D. is $954,000. The World Health Organization is contributing $353,000 to the project. Peace Corps will be providing one Peace Corps Volunteer for a contribution of approximately $40,000.

The project has been analyzed from the social, economic, technical, institutional, financial, environmental and engineering points of view with the appropriate inputs from REDSO/WA; the project has been found to be technically sound in all these respects. The IEE recommendation for a Negative Determination was approved by AA/AFR on August 26, 1981 (81 STATE 247357).

The Project Agreement will contain a condition precedent to any disbursement of funds to the effect that the GOUV must provide A.I.D. with written assurance, including detailed implementation plans, that the MOH personnel to be provided by the GOUV will in fact be provided and in place by June 1, 1983. The Project

Agreement will include a covenant that no later than January 15, 1986, the GOUV in cooperation with the technical assistance team, will develop and present to A.I.D. a detailed plan to cover recurrent costs after A.I.D. financing ends. There will be additional covenants ensuring that (1) the MOH personnel sent for training in excess of six months are required to return to their jobs in the DPOR for a minimum of three years, and that (2) local currency expenditures are paid directly by A.I.D. until the arrival of the Chief-of-Party at which time he/she will be responsible for maintaining the project checkbook (although the GOUV Project Manager and another MOH official will co-sign the checks). The Project Agreement will include several other standard conditions precedent to disbursement of funds, as well as several other standard covenants.

In developing the project, we have given careful consideration to the appropriateness of sector-specific conditioning as part of the Project Agreement negotiations. We have concluded it is not appropriate at this time to use the project for inducing or discussing policy reform. Indeed, the project itself will lead to a self-examination of how the GOUV can best provide primary health care to its rural poor majority given the very limited amount of internal resources available to the Ministry of Health. Other donors will also have more confidence in the Ministry of Health as the project progresses. We further feel this project itself represents a determination by the Ministry to put a planning mechanism in place prior to its launching of major, on-the-ground, rural health care delivery systems and, as such, is a signal that they recognize the need to dramatically improve their own operation. Finally, as the project develops, and as opportunities present themselves, A.I.D. (and as appropriate, the World Bank) will give critical attention to such policy issues as cost recovery, the proper role of the GOUV vis-a-vis pharmaceutical supply, and the significant share of the budget given to medical evacuations. Institution and refinement of the health information system proposed in the project will yield the necessary information base on which to initiate a dialogue. We will also use the lessons learned from the project as foundation for commentary and observations on forthcoming IDA loans to the GOUV health sector.

Procurement source/origin waivers are requested for the purchase of two motorized bicycles and a photocopying machine. The justifications are included in Annex O.

The project implementation plan has been reviewed by the Project Review Committee which found it to be reasonable. The implementing agency for the project will be the Ministry of Health.

The Project Review Committee has met periodically throughout the design of this project; it recommended approval of the project on September 20, 1982.

A draft Congressional Notification (CN) was forwarded to AID/W on August 16, 1982. However, the CN only went forward on September 10, 1982, because Section 121(d) of the Foreign Assistance ACT (FAA) had to be certified prior to sending the Notification to Congress. AA/AFR made the 121(d) determination on September 1, 1982, (see Annex C of the Project Paper). The 15-day CN waiting period expires on September 24, 1982.

The requirements of Section 611(a) of the FAA have been satisfactorily met, (See Annex D).

Project implementation will be the responsibility of Dr. Oliver M. Harper, USAID Public Health Advisor, Office of General Development. The AFR/DR/SWAP backstop officer will be David Dawson.

III. Recommendation: That you sign the attached Project Authorization, thereby approving the Strengthening Health Planning Capacity Project at a life-of-project funding level of $4,000,000, and waivers for the purchase of two motorized bicycles and a photocopying machine.

Drafted by: OPR:PJLerner:cd

Clearances: OFM: JStanford

OGD:OMHarper

REDSO/WA RLA:Newton (in draft

OPR:AAVollbrecht

PROJECT AUTHORIZATION

COUNTRY: Upper Volta

PROJECT: Strengthening Health Planning Capacity

PROJECT No.: 686-0251

1. Pursuant to Part 1, Chapter 1, Section 121 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Strengthening Health Planning Capacity Project for the Republic of Upper Volta ("Cooperating Country") involving the planned life-of-project obligation of not to exceed four million dollars (U.S. $4,000,000) in grant funds prior to the end of FY 82, subject to the availability of funds in accordance with the A.I.D. OYB allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project consists of the provision of technical assistance, training and commodities, the construction of a building to house the Directorate of Planning and Operational Research (DPOR) of the Ministry of Health (MOH), and the financing of a portion of the local operating costs of the DPOR in order to provide institutional support to the primary health care system in Upper Volta.

3. The Project Agreement shall be subject to the following essential terms and covenants and major conditions, together with such terms and conditions as A.I.D. may deem appropriate.

4. A. Source and Origin of Goods and Services

Goods and services financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing.

B. Conditions Precedent

(1) Prior to any disbursement of funds or the issuance of any commitment documents under the Project Agreement (except for commodities, equipment, training, the preparation of construction plans and specifications, and as A.I.D. may otherwise agree in writing), the Cooperating Country shall furnish in form and substance satisfactory to A.I.D.:

(a) written assurance by the Minister of Health, including detailed implementation plans satisfactory to A.I.D., that the MOH personnel listed in the Project Agreement to be provided by the Cooperating Country will be provided and in place by June 1, 1983. The Cooperating Country understands that failure to comply by said date with such assurance and plans may result in the termination of funding for the project by A.I.D.

(b) the names and specimen signatures of the Minister of Health, the MOH official who will be assigned to act as the GOUV Project Manager and who will be the counterpart and primary contact for the A.I.D. Project Manager, and the MOH officials who will be assigned to act on behalf of each of the above-named officials in their absence.

(2) Prior to the first disbursement of funds or the issuance of any commitment documents under the Project Agreement for the construction activity financed by A.I.D. under the project (except for disbursement of funds for the preparation of construction plans and specifications, and as A.I.D. may otherwise agree in writing), the Cooperating Country shall furnish, additionally, in form and substance satisfactory to A.I.D.:

(a) detailed plans, specifications and construction schedules with respect to such activities;

(b) a description of the arrangements made for providing construction services for such activities; and

(c) a description of the arrangements made for providing engineering supervisory services for such construction activities.

(3) Prior to the disbursement of funds or the issuance of any commitment documents under the Project Agreement for the procurement of any item or items of equipment and/or commodities financed by A.I.D. under the project, the Cooperating Country shall furnish in form and substance satisfactory to A.I.D. detailed specifications for such equipment and/or commodities.

(4) Prior to the disbursement of funds or the issuance of any commitment documents under the Project Agreement for the procurement of equipment and commodities from sources other than the Cooperating Country financed under the project by A.I.D., the Cooperating Country shall furnish, additionally, in form and substance satisfactory to A.I.D. an executed contract for the services of a procurement agent or other arrangements satisfactory to A.I.D. for providing such services.

C. Covenants

The Cooperating Country shall covenant in substance that:

(1) The MOH shall have overall responsibility for the project.

(2) No later than January 15, 1986, in cooperation with the U.S. technical assistance team to be financed under the project, it shall develop and present to A.I.D. a detailed plan to cover recurrent costs after A.I.D. financing ends.

(3) The MOH personnel sent for training in excess of six months under this project shall be required to return to their jobs in the DPOR for a

minimum of three years, and that it understands that failure to comply with this covenant may result in the collection of costs incurred by A.I.D. for such training.

(4) The terms of the accounting system described in the Project Agreement and all Annexes thereof shall be adhered to, such that:

(a) local currency expenditures will be paid directly by A.I.D. until the arrival of the Chief-of-Party of the long-term technical assistance team financed under the project; and

(b) upon the arrival of the aforementioned Chief-of-Party, he or she will be responsible for maintaining the checkbook for the project, although it will be the GOUV Project Manager and another MOH official who will co-sign the checks pursuant to the Project Agreement.

(5) The terms relating to the taxation of commodities financed under the Project Agreement and all Annexes thereof shall be adhered to; specifically, all such commodities shall be exempt from all taxes, tariffs, duties and other levies imposed under the laws of the Cooperating Country.

(6) Prior to the release by A.I.D. of any funds to a checking account set up by the Cooperating Country for the project, the Cooperating Country shall furnish in form and substance satisfactory to A.I.D. the name and specimen signatures of an official of the MOH who will co-sign checks with the GOUV Project Manager.

(7) In collaboration with A.I.D., it will establish an evaluation program as part of the Project, and, except as the Cooperating Country or A.I.D. otherwise agree in writing, the program will include, during the implementation of the project and at one or more points thereafter:

(a) evaluation of progress toward attainment of the objectives of the project;

(b) identification and evaluation of problem areas of constraints which may inhibit such attainment;

(c) assessment of how such information may be used to help overcome such problems; and

(d) evaluation, to the degree feasible, of the overall development impact of the project.

d. <u>Waivers</u>

(1) The following waivers to A.I.D. regulations are hereby approved:

(a) a procurement source and origin waiver from A.I.D. Geographic Code 000 (United States) to A.I.D. Geographic Code 935 (Special

Free World) for motorized bicycles in an amount of approximately $ 2,000; and

(b) A procurement source and origin waiver from A.I.D. Geographic Code 941(Selected Free World) to A.I.D. Geographic Code 935 (Special Free World) for one photocopying machine in an amount of approximately $ 13,000.

(2) I hereby certify that the exclusion of procurement of the above described commodities from Free World Countries other than the Cooperating Country and countries included in A.I.D. Geographic Code 941 would seriously impede the attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

(3) With respect to the procurement of the above described vehicles, I hereby find that special circumstances exist to waive, and do hereby waive, the requirements of Section 636(i) of the Foreign Assistance Act of 1961, as amended.

Date: September 21, 1982

Mission Director

Drafted by: OPR:PJLerner:cd

Clearances: OPR:AADIR:MARugh

OFM:JStanford

REDSO/WA RLA:ANewton (in draf

I. INTRODUCTION

Health conditions in Upper Volta are among the worst in the world. Malnutrition is widespread, preventable infectious diseases are common, and a wide variety of parasitic diseases are endemic to the area. The health infrastructure available to combat problems of this magnitude is weak, even by Sahelian standards. The existing health delivery system is geared towards facility-based, physician-oriented care, with the result that access to modern health care is severely limited for the majority of rural Voltaics. The drain on limited financial resources just to maintain this low level of service is so great that expansion of similar coverage to reach more people is not possible given Upper Volta's present financial situation.

At the level of the Ministry of Health (MOH), the problems are compounded by the inadequacy of the available health information for decision-making purposes. At the central level there is also a serious lack of trained personnel, particularly in the fields of planning and programming. Attempts to improve the present poor coverage of the rural populations with primary health care services even more dramatically reveal the shortcomings.

Health is a priority concern in Upper Volta as elsewhere, not only because it is a key measure of development achievement (on which the Sahel rates markedly low), but also because improved health helps productivity. There are complex interrelations between health and other socio-economic factors such as education, nutrition and population growth. A well-planned health program will be ineffective if it is not correlated with commensurate increases in agricultural production, improvements in education, and - broadly speaking - if the conditions of the poor are not substantially improved.

II. DESCRIPTION OF THE PROJECT

During the past year and a half, USAID has held discussions with the Minister of Health, the Secretary-General and various other officials of the Ministry of Health (MOH) to determine in what ways AID can be of assistance in putting the GOUV ten-year health plan into effect, and more generally, in what ways AID can assist in alleviating the health problems facing Upper Volta. As a result of these discussions, AID and the MOH determined that an important first step is for AID assistance at the central level to provide a strong planning and support structure for the envisaged primary health care system. The six-year Strengthening Health Planning Capacity Project (686-0251) is designed to provide that institutional support.

A. Project purpose: The project purpose is to strengthen the planning capacity of the Directorate of Planning and Operational Research (DPOR) of the Ministry of Health (MOH) for the systematic analysis of health needs and resources, the development of health strategies and programs, and to provide a more effective MOH contribution to national planning efforts.

This project, along with other AID health initiatives in Upper Volta, contributes to the overall project goal of improving the health status of the Voltaic population by increasing delivery of health services to rural areas.

B. Specific objectives: The specific objective of making the DPOR operational entails training MOH personnel in the areas of health management, health planning, program evaluation, statistical analysis and planning/programming/documentation (through both on-the-job training and formal training). At least five MOH staff members will receive professional training under this project. Another element necessary for making the DPOR operational is the establishment of a Health Information System (HIS) to comprehensively gather data on vital statistics, health status, health service activities, donor and PVO activities in health, etc., to be periodically updated to constitute a central data bank.

In addition, the project will construct and equip a building for the DPOR, as well as provide a portion of its operating costs during the life of the project. Finally, project staff (technical assistance and MOH counterparts) will carry out several operational research studies and produce a variety of sector analyses, systems development, project development, sectoral planning and national planning documents for use by the MOH and the donor community.

An operational DPOR will possess more precise knowledge of the health needs and services in Upper Volta, will be better able to recommend policy options attuned to the realities of the country, and will have a better chance of allocating resources to the actual needs. Once the DPOR is operational there will be improved possibilities for evaluating health interventions, there will be a stronger possibility of channeling foreign aid funds for health to cost-effective projects and, lastly, the DPOR will be better able to present MOH priorities and concerns at the national planning level.

C. Relation of the Project to the National Health Plan: The ten-year National Health Plan which grew out of the 1978 Country Health Programming exercise with the assistance of the World Health Organization (WHO), has two principal foci: (1) development of a primary health care delivery system; and (2) an expanded program of immunizations.

The first level of the primary health care delivery system is to establish in each of approximately 7,000 villages in Upper Volta a team consisting of a traditional midwife, whose skills must be upgraded, and a village health agent. The primary function of these 14,000 health workers will be to promote preventive health practices and improved sanitation, although they will also be trained in basic curative care.

These village health teams will be trained, supervised, and supported by the staffs of 450 Centers of Health and Social Advancement (CSPS), each covering some 15 villages (15,000-20,000 persons). Each CSPS in turn will receive support from a Medical Center headed by a medical doctor in each of Upper Volta's 80 sub-prefectures. Finally, the central administration of the MOH will be responsible for basic health policy and planning, as well as national management of the health care system. The reforms which must occur if a village-based strategy is to be put in place will be the concern of the central Ministry. Similarly, a reorientation of national health manpower policy, the development of plans, and overall evaluation of the regional programs will take place at the central level.

Besides reaching the population through this rural primary health care system the program calls for an expanded immunization program (EPI). In established centers, as well as through mobile units and cold chains, the MOH plans to provide vaccinations against measles, poliomyelitis, diphtheria, whooping cough, tetanus and tuberculosis to all children by 1990 - a world goal set by WHO in 1977.

The program described above would cost approximately $ 400 million over the ten-year period. While this is only about $ 6/year per capita, it is still twice as much as the current GOUV budget for health. Achievement of the program would also require major increases in all levels of trained health personnel. By providing trained staff, facilities, equipment and operating funds to the DPOR, this project will directly assist the GOUV in carrying out its policy and in attaining its goal of making health care available to all Voltaics by the year 2000.

D. CILSS Health Strategy: The ten-year health program of the GOUV is based on and follows the strategy formulated during the Club du Sahel meetings in Ottawa in May, 1977.[1/]

The principal elements of the CILSS strategy are: (a) an expanded program of immunization (EPI) and the control of transmissible diseases; (b) the provision of sanitation and water; (c) the improvement in the nutrition of the Sahelian population, especially of lactating mothers and children; (d) demography and health planning; and (e) the development of basic health services at the village level. The GOUV ten-year health program which this project supports, parallels the CILSS strategy, but focuses most directly on the first, fourth and fifth of the CILSS health program components.

This project is directly supportive of the fourth element of the CILSS program, and indirectly contributes to the attainment of the third and fifth objectives.

1/ Elements de Strategie: Santé-Eau-Nutrition dans le cadre d'un Développement Socio-Economique Harmonieux des Pays du Sahel, Club du Sahel, Ottawa, May 1977.

E. SDP Regional Health Strategy: In terms of AID's strategy for addressing health and population concerns, this project conforms with the regional strategy fo the Sahel Development Program (SDP). In the area of health planning, the Regional Development Strategy[1/] identified the "lack of adequate central planning capacity with feedback mechanisms from the field /as/ one of the most common obstacles to improvement of health services". The RDSS goes on to say that in response to this problem "AID will provide such Ministry health planning units with experienced short- and long-term personnel and material to develop standard drug and equipment procedures, better logistics, data collection, health budget analysis and feedback from the rural areas".

The project addresses itself to several other RDSS concerns, including the strengthening of existing health infrastructure, health training and communicable disease control through epidemiological surveillance.

F. USAID Health Strategy and Activities in Upper Volta: In the 1982 CDSS, as well as the 1983 and 1984 updates, health and population concerns figure among the priorities for U.S. development assistance to Upper Volta. The Strategy set forth in those documents, to which this project responds, is premised on three basic assumptions about GOUV health care policy. First, while the emphasis on rural primary health care in the ten-year plan is laudable and to be encouraged, the MOH is presently in no position to plan realistically or administer such an ambitious program. Secondly, given the lack of an officially-stated GOUV population policy, it will be necessary to establish a relationship of trust and collaboration in health matters which Voltaics view as important before we will be in a position to enter into serious discussions on the population program. Finally, a primary health care delivery system is an important first step for a successful population program.

As opportunities present themselves during the course of implementation of the Project and as other elements of the Upper Volta family planning situation gel, we will encourage the inclusion of family planning in policy and planning dialogue.

Based on these assumptions, the strategy set forth in the CDSS documents is to provide health planning and training assistance at the central level in order to lay the groundwork for the implementation of the primary health care delivery system, as well as to develop good working relationships within the Ministry for future discussions on population policy. By providing both technical and material assistance to the MOH Directorate of Planning and Operational Research, this project will be one of the concrete measures taken by the USAID to implement the Country Development Strategy.

USAID is involved in the health sector in Upper Volta through the PL 480 Title II maternal-child health and school feeding programs, which directly address the endemic child malnutrition. In addition, USAID is implementing sanitation education as part of a rural water supply project (686-0228). In population, the USAID is pursuing a "consciousness-raising" strategy which is progressing well. Over the past two-and-a-half years there have been several "RAPID" presentations and USAID has funded family planning-related short-term training.

1/ Sahel Development Program Regional Development Strategy Statement (RDSS), draft, November 1981, p. 49.

On a regional basis, AID is one of 15 donors to the WHO-implemented West Africa Onchocerciasis Control Program which seeks to control levels of the black-fly population which causes river blindness. Fly levels are currently down to the point at which Upper Volta has been declared oncho-free and any area can be inhabited.

G. Detailed Project Description:

1. Project Strategy: The MOH is confronted by difficult problems - a scarcity of health personnel, medicines and supplies, facilities in disrepair, and coverage of the population at only 25%[1/]. In order to improve the situation, the planning capability of the MOH must be strengthened and the rural health sector must be targeted as a priority area for development. The proposed strategy is to correct the deficiencies of the current MOH operations, specifically the lack of good-quality data and data analysis, poor administration, ineffective coordination between the various MOH Directorates, and an inability to channel foreign assistance to worthwhile projects.

During the six years of the life of this project, actions will be taken to correct these deficiencies, to revise the existing system, and to evaluate the quality of the reporting mechanisms. Data will be gathered and analysed in a systematic manner to permit the early detection of trends, to measure needs, etc., and ultimately, to present a clearer picture of the work of the Ministry to the national planners, the GOUV and the donor community.

2. The Project: As briefly described earlier, this project is designed to strengthen the planning capacity of the newly established DPOR, staffed by trained Voltaics. The Directorate has a mandate to establish an improved data base for Ministerial decision-making, to provide for more effective MOH contributions to national planning efforts, and to develop better-managed and coordinated health programs and strategies, particularly for the Ministry's priority concern of the delivery of primary health care services to the rural areas.

The activities of the project will be carried out by the DPOR under the direction of the Ministry of Health[2/] and its policy committee, the Higher National Public Health Council, as well as the National Commission of Planning and Research for the multisectoral dimensions of program coordination. The DPOR will also work closely with other line Directorates in program development, and with the Ministry of Economy and Plan in its sectoral efforts.

(a) Inputs: The USAID inputs necessary to strengthen the DPOR and develop its planning and programming capacity include the following:

(1) Five technicians for a total of 162 person months:

One health manager for 60 person months to serve as Chief-of-Party to coordinate the activities of the technical assistance team, and to work closely with the Director of the DPOR in the overall improvement of the effectiveness and efficiency of the DPOR by increasing the degree to which it meets its objectives in the areas of planning,

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1/ "Coverage" as defined here refers to the percentage of the target population receiving MOH services.

2/ Please see the organigram of the Ministry of Health in Section III C.

programming, organizing, directing, supervising and evaluating health resources. All these activities are aimed at improving the health status of the population as a whole and, more particularly, of the rural population. Aspects such as the functional analysis of the health delivery system, including personnel and resources, and the subsequent increasing involvement of the periphery and the population in planning responsibilities, should be considered as priority working areas of the health manager;

One health planner for 36 person months to advise on the definition of the five-year and yearly health plans of action, the priorities of the health sector, the steps to be followed in health planning procedures, the selection of health indicators and of an adequate minimum data base for planning the development of strategies in order to enlist the participation of the lower echelons of the health system in the planning process, the establishment of modular standards for drugs, equipment, and construction, along with the improvement of the appropriate logistical system;

One economist with a health specialization for 24 person months to help translate plans and programs into operational projects and to establish operational budgets which can be realistically executed; to analyse the financial implications of present and proposed health programs and projects, and to carry out financial analyses and projections of health resources and requirements for sectoral health planning. The study of recurrent costs and of actual costs of the current health services should be central to the activities of the economist;

One epidemiologist/evaluator for 24 person months to review the existing health information system in order to identify the missing elements and to recommend modifications necessary to establish a simplified system; to define and quantify the specific objectives of the various projects and programs of the DPOR; to contribute to the identification of health indicators for monitoring and evaluation purposes; and to define clear guidelines for the epidemiological surveillance of diseases of public health importance in Upper Volta; and

One documentalist for 18 person months to establish coding, classification and storage systems for the technical information materials of the DPOR in the documentation center; to propose the type and amount of professional and technical information needed; to establish a retrieval system; to prepare materials for the semestrial epidemiological bulletin; and to organize the display and dissemination of informational and educational material.

(2) One locally hired highly skilled French-speaking administrative secretary for 60 person months to improve the skills of the three DPOR office typists and to ensure the functioning of the DPOR with the capability of producing timely reports and documents and to communicate successfully with the other Directorates of the Ministry and the Government.

(3) 14.2 person months of short-term consultants for planning assistance in the areas of epidemiology, financial analysis, systems analysis and record systems development. Three person months are reserved as a discretionary pool from which presently unforeseen consultancies can be filled as necessary.

(4) 7.2 person months of short-term consultants to carry out mid-term and final project evaluations.

(5) 48 person months of long-term participant training for three Voltaic counterparts (statistical analyst, economist and documentalist).

(6) 18 person months of medium-term training for three Voltaic counterparts (health manager, health planner and health evaluator).

(7) Attendance at 16 workshops and/or scientific conferences during the life of the project for both local and expatriate personnel participation.

(8) Technical assistance and operating costs for five operational research studies on: (a) community financing of primary health care services; (b) community organization of primary health care; (c) the role of the village health worker; (d) epidemiological surveillance of selected diseases of public health importance; and (e) development of integrated maternal-child health services.

(9) Construction of one building (300 m^2) with 10 technical offices, support and general services to house the DPOR (see Construction Plan in Annex M).

(10) Commodities to furnish and equip the DPOR and to enable field visits necessary for project planning, programming, monitoring, evaluation and on-the-job training.

(11) Two four-wheel drive all-weather vehicles (one initial one and one replacement) and two four-door sedan vehicles (one initial one and one replacement); two mobylettes (one initial and one replacement) and spare parts for the vehicles and mobylettes in order to ensure transportation for the supervision and monitoring activities of the DPOR technical personnel.

(12) One-half of the operating costs, including, inter alia, per diem for field visits, during the life of the project. The MOH will assume 20% of the operating costs in Year 2, 40% in Year 3, 60% in Year 4, 80% in Year 5, and 100% in Year 6.

The Peace Corps will be providing one volunteer for 24 person months to provide documentalist services to the DPOR. This individual will assist the DPOR from the early start-up of the project until shortly after the return of the Voltaic counterpart from a two-year training course in Dakar. The USAID-funded documentalist will come in to provide technical assistance once the Voltaic counterpart has been trained and has returned to his or her post in the DPOR.

The World Bank is proposing assistance to the health sector in Upper Volta in the form of sector-type IDA credit up to $ 20 million beginning in and around June, 1984. In order to prepare a project loan for presentation to the Board of Governors of the World Bank and in order to assist the DPOR in becoming operational as soon as possible, the Bank is planning to provide the MOH with a "Project Preparation Fund" (PPF). The PPF will run from September 1982 until September 1983 and will fund the following.

(1) Four technicians for a total of 36 person months, consisting of:

(a) One health planner (12 person months);

(b) One MD/MPH (12 person months) whose primary [illegible] the documentation for the World Bank's long-term loan;

(c) Two economists (for a combined period of 12 person months) from the Institut de Recherche sur l'Economie de l'Education of Dijon, France;

(2) Ten person months of short-term training to MOH staff, of which one month for one person in management and three months for three persons in health economics;

(3) The technical assistance and operating costs for two special studies, one on cost recovery mechanisms and the other on the improvement of the drug distribution system and village pharmacies;

(4) Commodities to equip a building to be rented by the GOUV for the DPOR until the AID-financed building is constructed; and

(5) Two vehicles for DPOR staff and technical assistance personnel (plus maintenance, spare parts and operating expenses).

The World Health Organization has been assisting the MOH in a variety of technical areas, including health planning. Directly related to this project will be a WHO-financed statistician for a period of 60 person months to provide technical assistance in the development, upgrading and analysing of health data and health information systems.

The GOUV will provide the following personnel to the project:

(1) One MD who is the Director of the DPOR;

(2) One MD with Public Health training, who will be the Chief of the Planning and Programming Service;

(3) One statistician who will be the Chief of the Statistical Service;

(4) One statistician for the Office of Statistics;

(5) One documentalist for the Office of Documentation and Archives;

(6) One economist for the Office of Projects and Operational Research;

(7) Two public health nurses for the Office of Monitoring and Evaluation

(8) One nurse educator trainer;

(9) One logistical supervisor.

The GOUV will also provide ten support staff including one secretary, three typists, one administrative assistant, two drivers, one clerk, one watchman, and one janitor. In addition to the salaries for the 20 staff members of the DPOR, the GOUV will provide for the rental of temporary facilities to house the DPOR until the AID-financed building is constructed, utilities for the DPOR, logistical support to the Director of the DPOR, and operating costs of the DPOR at the rate of 20% in the second year, 40% in the third year, 60% in the fourth year, 80% in the fifth year and 100% in the sixth year.

(b) Outputs: In order to develop a functional Directorate of Planning and Operational Research, the following outputs are necessary:

(1) Five MOH staff must be trained in the areas of health management, health planning, program evaluation, statistical analysis and planning/programming/documentation through both on-the-job and formal training;

(2) A Health Information System (HIS) must be established to comprehensively collect data on population, vital statistics, health status, health service activities and donor and PVO activities in health in order to constitute a central data bank;

(3) The DPOR staff must have regular regional and national technical exchanges of information through field visits, workshops and conferences;

(4) The DPOR office building must be built and equipped; and

(5) The DPOR must be capable of preparing operational research projects and policy proposals of potential importance to health planning.

(c) End-of-Project status: AID inputs are primarily of an institution-building nature. As such, the project is designed to develop a planning capability in the MOH in order to enable it to provide a better and more extensive health care delivery system with limited financial resources.

At the end of the project in 1988 it is expected that there will be:

(1) A functional Directorate of Planning and Operational Research, staffed by a Statistical Service consisting of an Office of Statistics and an Office of Documentation and Archives, and a Planning and Programming Service consisting of an Office of Projects and Operational Research, an Office of Program Monitoring and Evaluation, and an Office of Human Resources Development; these Services and Offices will be under the responsibility of well-trained Voltaic personnel, capable of operating their units in a professionally integrated manner;

(2) A functional Health Information System installed and operating;

(3) A series of planning and programming recommendations proposed by the DPOR and followed on a regular basis by the different MOH Directorates;

(4) A detailed "plan of action" consisting of specific priority activities and strategies will be developed for the years 1984, 1985, 1986, 1987 and 1988.

Furthermore, at the end of the project, the DPOR should be able to:

(1) Analyse population data, health and service statistics in order to determine health needs and resources;

(2) Assess programmatic and financial feasibility of projects and policy alternatives;

(3) Assist the administration of health services on a national, regional community basis to develop health plans of action adapted to existing health resources;

(4) Make specific recommendations about epidemiological surveillance of selected diseases of public health importance for Upper Volta;

(5) Plan programs and projects in cooperation with other Ministries, othe Directorates in the MOH, and with foreign donors;

(6) Prepare health policy options for Ministerial decision-making groups their consideration and eventual action; and

(7) Coordinate with other MOH Directorates the development of operational research studies in order to illustrate the efficient use of limited health resources.

(d) Beneficiaries: Initial direct beneficiaries of the project are the employees of the DPOR and other GOUV personnel who interface with the DPOR, employees of the MOH who work in towns and villages outside the capital city, a rural residents participating in workshops funded by the project. Longer-term benefits will accrue to rural residents who receive drugs and other medicines in a more efficient and consistent manner as a result of improved distribution logistics, and rural residents who participate in the pilot or test activities through which the DPOR will gather data during the project. Ultimately, the entire country will benefit directly from having the health needs of its people met more efficiently and comprehensively through better application of both internal and external resources.

Women will be both direct and indirect beneficiaries of the project. As women occupy important field positions in the MOH, in departmental hospitals, medical centers, health and social promotion centers, and health posts, they will benefit from the improved management and the opportunity to participate in the work of the DPOR through its field visits, workshops, conferences, pilot activities and publications. Village women are less likely to participate in the workshops, but will be the principal people with whom the DPOR will speak during visits to the field. To the extent that the DPOR is able to improve the drug distribution system, village women and their children who receive improved services will benefit directly from the project. Women will indirectly benefit from the project in that their health needs will be met more efficiently and comprehensively through the improvements introduced by the DPOR.

For a more detailed discussion of beneficiaries, please see the Social Soundness Analysis and Annex H.

(e) How the Project Paper differs from the Project Identification Document: On numerous occasions, the GOUV has stressed the high priority it places on an early start-up for this project. The MOH's interest in improved planning has been prompted by the glaring inadequacy of the health information which is necessary for rational decision-making, especially in terms of the allocation of scarce resources.

It is expected that a functional Directorate of Planning and Operational Research within the MOH will provide better knowledge of the health status of the Voltaic population and a greater ability on the part of the MOH to organize better-managed health services and new health services in the rural areas of the country.

The PP design team recommended certain changes from what was set forth in the PID in order to assure that at the end of the project, in 1988, when technical assistance finishes, the MOH is left with a well-trained and experienced planning and programming team of Voltaic professionals.

First, AID-financed technical assistance was increased from three technicians to five. A physician with an MPH in Health Planning and a Public Health nurse with planning experience will not have the necessary expertise to train counterparts in a project depending so much on on-the-job training in areas as diverse as health management, financial and administrative analysis, program development and policy planning. An Administrative Secretary has been added as Office Manager and to provide training to the Voltaic typists, as the DPOR will rely to a great extent on the production of technical materials.

Secondly, the number of Voltaic counterparts was increased from 13 to 20 to reflect the expanded view of the functions of the DPOR. Of this staff, ten are of a professional level and ten have support functions. The PP added a Logistics Supervisor in charge of both logistics and administrative aspects of the office, an MD/MPH specialist who will become a health planner, an economist to carry out economic and financial analyses, a second public health nurse for the combined Office of Monitoring and Evaluation, and a documentalist for the Office of Documentation and Archives.

Thirdly, the floor plan of the building to house the DPOR was changed in order to make the facility more functional. Technical support, managerial and service areas have now been strategically distributed. While maintaining a similar surface to the previous design, the working areas have now been brought closer to each other in an aesthetically pleasing design. The cost estimate for the improved facility was even lower than the original one in 1983 prices.

Finally, the features of participant training abroad were modified to allow more specific formal training in areas such as health management, health planning, epidemiology/evaluation, economic analysis, biostatistics and documentation. The original plan leaned towards training in public health, public health nursing, health statistics and secretarial management. The PP design team considered health management to be more relevant to the DPOR than secretarial management and thought other areas of health planning and programming were more appropriate for the purposes of the Directorate than general public health or public health nursing.

III. PROJECT-SPECIFIC ANALYSES

A. Economic Feasibility

In order to achieve the goal of improving the health status of the Voltaic population by increasing the delivery of health services to the rural areas, three sequential phases are necessary. The first is to establish a planning capacity within the MOH; the second is to reinforce the network of dispensaries, medical centers, health centers and health posts; and the third is to progressively extend primary health care to the rural population. For the most efficient use of scarce human and physical resources, the first phase is clearly the most cost-effective as it has the potential for designing and coordinating the strategies of the other two phases. The MOH has identified health planning as a top priority, but due to the lack of resources it has not been able to initiate the project. Until now, the collection and publication of rough health data has been carried out in an irregular manner. The last Annual Health Statistics publication was in 1978.

1. Expected results: One of the roles of the DPOR is to help the GOUV to carry out its strategy of development by shedding light on alternative ways to achieve the country's goals. Such planning will have several consequences or results. The most obvious of these results are described below for illustrative purposes, along with their impact on the health delivery system. These impacts can be thought of as intermediate outcomes, as distinct from "outcomes" concerned with changes in morbidity and mortality, which depend on many more factors than just the health delivery system, except in the case of projects targeted at specific diseases.

Results	Impact (Intermediate outcomes)
- channel investments toward priorities	- benefit rural and most needy populations
- avoid duplication of studies	- more money available for project implementation
- ensure that recurrent expenditures are covered	- increase utilization of services
- standardize construction and equipment	- decrease amount of money spent for spare parts and repairs and improve the rapidity with which such problems are solved
- standardize norms, activities and tasks for each personnel category and translate them into job descriptions	- increased efficiency of training facilities and more efficient use of personnel, allowing each health team member to become an element of the whole
- standardize drug lists	- reduce cost of pharmaceuticals and defines parameters of diagnosis
- more rational data collection and use of data	- more reliable data, hence more efficient use of resources

In brief, we can assume this project will increase coverage of care as well as quality of care. It is suggested the evaluation teams (mid-point and final) utilize criteria based on the aforementioned expected results and impacts.

2. Cost-effectiveness analysis: Cost-effectiveness analysis is a straightforward tool with broad applications for the purpose of evaluating the effectiveness relative to the costs of alternative systems. This method of analysis is used to evaluate alternative means for achieving specified ends. For this project, an illustration of the potential application of cost-effectiveness analysis is offered by proposing alternative ways to reduce infant mortality. Two alternatives are oral rehydration versus providing intravenous therapy-oriented intensive recuperation units for high-risk cases of infants suffering from diarrhoeal diseases. The former alternative is significantly more cost-effective than the latter in treating infants suffering from diarrhoeal diseases.

The DPOR will be able to study the impact of alternative means of reaching a given goal. The operational research studies funded by this project could be developed with this idea in mind.

3. Recurrent costs: The establishment of the Directorate of Planning and Operational Research will generate operating costs, some of which will be assumed by the MOH.

In addition to the utility costs of $ 30,000 per year (consisting of $ 19,200 for electricity, $ 1,800 for water and $ 9,000 for telephones), the MOH will increasingly take on the yearly local operating costs of $ 42,220. Beginning in the second year of the project, the MOH will pick up 20% of the local operating costs, followed by 40% in the third year, 60% in the fourth year, 80% in the fifth year, and 100% in the last year of the project. When technical assistance ends, the local operating costs should amount to $ 38,000 instead of $ 42,220 (in 1982 prices). This decrease is due to a reduction in office supplies (20%) and per diem (33%) when the technical assistance leaves.

The total cost of maintenance is estimated at $ 38,000; the total cost of utilities is estimated at $ 30,000; and the total cost of salaries is estimated at $ 58,760 for a total cost of $ 126,760. Salaries will not be a "new" cost for the MOH as the personnel to be transferred to the DPOR are already employees of the MOH. One-third of the DPOR personnel has already been transferred to the new Directorate. By early 1983 the remainder of the personnel will have been transferred to the DPOR. The completion of the transferring of personnel to the DPOR will be the subject of a condition precedent to the continuation of the project after June, 1983. Please see Section VII for a more detailed discussion of this and other conditions precedent to disbursement of funds.

From a technical point of view, these salaries do not constitute recurrent costs for the MOH. However, they are recurrent for the DPOR as it is a new Directorate.

For 1982, recurrent costs of the entire MOH were estimated at $ 9,900,000. Of this amount, $ 68,000 (total maintenance plus total utilities) would be 0.7% and $ 126,760 (total maintenance plus utilities plus salaries) would be 1.3% respectively. Therefore, if we include the salaries in the calculations, recurrent costs originated by the DPOR would be 1.3% of the total recurrent costs of the MOH. If we exclude salaries, the total is 0.7%. Please see Table I.

TABLE I. RECURRENT EXPENDITURES INSIDE AND OUTSIDE THE MOH

Recurrent Health Expenditures	1981 CFAF (millions)	$ (millions)	1982 CFAF (millions)	$ (millions)	% 1982
Personnel	2,486	8.3	2,381	7.9	79.6
Materials (supplies)	271	0.9	347	1.2	11.8
Recurrent costs of investment	76	0.3	79	0.3	3.2
Counterpart for foreign assistance projects	67	0.2	67	0.2	2.2
Contributions to International Health Agencies	93	0.2	93	0.3	3.2
MOH Recurrent Expenditures	2,993	9.9	2,967	9.9	100.0
Medical care abroad	580	1.9	250	0.8	24.3
Participation in the Caisse Nationale de Securite Sociale	27	0.1	25	0.1	2.4
Provision of annual salary increases	-	-	288	1.0	28.0
Maintenance/lease/ Government housing	100	0.3	100	0.3	9.7
Maintenance of public buildings	70	0.2	75	0.3	7.3
Training medical staff abroad	291	1.0	291	1.0	28.3
Recurrent Expenditures outside MOH	1,068	3.5	1,029	3.5	100.0
Total	4,061	13.4	3,996	13.4	-

Note: US$ 1 = CFAF 300.

Recurrent Expenditures inside and outside the MOH

In order to ensure that the DPOR does not become too heavy a financial burden when the technical assistance ends in 1988, the GOUV will pay all utilities and all local salaries from the outset of the project, and a progressively increasing percentage of the local operating costs beginning in the second year of the project. Compliance with the stated percentages of GOUV funding of local operating costs will be verified by the USAID.

B. Social Soundness Analysis

Upper Volta is a land-locked country with a population of approximately 6,200,000. There are nine major ethnic groups in the country, of which the Mossi comprise the greatest percentage (some 48% of the population). The climate, soils and water resources of the country provide a difficult setting for the people. Between 85% and 92% of the population is rural and they are almos all principally occupied in food and cash-crop production, with animal raising as an important secondary activity. It is the primary activity in the case of certain ethnic groups.

The health status of the Voltaic population is poor by any definition. Infant mortality estimates are approximately 161 per 1,000 live-births, and mortality of children 0-5 years old reaches levels above 270 per 1,000. Parasitic bacteriological, viral and nutritional disorders are the principal health problems The demographic profile of the country reveals a young and expanding population. Total fertility rate is 6.5 live-births per woman. The crude birth rate is 48 per 1,000 and the crude death rate is 22 to 24 per 1,000. The rate of annual natural increase is between 2.4% and 2.6% with a population doubling time of 29 years.

The most prominent feature of the Voltaic population picture is migration. Emigration to neighboring countries every year offsets approximately 30% of the natural increase of population. The emigration is heavily skewed toward adult males between 20 and 29 years of age, but there is a trend toward movement of family units and individual women.

There is a traditional health care system which is based on beliefs, techniques and pharmacology which has evolved through time as a means of meeting physical and psychological stresses from the natural and social environment. The traditional system exists apart from the modern health care delivery system, but generally in co-existence with it. However, the training of traditional birth attendants (TBAs) or midwives is being carried out successfully in various efforts being undertaken by the GOUV, donor organizations and non-governmental organizations (NGOs). Two problems would exist, however, if there were to be a comprehensive effort to integrate traditional healers (male guerisseurs) into modern health care delivery roles. First, the process of selection of healers is a mix of inspiration with inheritance, usually involved with contact with supernatural entities. Secondly, "training" or the process of learning the art and practice, involves developing individual skills and knowledge which, of necessity, are exclusive to the individual healer. These factors contrast greatly with the more standardized selection and training done in primary health care projects.

The modern health care delivery system has not adequately met the needs of the rural Voltaics. However, the GOUV policy of establishing a system of primary health care offers the promise of meeting those needs. In the last 10 years there have been primary health care programs and projects serving specific, delimited areas in many parts of Upper Volta, organized and implemented by donor organizations and NGOs. One important task of the DPOR will be to comprehensively map and collect information on these efforts. A study should be undertaken to examine results obtained, focusing particularly on the comparisons and contrasts in community participation, support given to the system, and organizations developed in these efforts. Ethnicity and economic occupation would be two important factors for comparison.

1. Benefits of the Project and their distribution: The principal benefit of the creation of the DPOR will be the rationalization of decision-making for the use of scarce financial and human resources in providing health care delivery services. Special benefits of an effective planning capacity in the MOH include: (a) improving of logistics planning and implementation for drug distribution and vaccination; (b) improving of data collection, analysis, and reporting for planning, implementation monitoring and evaluation; (c) establishing an information system on all activities related to health currently being planned or implemented; (d) providing access to health care delivery system planning implementation, monitoring and evaluation to all levels of participants in the system, especially residents of rural villages; (d) adapting the health care system to focus on the most important needs of the rural population reflecting the real constraints and problems they face.

Initial direct beneficiaries of the project are the employees of the DPOR and other GOUV personnel who interface with the DPOR, employees of the MOH who work in towns and villages outside Ouagadougou, and rural residents participating in conferences and workshops funded by the project. Longer-term benefits will accrue to rural residents who receive drugs and other medicines in a more efficient and consistent manner as a result of improved distribution logistics, and rural residents who participate in the pilot or test activities through which the DPOR will gather data during the project. As indicated in the earlier section on beneficiaries in Section II, ultimately, the entire country will benefit directly from having the health needs of its people met more efficiently and comprehensively through better application of both internal and external resources. Indirect beneficiaries will be the donor organizations and NGOs who will benefit from the rationalization of use of their resources.

Considering the tremendous unmet needs and the fact that 85% to 92% of the population are resident in rural areas, the current orientation of the MOH towards rural needs should be maintained.

2. Participation - objectives, structures and obstacles: The objective of participation in the work of the DPOR is to provide a better means of testing out ideas, assumptions and plans through discussions with people who are close to, and actually living in, the rural areas. The mechanisms and structure for promoting participation in the project will be the following:

(a) regular field trips by DPOR staff and the technical assistance team to visit personnel working at all levels of the health care delivery system and rural residents to discuss their views on health care needs, on how to improve service delivery, and other related questions;

(b) the holding of an annual national conference during each of the last four years of the project and at least one regional workshop or conference each year to bring together health care delivery system personnel, representatives of village health committees, the DPOR staff and the technical assistance team to discuss health care delivery issues;

(c) data collection should include data on community participation and its characteristics as well as the community assessment of the health services available;

(d) any pilot activities undertaken by the DPOR will include community participation in planning, implementation, monitoring and evaluation;

(e) the DPOR will publish an epidemiological bulletin on a semestrial basis to be distributed throughout the Ministry and the departmental levels, including all units down to the health and social promotion centers (CSPS), which will discuss the plans and work of the DPOR and publish comments, letters and articles by people working in the health care system, with an emphasis on hearing what people working at the departmental level and below have to say; and

(f) representation of all MOH Directorates in regular meetings to discuss the work of the DPOR and the relation of their offices to the DPOR in order to learn their views and improve communication and therefore acceptance of the DPOR.

In the design of the new data collection systems, people at all levels of the system should be consulted about what information should be collected, how it should be collected, how it should be analysed, and how it should be disseminated. Participation of village health committees would be recommended, along with that of field MOH personnel from the departmental level to the village. The latter would be important because they would no doubt do most of the data collection and would have insights on what information is relevant and feasible and how dissemination of analysis might be carried out. This would be institutionalized in the DPOR by constant attention from DPOR management in looking for the means to build and increase participation.

The most important result of participation should be the design of a system which is viewed by the rural population, both health delivery system personnel and villagers, as one which meets their needs, includes them in its design and operation, and one for which they are willing to dedicate resources to maintain service delivery.

Obstacles to effective participation in the work of the DPOR will have to be addressed. First, some MOH personnel may not perceive the need for solicitation and consideration of the opinions of subordinates and of villagers - an attitude which may not be conducive to the effective sharing of decision-making. Secondly, there may be little motivation to develop participation in planning because to do so may be perceived as complicating actions and diluting authority. Thirdly, people in subordinate positions in the health care delivery system and villagers may not perceive the importance of their participation and may not avail themselves of opportunities presented to them. Fourth, donor

organizations and NGOs may not perceive it in their interest to expend resources and time in sharing information with the DPOR. Fifth, due to the centralization of authority characteristic of the present system, participation in conferences and in the epidemiological bulletin may be skewed toward the interests of central administration. Finally, there may be resistance from other Ministry offices to the new and prominent role which the DPOR is envisioned to play, which may undercut its efforts. None of these obstacles should be insurmountable, but they should be taken into consideration as the work of the DPOR begins.

Planning may be defined as a process of setting goals and designing actions to produce desired outcomes. It also includes analysing constraints on the actions proposed, evaluating alternative courses of action and modifying actions as goals are pursued. A discussion of the goal formation and decision-making processes among the various ethno-cultural groups which constitute the rural Voltaic population would not be relevant to the project. The same holds true regarding the urbanized elite employed in the MOH. It would be more appropriate to address the question of the means of participation and the obstacles to that participation in the plans of action designed by the DPOR, as discussed above.

A successful planning effort will achieve the following:

(a) adoption of the means recommended;

(b) development of mechanisms for surmounting the obstacles identified; and

(c) acceptance of the validity and feasibility of the goals and actions as developed by the DPOR, by both the MOH personnel and the target population.

Please see Annex H (Social Soundness Analysis) for elaboration upon this section.

3. Evaluation - the role of social analysis: In relation to the evaluations to be carried out at the mid-point and end of the project, a social analyst should be a member of those teams for up to four weeks on each occasion. The analyst will examine: (a) the level of participation of people at all levels of the health care delivery system in the work of the DPOR; (b) the progress of the DPOR in providing the benefits described above and in the distribution of those benefits; and (c) the potential for self-support of the system.

One indicator of the level of participation will be the numbers of visits by DPOR staff to the field and reports written about those visits in order to ascertain the nature of communication with MOH staff and villagers, especially whether their views on health, health delivery and other related matters were obtained and used to modify DPOR work as appropriate. A second indication will be the program and reports from national and regional conferences and interviews with attendees to ascertain how the agenda was developed, who were the important "actors" in the conferences/workshops and the nature of participation of field MOH staff and villagers in the conferences/workshops. A third indicator will be the documents and records of the DPOR on health activities in Upper Volta and interviews with field MOH staff and villagers to ascertain how their participation in health care activities was examined as information was collected by the DPOR. A fourth indicator will be the documents and records of any pilot activities such as pilot innovations in data collection system revision to ascertain how field MOH staff and villagers played or are playing a role in their design and implementation. Fifth, the epidemiological

bulletin and interviews with DPOR staff, other central-level MOH staff, MOH field staff, and villagers to ascertain the nature of their participation in the publication by examining its availability, its relevance to MOH personnel and villagers, the access of non-DPOR MOH staff to publishing in it, and whether the MOH planned to continue it after AID funding of it ceased. Yet a sixth indicator would be the records of meetings and interviews with non-DPOR MOH staff to ascertain the nature of their participation in the planning and implementation of DPOR work.

Indicators for the provision of benefits mentioned previously which are related to the evaluation of social issues are the same as indicated in the preceding paragraph. Indicators for distribution of those benefits will be the identification of all MOH staff, villagers, and other GOUV personnel who have been involved in the project through its participating mechanisms.

Finally, one indicator for self-support will be identification with the work of the DPOR and with improving the health care delivery system on the part of non-DPOR MOH staff, other GOUV personnel and villagers. A second indicator will be if planning and implementation of participatory activities is being done through initiatives of DPOR staff. A third indicator will be if non-DPOR MOH personnel and villagers initiate contact with the DPOR to utilize its participatory mechanisms.

C. Technical Analysis

1. Mandate of the DPOR: The DPOR was created by Presidential Decree in October 1981, with a mandate to centralize and analyse statistical information necessary to overall planning, to design projects and plans of action in accordance with the national health policy, to seek sources of financing, and to monitor implementation and evaluation activities.

As such the DPOR is to:

(a) centralize, systematize, analyse, store and disseminate selected information allowing the orderly planning, programming and evaluation of MOH activities, in accordance with the National Health Plan and its yearly Plan of Action. A data bank will stock historical health series for statistical and evaluative purposes, and an Annual Health Bulletin should be published at the beginning of each year, summarizing the health activities and the health status of the country during the preceding year;

(b) facilitate managerial, coordinative and administrative activities related to the delivery of health services through the regular and orderly analysis of data collected by the various technical and administrative Directorates, Services and Offices of the MOH, as well as by the various health service units throughout the country. These analyses should be sent to the original gathering points at the departmental level for appropriate utilization and action;

(c) advise on the type and characteristics of studies and projects to be carried out by the MOH and/or cooperating agencies and determine their priority in application of existing health policies. The preparation of sectoral health plans and the establishment of specific strategies for their implementation are core activities of the DPOR;

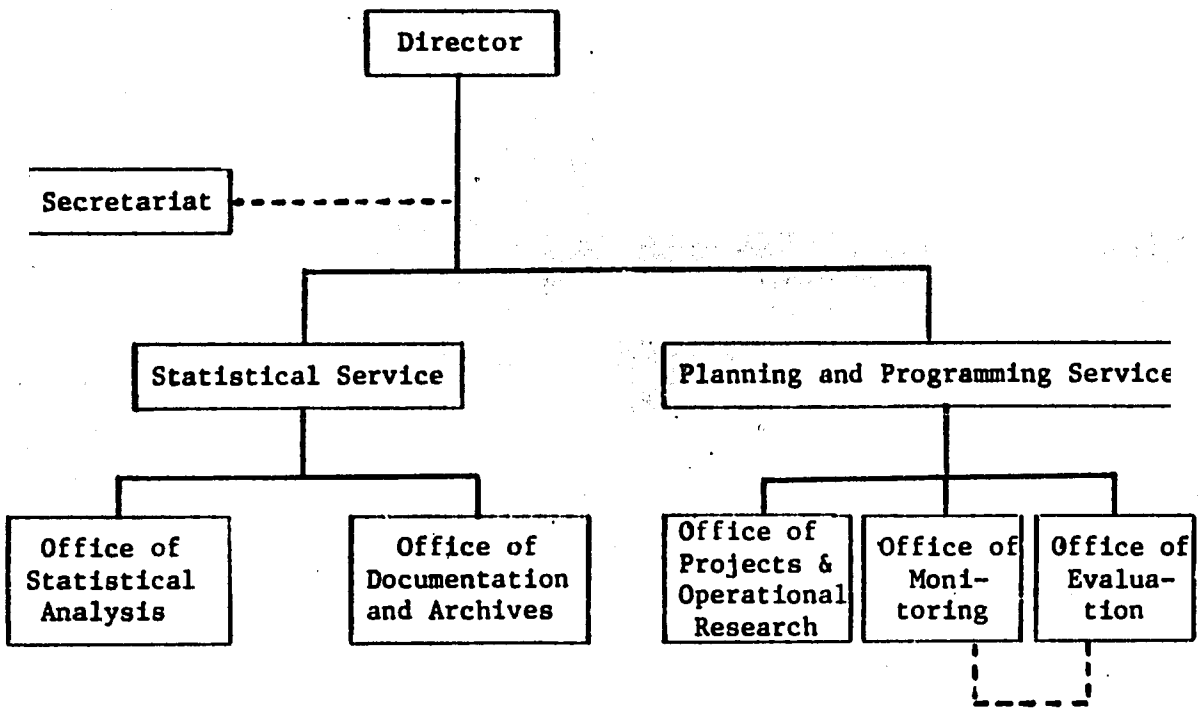
(d) monitor and evaluate data dealing with the implementation of delivery of health services in order to determine if the specific objectives sought by the National Health Plan are being accomplished and if the quality of the services corresponds to the established norms set by the MOH;

(e) advise the decision-making levels of the MOH on norms, methods and policies for strengthening and improving the delivery of health services;

(f) provide health and health service statistics as well as background information which may be required from time to time by health service agencies, by international organizations and by the general public; and

(g) serve as a clearing house and central data bank for studies and projects financed by foreign donors and actively seek possible sources of financing for programs considered of high priority by the GOUV.

The Ministerial Decree of February 1981, which further defines the tasks and composition of the DPOR, can be automatically represented as follows:



The functional analysis which is presented later in this section reveals that the Office of Monitoring and the Office of Evaluation could be combined without overloading the personnel or their functions. This amalgamation would permit the creation of a third office - the Office of Human Resources Development - which could deal with pertinent planning and programming aspects of health personnel within the DPOR. It is expected that the DPOR will make this recommendation to the MOH early in the Project. If such a modification is accepted by the MOH, the new office should coordinate with the Directorate of Professional Training.

2. Coordination: At this time the DPOR exists on paper and is just barely getting off the ground. As of this writing the DPOR consists of the Director the WHO-financed expert in Statistical Analysis. Such as it is, the DPOR develops and maintains coordination and working relationships with other Directorates within the MOH, the network of health service units under the Directorate of Public Health, and with all organizations and institutions of similar or complementary nature.

Lines of authority are illustrated in the organigram of the MOH (Fig. 1). The DPOR is under the authority of a Director, who is responsible to the Secretary-General and the Minister of Health, for the organization, coordinatio operation and supervision of the Directorate. The DPOR functions as the Secretariat of the National Commission of Planning and Research, which is an organization attached to the MOH cabinet.

3. Staffing: A list of the DPOR's personnel is shown in Table II.

4. Responsibilities: The DPOR is responsible for: (a) centralizing all reports written by other Directorates; (b) initiating and maintaining contact with external sources of financing except for operational actions involving other Directorates; and (c) furnishing the technical link between the MOH and the Ministry of Plan.

5. Outputs of the DPOR and other Directorates: Table III shows a matrix corre lating the outputs of the DPOR with those of other Directorates. Prior to the creation of the DPOR other Directorates had the tasks now assigned to the DPOR, with the exception of the task of developing a planning model. The DPOR meets with the other Directorates to plan and review their respective roles in these and other tasks.

The relationship of the DPOR with the implementing services of the MOH will be principally through the Directorate of Public Health, to which the departmental services report. The departmental services are responsible for ensuring that programs defined by the MOH are implemented and for supervising, training and providing refresher courses for health personnel. In addition, they are responsible for data collection and writing reports.

Using these outputs we can now proceed to a functional analysis of the DPOR with a description of the principal activities to be carried out by its services and offices.

6. Functional analysis of the DPOR: The services and offices of the DPOR are charged with the functions described below:

(a) Planning and Programming Service:

(1) In charge of establishing a five-year health plan of action for all Directorates of the MOH:

- Identify in the five-year plan the actions to be undertaken on a yearly basis according to strategies set by the MOH;
- Identify staff in charge of specific actions to be undertaken within each year;
- Establish a yearly timetable for the actions to be carried out by those so designated;
- Define sector priorities.

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Fig.1 Organigramme of the Ministry of Public Health - Republic Upper Volta West Africa (1982)

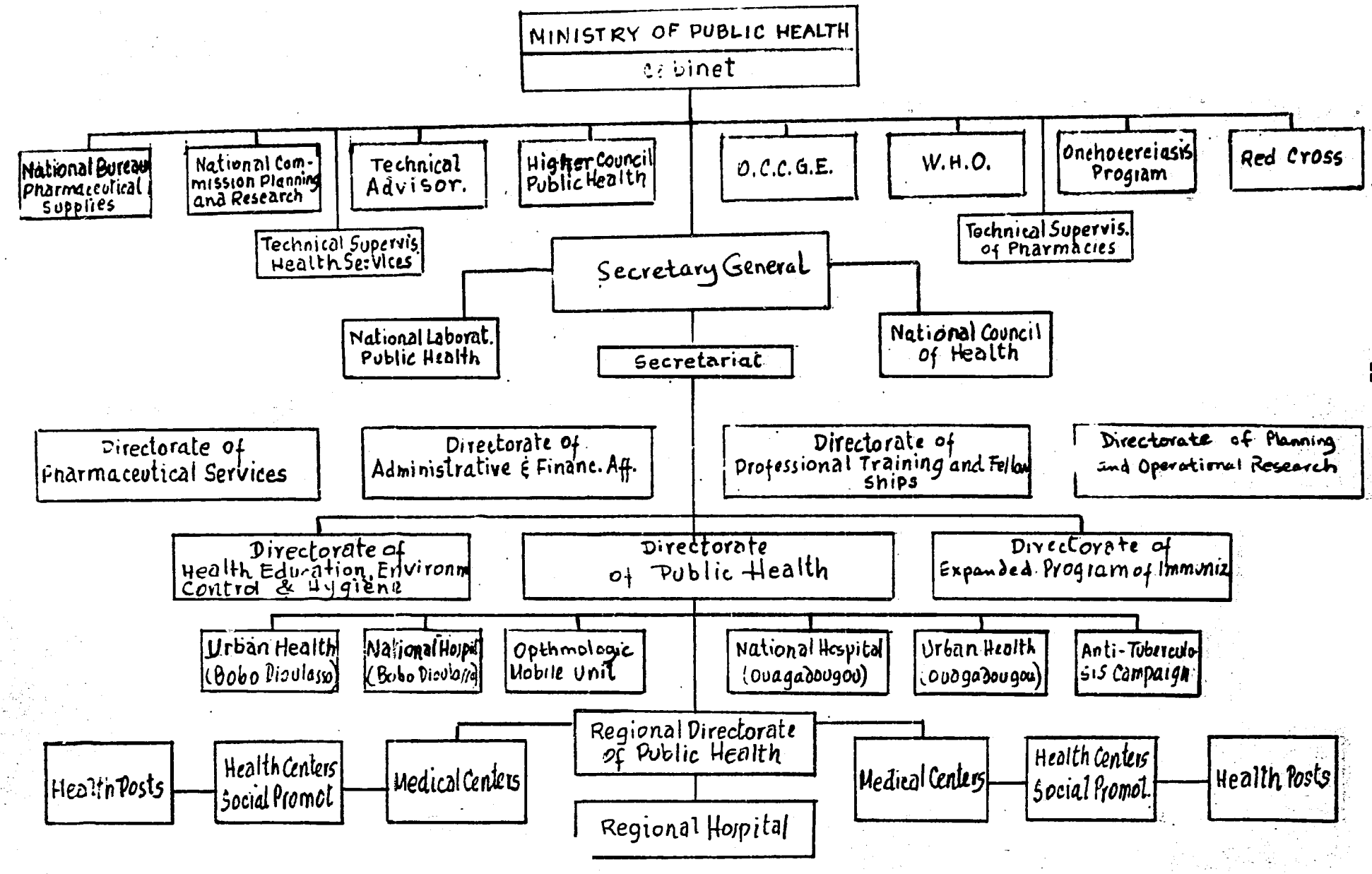

TABLE II. DPOR PERSONNEL BY TYPE, NUMBER AND QUALIFICATIONS

Office	Voltaic Personnel	AID-Financed Expatriate Technical Assistance	Total number	Qualifications of Voltaic Personnel
Office of the Director	2	1	3	1 MD in Public Health and 1 Logistical Supervisor
Planning & Programming Service	1	1	2	1 MD in Public Health
Office of Projects and Operational Research	1	1	2	1 Economist
Office of Monitoring & Evaluation	2	1	3	2 Public Health Nurses
Office of Human Resources Development	1	0	1	1 Nurse Educator Trainer
Statistical Service	1	1	2	1 Biostatistician
Office of Statistical Analysis	1	0	1	1 Statistician
Office of Documentation & Archives	1	1	2	1 Documentalist
Sub-total of Technical Staff	10	6	16	
Support staff: Administrative Secretary	0	1	1	
Secretary	1	0	1	
Typists	3	0	3	
Xeroxing/Mimeographic Clerk	1	0	1	
Administrative Assistant	1	0	1	
Drivers	2	0	2	
Watchman	1	0	1	
Janitor	1	0	1	
Sub-total of Support Staff	10	1	11	
Total - Personnel	20	7	27	

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TABLE III. CORRELATION BETWEEN DPOR'S OUTPUTS AND RELATED OUTPUTS OF OTHER MOH DIRECTORATES

DPOR's Outputs	DPOR has primary responsibility for these tasks, which lead to the outputs listed in the first column	Directorates which Contribute to DPOR's Outputs					
		Directorate of Financial and Administrative Affairs	Directorate of Professional Training	Directorate of Pharmaceutical Services	Directorate of Public Health	Directorate of Expanded Program of Immunization	Directorate of Health Education, Hygiene and Environmental Sanitation
Yearly Plans of Action	1. Defining priorities	-	x	-	x	x	x
	2. Reviewing yearly plans of action	x	x	x	x	x	x
	3. Readjusting yearly budget	x	-	x	x	-	-
	4. Evaluating investment and recurring expenditures	x	-	x	-	x	x
	5. Developing a planning model	-	-	-	-	-	-
	6. Keeping files on private- and donor-financed health activities	x	-	x	x	x	-
Standards for construction, equipment, drugs, personnel	7. Preparing functional analysis of health	-	x	-	x	x	x
	8. Defining construction, equipment, personnel and drug norms	-	x	x	x	x	x
Special studies	9. Identifying and planning necessary studies	-	-	-	x	x	-
Project monitoring	10. Defining technical supervisory standards	-	x	x	x	x	x
	11. Ensuring implementation of supervision	-	-	-	x	x	-
	12. Administrative monitoring	x	-	x	x	-	-

TABLE III. CORRELATION BETWEEN DPOR'S OUTPUTS AND RELATED OUTPUTS OF OTHER MOH DIRECTORATES (Continued)

DPOR's Outputs	DPOR has primary responsibility for these tasks, which lead to the outputs listed in the first column	Directorates which Contribute to DPOR's Outputs					
		Directorate of Financial and Administrative Affairs	Directorate of Professional Training	Directorate of Pharmaceutical Services	Directorate of Public Health	Directorate of Expanded Program of Immunization	Directorate of Health Education, Hygiene and Environmenta Sanitation
Project Evaluation	13. Reporting on progress, bottlenecks, solutions	x	x	x	x	x	x
	14. Evaluating projects and programs	-	x	-	x	x	-
Rational data collection, analysis and diffusion	15. Developing a statistical information system	-	-	x	x	x	-
	16. Evaluating training needs for statistics	-	x	-	x	x	-
	17. Collecting data	-	-	x	x	x	x
	18. Analysing and diffusing data	-	-	x	x	x	x
Centralized health documentation for Upper Volta	19. Collecting documentation	-	x	-	-	-	-
	20. Diffusing documentation	-	x	-	-	-	-
	Total number of items	6	10	11	16	15	9

(2) In charge of reviewing and finalizing the draft proposed yearly plans of action prepared by each Directorate:

- Compare the actions accomplished with those planned for in the yearly timetable;

- Identify the bottlenecks that prevented planned actions from being undertaken;

- Reassess the budget for the yearly plan of action as well as for the five-year plan.

(3) In charge of developing a planning model based on primary health c which has as a principle the community participation in the choice their priorities.

(4) In charge of defining health development strategy norms for each department or other administrative area.

Office of Projects and Operational Research:

(1) In charge of preparing realistic and financially sound projects:

- Demonstrate the feasibility of projects and studies by means of a functional analysis of their elements;

- Establish investment and recurrent costs of identified actions within all studies and projects.

(2) In charge of establishing norms for buildings, equipment, drugs an personnel for all health infrastructure:

- Establish and update the functional analysis of health infrastructure;

- Establish norms for construction, equipment and personnel for each category of health infrastructure as well as standardized drug lists for the same health infrastructure;

- Establish the list of personnel necessary for each category of health infrastructure with detailed activities to be carried out by each category of personnel.

(3) In charge of planning the studies necessary for the preparation of projects:

- Identify on a yearly basis the studies necessary for the improvement of other office activities;

- Review the available reading material to verify the validity of undertaking a submitted study project;

- Define the objectives and the evaluation criteria of each study;

- Identify the various components of the survey and the necessary resources for its implementation.

(4) In charge of keeping and updating files for all private (village) and donor initiatives.

(c) Office of Monitoring:

(1) In charge of establishing technical supervisory norms of the plan's projects and programs:

- Identify those responsible for the implementation of the projects and programs;

- Establish the list of duties and responsibilities for those in charge;

- Establish supervising norms (i.e. standard treatment) and the supervisory system for those in charge.

(2) In charge of establishing a supervisory system:

- Subsequent to (1), design for each level of supervisory authority the appropriate forms containing supervision tasks and mechanisms showing if any of them has not been carried out;

- Check how supervision is being accomplished, through both field trip and using the above-mentioned forms.

(3) In charge of writing reports on the on-going projects:

- Periodically produce written summaries of the forms received as well as of the information gathered during field trips;

- Periodically edit a concise report on the on-going activities, the identified bottlenecks and the proposed solutions; this is done through the analysis of the summaries of the forms with the norms of number (1) as criteria.

(4) In charge of the administrative follow-up of all projects and programs:

- Check construction, procurement, and other work progress for each project.

(d) Office of Evaluation:

(1) In charge of evaluating the projects and programs included in the yearly health plans:

- Define the objectives for each project and program;

- Establish health indicators necessary for the evaluation of each project according to the proposed objectives;

- Make sure that these indicators are being recorded; if they are not, specify the methodology by which it will be done (forms, surveys, etc.);

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- Analyse the projects in relation to the objectives to be reached.

(e) Statistical Service:

This service will provide information upon which sound decisions can be made. In order to do so, it will have:

(1) To develop an information system model adapted to the needs and capacity of the MOH by:

- Defining the objectives of the new system;
- Determining the qualitative and quantitative aspects of the information;
- Defining the flow pattern of information within and outside the MOH;
- Developing a plan for tabulation and analysis;
- Designing the appropriate recording system.

(2) To assess the estimated resource needs for the implementation of an adequate information system.

(3) To define the training needs in order to promote a greater efficiency in data gathering capability and enhance the analytical capacity necessary for its exploitation.

(4) To produce and disseminate information (annual statistical book).

(f) Office of Statistical Analysis

(1) Data collection:

- To review (periodically) data needs and data sheet forms;
- To design new forms if necessary;
- To dispatch and collect the forms;
- To determine the routing to and from the Office of Statistical Analysis of the data forms and specify the frequency;
- To train field personnel in data gathering.

(2) Data analysis:

- To tabulate and synthesize collected data;
- To compare variations in time and space;
- To translate from numbers to charts and vice-versa;
- To comment on observed changes;
- To edit reports.

(3) Data diffusion:

- To determine who are the users and to assess the quantitative needs of the receivers;
- To determine the spectrum and the refinement of data to be diffused;
- To specify the frequency of data output;
- To determine the quality of printing and packaging;
- To design the routing of shipped data.

(4) Self-evaluation:

- To design a self-evaluation system.

(g) <u>Office of Documentation and Archives</u>:

(1) Information collection:

- To determine which service needs what kind of information,
- To list the types and amounts of professional and technical information needed (books, articles, documents, and audio-visual materials);
- To organize an ordering/procurement system;
- To research information sources;
- To define space allocation;
- To specify the type of storage;
- To design a classification system;
- Periodically assure review-binding.

(2) Diffusion:

- To establish a retrieval system;
- To organize the display of information for accessibility;
- To organize the dissemination of information (To whom is it sent? Where? How?);
- To establish a recalling system;
- To ensure reproduction.

(3) Evaluation:

- To review the quality of information available and sent;

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- To check the regularity of shipping;
- To keep track of budget allocation.

The offices will need support in terms of procurement, shipping, printing and reproduction. The Logistical Supervisor will be responsible for providing this support.

A comparative analysis between the structure of the DPOR and the structural elements of a health delivery system yields the outputs expected from the DPOR by the end of the project. These outputs show a close correlation with the outputs identified in Table III, with the exception of human resources development, which was not taken into consideration when the matrix was developed.

Fig. 2 is a schematic representation of the comparative analysis described above. The homogeneity of the structure and the functions is significant. Given these elements, realistic end-of-project outputs can be determined.

7. Outputs of the DPOR by the end of the project: These outputs are schematically presented in Fig. 2 according to the type of service or office.

The outputs will be the following:

(a) Directorate of Planning and Operational Research:

Functional analysis of the health delivery system; policy options recommended for the strengthening of the health delivery system.

(b) Statistical Service:

Development of a simplified Health Information System installed and functioning with data coming from central offices of the Ministry of Health and peripheral MOH Directorates from the 11 Departments.

(c) Planning and Programming Service:

Specific strategies and plans of action developed (in coordination with appropriate MOH offices) reflect priorities assigned by the master health plan and priority needs from the community.

(d) Statistical Service and Planning and Programming Service:

Standards for drugs, equipment, transportation, construction; logistical aspects to ensure the timely distribution of health supplies to health units; definition of modular needs of drugs, equipment, other supplies by category of health unit.

(e) Office of Human Resources Development:

The Office of Human Resources will coordinate policy, planning and program development with the Directorate of Professional Training. This will ensure that manpower development in the MOH will be integrated with strategies and policies formulated by the DPOR.

HRD model developed with norms on recruitment, selection, training, supervision, evaluation, continuous education, incentives, etc., for each level

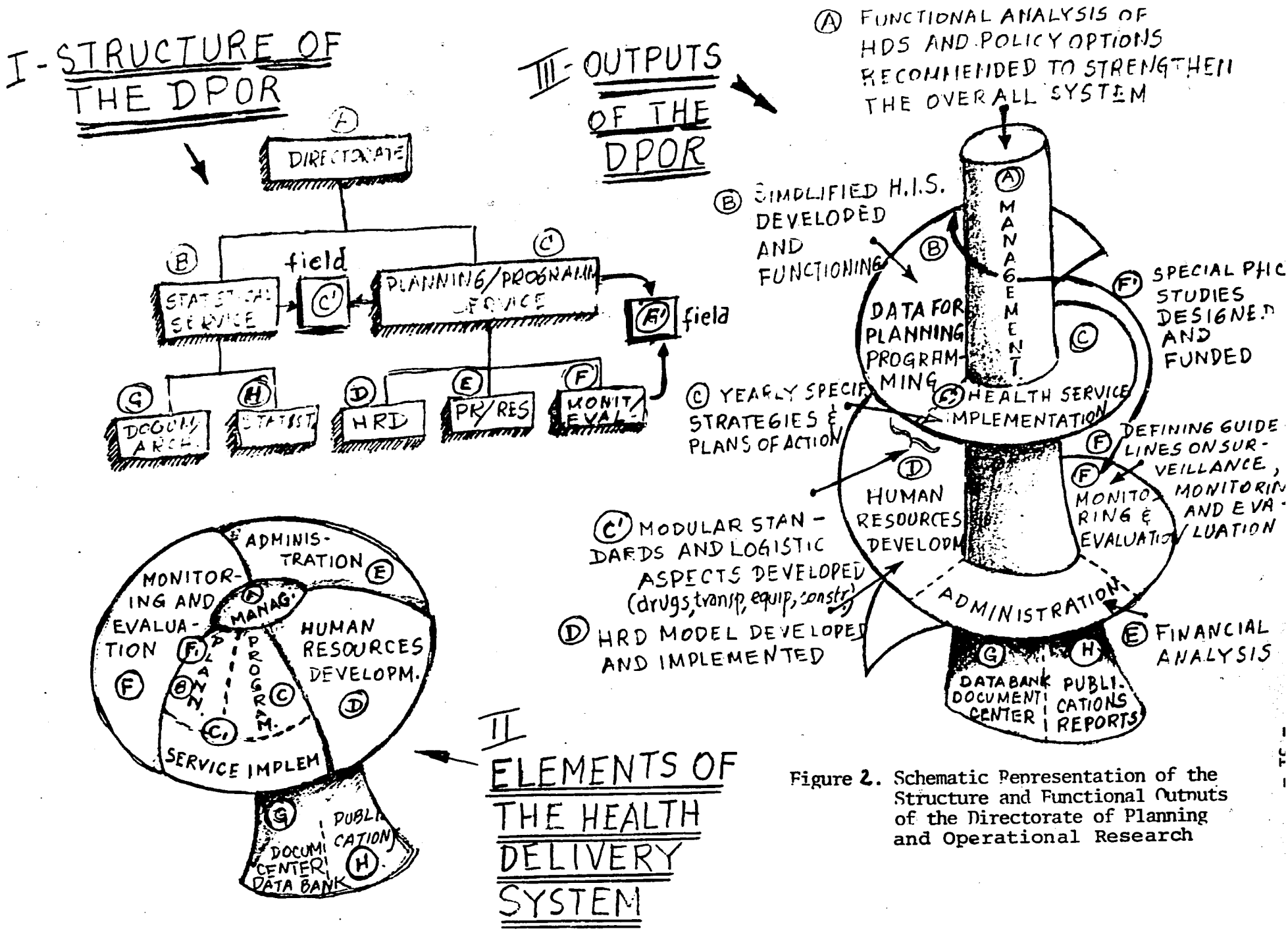

Figure 2. Schematic Representation of the Structure and Functional Outputs of the Directorate of Planning and Operational Research

and category of health personnel; development of job descriptions and task analysis.

(f) Office of Projects and Operational Research:

Financial analysis of health interventions (primary health care, vaccination campaigns, etc.), study of health costs per capita, cost/effectiveness, recurrent costs, budgeting and accounting operations.

(g) Office of Monitoring and Evaluation:

Definition of guidelines for epidemiological surveillance, health monitoring and program evaluation; testing the guidelines and recommending specific actions from the support services and other MOH services.

(h) Planning and Programming Service and Office of Monitoring and Evaluation:

Design and coordinate operational research activities with other members of the DPOR, appropriate MOH officials and when necessary short-term technical assistance; subjects recommended are:

- Community organization of Primary Health Care Services (PHCS);
- Community financing of PHCS;
- Role of the village worker;
- Epidemiological surveillance of diseases of public health importance;
- Development of integrated maternal-child health (MCH) (demonstration program for replication on a national scale).

(i) Office of Documentation and Archives:

Keep files on private, public and donor health activities; collect and organize documentation; keep updated data bank ready for information purpose organize DPOR library and establish retrieval system.

(j) Office of Statistical Analysis:

Under the supervision of the Statistical Service, process population, health statistics, health services, vital statistics data; make tabulations according to instructed dummy tables; prepare graphs based on tabulated historical series; establish statistical significance of tabulated data.

8. Expected role of the DPOR: The DPOR is expected to become the principal source of data on the health status and health activities of Upper Volta. Th data are expected to furnish the basic information which is necessary for management and planning purposes, for ministerial decision-making, and as a contribution to national planning efforts.

It is expected that the principal users of the information produced by the DPOR will be the Minister of Health, the Higher National Public Health Council, and the National Commission of Planning and Research. Secondly will be the MOH Directorates of Public Health, Health Education, Hygiene and Environmental Sanitation, Expanded Program of Immunization, Pharmaceutical Services, Financial

and Administrative Affairs, and Professional Training. Further down the ladder of users will be the MOH Directorates at the departmental level. The Table III matrix of the DPOR outputs and the specific Directorates which will contribute to those outputs gives an idea of the practical use by the Ministerial level of the information produced by the DPOR.

9. Measures necessary to provide data to the DPOR: The measures necessary to provide the DPOR with sound data have to do mostly with the motivation of field workers in charge of gathering information. In order to motivate field personnel it will be necessary to undertake a sample interview survey in order to learn the reasons for the workers' satisfaction and dissatisfaction. Given this knowledge it may be possible to design interventions geared towards reinforcing motivation. Such interventions could be monetary, social or status oriented incentives. In addition, a rapid feedback system to the lower echelons is necessary to motivate local personnel to obtain good quality data. Pilot studies of this kind could be carried out by the DPOR as part of their operational research activities. Finally, community participation, when appropriately addressed, could favor the provision of more sound data.

10. Priority planning needs: Priority planning needs are numerous:

- Morbidity by type, severity and outcome;
- Data on notifiable diseases, on blindness, incapacity, etc.;
- Numbers and types of available services and their utilization rates;
- Organization of private, Government or mixed health care systems;
- Budget and expenditures by type and geographical distribution;
- Payment mechanisms and related information;
- Numbers of malnourished children under five years of age;
- Per capita intake of protein;
- Total and per capita supply of energy (calories);
- Specific activities of MCH programs including attendance by sub-programs, number and types of deliveries, of abortion cases, malnourished children, birth-spacing data;
- Administrative logistics and maintenance information; and
- Provision, turnover and inventory of drugs by region, department and health facility.

A strengthened DPOR will be suited to addressing such needs through the development of a simplified Health Information System. DPOR staff, with technical assistance and additional training, will have the necessary variety of training in order to assure the required expertise and to ensure that proper data are assembled, tabulated, analysed and published.

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D. Institutional Analysis and Administrative Capabilities

1. Description of the Ministry of Health:[1/] The Ministry of Public Health is responsible, at the Government level, for all the matters related to health in the country. Another Ministry, the Ministry of Social Affairs, is in charge of welfare, rehabilitation of the disabled, and childhood protection. The Caisse Nationale de Sécurité Sociale (which deals with pensions, dependency allowances, and occupational injuries) is under the Ministry of "Fonction Publique". Population surveys are the responsibility of the "Direction des Etudes Demographiques" under the Ministry of Plan. Both the Ministry of Health and the Ministry of Rural Development have a special unit dealing with nutrition. The newly established school of medicine is part of the University under the Ministry of "Enseignement Supérieur".

Private practice is not permitted for medical officers, unless they have devoted 10 years to public service with the MOH. At present, the Government recognizes only two private clinics. In fact, most of the physicians do private practice within Government facilities. Moreover, many nurses operate illegal private clinics at home after business hours.

At the peripheral level, the health administration is decentralized through 11 Directions Départementales de la Santé (one per department), each headed by a medical officer. The medical officer is in charge of all the various aspects of health, supervising a departmental hospital and the rural health facilities, organizing the work of two mobile teams for preventive medicine and immunizations, and advising the local administration on all matters relevant to health and sanitation. The DDS does not directly handle money, except for the health chapters of the local budgets which are used at their request. The MOH intends to give them the opportunity to participate in the planning process in order to improve the validity of the exercise which is presently very technocratic and formal.

By the end of 1980, the MOH was operating 413 facilities: (a) two national hospitals, representing 40% of the available beds in the country; (b) three regional hospitals; (c) 13 medical centers - smaller facilities effectively supervised by a physician (including two private clinics); and (d) 395 other facilities totaling approximately 1,820 beds, with one-half of them in maternity wards. In addition, 24 facilities are not in operating condition, either resulting from lack of staff, or because they have just been completed. (Fourteen new facilities have been completed, with Canadian assistance, in the Centre-Est Department and are expected to be in operation sometime in 1982.) Finally, 25 projects have been approved by the MOH and are in the process of realization (mostly by local initiative), and funds have been allocated from the national budget to build a 200-bed military hospital in Ouagadougou. It should be noted that a large number of existing facilities are in need of renovation, both in terms of buildings and equipment.

1/ The section describing the Ministry of Health comes from the World Bank Health and Nutrition Sector Review (Population, Health and Nutrition Department), p. 8.

Regional discrepancies are very evident. The population of four departments is served by about one or less than one facility per 20,000 inhabitants as compared with 11,000 people in other regions. Very noticeable inequalities also exist between urban and rural areas. The difference in the population/bed ratio is less critical since national hospitals serve the whole country.

The average ratio for medical centers and hospitals is one per 330,000 population, which represents a 15% realization of the WHO standard (1 per 50,000). The average ratio of one facility per 15,000 population, closer to the desirable standard (1 per 5,000 to 10,000), should be balanced by the consideration that only about 45% of the population lives within a distance of 10 km from a health facility. Studies have demonstrated that the efficacy of a dispensary is close to zero beyond that distance in rural areas.

Two hundred and twenty-three of the 413 existing facilities operate a maternity ward, which represents approximately 25% of the bed capacity ($\pm$ 1,000 beds). This network handles about 23% of the deliveries in the country, together with maternal and child health services (MCH) which are integrated into other health services and do not constitute vertical institutional programs. It is estimated that only about 10-15% of the pregnant women and pre-schoolchildren have any access to MCH services.

From 1974 to 1980, the number of outpatients in Government facilities remained relatively unchanged: 2.3 to 2.6 million patients, representing 5-6 million visits. The average utilization of the health services is low, 0.47 times per inhabitant per year, similar to the utilization recorded in neighboring countries (e.g., 0.58 in Niger during 1978).

The number of technical health personnel in service, by department and for the country as a whole, was 2,051 for all categories (1981). It should be noted that there are numerous discrepancies among the various available sources of information on personnel in the health sector, and thus only general conclusions can be drawn about the deployment of current manpower. Functions and training for each category are difficult to assess with the existing data.

It is apparent that there are sharp inequities in the allocation of the main categories of health manpower, relative to population, in the 11 departments. Not surprisingly, Koudougou and Kaya, two of the most populous departments, and Sahel, one of the poorest, have the highest ratios of inhabitants to health personnel. Hauts-Bassins, Gaoua, and Comoé, regions of low population density but relatively good economic potential, appear among the most favored departments.

The allocation of health manpower to the departments as compared to the country as a whole indicates the rural-urban discrepancies in personnel availability, since staff not in the departments are placed in the urban facilities in Ouagadougou and Bobo-Dioulasso and in the central administration. Although the departments account for 94% of the total population, they receive less than two-thirds of all health professionals in the top three classifications. However, the actual placement of health staff in some categories may be even worse than the official figures indicate because staff refusing to serve in a rural post may be transferred to urban facilities. For example, at the end of 1981, 190 of 208 midwives (91%) were reported to be working in and around the two main towns, rather than 72% as officially recorded in the annual budget.

The proportion of health personnel in categories A-C[1/] (descending order), working in the central administration, was only 3% in 1981 according to the draft budget of the Ministry of Health. However, it is worth noting that 224, or an additional 12.3% of A-C personnel in the Ministry budget in 1981 were posted to the Directorate of Professional Training and thus were not performing health functions. Of this number, about 85 were reported to be engaged in full-time training, and 42 were full-time instructors at the Ecole Nationale de Santé (ENS)

2. MOH administrative capabilities: The largest and most important division is the Directorate of Public Health which has primary responsibility for MOH field operations. Under the aegis of this Directorate are the 10 chief medical officers, each of whom is responsible for a geographic medical sector. These doctors are responsible for all health activities in their sectors, including supervision of all medical personnel and a network of dispensaries, maternities and maternal and child health centers. Health supplies, medications, and operating funds are in chronic short supply in rural medical facilities with the result that the health impact of even the few medical personnel available is severely limited. While the National Health Plan calls for village health workers throughout Upper Volta, they currently exist only on an experimental basis.

The trained health manpower of the country is extremely limited, even for the Sahel. The following table compares the manpower availability in Upper Volta with that in Mali and Senegal.

HEALTH MANPOWER[*/]

	Upper Volta		Mali		Senegal		WHO
	No.	% WHO Norm	No.	% WHO Norm	No.	% WHO Norm	
1. Population per physician	50,000	19	31,957	31	16,181	62	10,000
2. Pregnant women per mid-wife	2,821	9	1,383	18	719	35	250
3. Population per nurse	3,650	114	2,075	141	1,938	258	5,000
4. Population per health center	146,134	27	132,235	30	142,725	28	40,000

[*/] Upper Volta 1982 CDSS, p. 5 and World Bank Sector Review, July 1982.

[1/] Level A - Planners and conceptualizers with at least Bachelor's Degree level of training; Baccalaureat plus three years at University level. e.g. physicians, surgeons, dentists, pharmacists, nutritionists, senior lab. technicians;

Level B - Implementors at Baccalaureat level. e.g. nurse practitioners, midwives, registered nurses, sanitarians;

Level C - Practical nurses;

Level D - Auxiliary midwives, community health workers (itinerant health agents).

3. Administrative management: As an institution-building project the major impact and the principal issues are administrative. The administrative manifestation of strengthening the planning capacity of the MOH will be a functioning planning office with direct access to the Secretary-General and Minister of Health. The Project is designed to assist the MOH in increasing its administrative and technical capacity to utilize effectively the planned large volume of documents which will be produced. It is the USAID's judgement that the MOH has the administrative capacity to manage the Project, given the technical caliber of the Director of the DPOR and the sincere concern, interest and involvement of the MOH in the development of this Project.

USAID experience over the years has led us to believe that the Ministry of Public Works is capable of carrying out their tasks in the construction process, as detailed in the Engineering Analysis, Section III F.

The financial management of the Project will be the responsibility of the Chief-of-Party of the long-term technical assistance team. During the course of the five years the Chief-of-Party will be in Upper Volta, he or she will be responsible for training the Logistical Supervisor to eventually assume financial management responsibilities on a phased basis.

On the USAID side, financial management will be assured by the Office of Financial Management. Project Management will be the responsibility of the USDH Public Health Advisor. The Project Review Committee (PRC) which was established at the beginning of the design of this Project will continue in existence in order to advise on the implementation of the Project. The PRC consists of the Program Officer, the Project Development Officer, the Project Manager, the Engineer and the Financial Analyst (all USDH employees). In addition, the USAID conducts a quarterly review of project progress on all bilateral and regional projects in the USAID/Upper Volta portfolio. The quarterly reviews are chaired by the Project Development Officer and attended by the Project Manager, Chiefs of Divisions, and representatives from the Program Office and the Office of Financial Management. The USAID is planning to begin reviewing the projects with host-country counterparts as well.

Logistical support to the long-term technical assistance team and short-term consultants will be ensured through one of the following two ways: The USAID is considering the possibility of establishing a modest Management Office which could be in place by the time the Chief-of-Party arrives in Ouagadougou. Such a Management Office could handle all logistical support for contractors, as well as the procurement and customs liberations for project commodities. In the event that this possibility does not yet materialize, provision will be made under the technical assistance contract for funds to hire a person resident in Upper Volta to assist on logistical support problems.

4. Functional relationship of the DPOR: The planned functional relationship between the DPOR and the different organization units is such that the DPOR will be working in close coordination with the other six Directorates through weekly meetings. The matrix in Table III will help to understand the points of contact between the DPOR and the other Directorates.

The programmatic analysis and policy recommendations of the DPOR will pass through the Secretary-General and Minister for reference to the National Commission of Planning and Research for review. After review and reformulation to meet budgetary and other requirements, policy directives will move

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back down through the system to be translated into budgeted projects at the division level with assistance from the DPOR.

Despite the generally high caliber of the various department directors, the Ministry of Health's capability for planning and evaluation is very weak. Many departments are understaffed at the professional level and the managers spend most of their time on operational details. The Ministry wishes to increase the MOH capability by establishing the DPOR. The present project responds directly to this need. The DPOR will serve an essential management tool, but it needs to be complemented by an efficient evaluation capacity. The first priority is for a management system evaluation and analysis. On the technical side, there is a need for a statistical capacity in order to monitor the major health standards and maintain the recording systems. The MOH should be able to undertake limited epidemiological surveys, to assess immunization coverage in population samples, and to evaluate the results of specific campaigns.

5. Training capabilities: Below the A-level, the annual training outputs required to meet staffing objectives and attrition by 1990 substantially exceed the planned figures for all categories except midwives, for whom recruitment could be reduced, and medical assistants. As noted earlier, the effectiveness of midwives in serving the health needs of the population is minimal because they are heavily concentrated in urban areas, the result of which is considered to be a negative impact on the quantity and quality of maternity services. The problems of deploying staff to rural areas concern all professions, of course, and must be addressed directly (see below), but it is particularly serious in the case of midwives who seek positions in the towns where their husbands (usually civil servants or other salaried employees) work.

It was found that the imbalance between the demand and planned supply is most acute in the case of practical nurses (both for the basic and specialists' streams). Although licensed nurses play an essential role in the health referral system, given the relative scarcity of physicians, the practical nurses form the major link between the preventive and curative functions of the primary health care system. A higher priority should perhaps be placed on filling the gap of practical rather than licensed nurses, in order to extend the base of the primary health pyramid.

The shortage of mobile health agents is in fact much larger than the number indicated (650) because the 150 persons presently bearing the title have virtually no training, in particular with respect to hygiene and sanitation. The provision of personnel to carry out public education in these areas, oversee the maintenance of clean water points and vector control, and supervise the construction of latrines in rural communities deserves special mention. Although almost no hygiene and sanitation activities or related public education are being carried out by health personnel in rural areas at present, the need for an effective system has become increasingly apparent to both Government and donors as the number of new wells and boreholes under construction has expanded under the National Rural Water Supply Program. It is essential to assure sanitation which can enable the health benefits of clean water supply to be realized. In addition, the mobile health agents will regularly visit the village workers and thus constitute the first step of supervision as well as the first referree.

6. Retraining: As suggested above, large numbers of the existing health personnel have received either little training in the past or training which did not cover such essentials as supervision and education in preventive health, which are important features of the Primary Health Program. The ENS is presently preparing a program for retraining of nurses. A high priority should be assigned to implementing this program both to achieve the maximum impact from current staff and from limited training resources, and to ensure that newly trained personnel will receive appropriate support in carrying out the primary health objectives.

E. Environmental Concerns

Ultimately, this project is expected to improve the human environment as a result of the DPOR recommendations on the health delivery system. Emphasis on improving personal hygiene and sanitary habits through health education is one of several actions with a positive environmental effect.

As the only construction planned is one office building and the only implementation actions (pilot activities) are small-scale research activities which will be carefully controlled and monitored, the project will have no significant environmental consequences. Therefore, the IEE (Annex G) recommended a negative determination.

F. Engineering Analysis

1. Building Site: The proposed site is adjacent to an unpaved access road and is surrounded by other Ministry of Health buildings. The site has good drainage and access to water and electricity. The property belongs to the Ministry so there are no acquisition problems. The proposed site has ample space for locating a building of the size needed as well as future expansion.

2. Design: A preliminary lay-out plan has been prepared by the project design team and is shown in Annex M. This plan is based on the required space for the DPOR personnel, furniture, files, equipment, etc. The plan has been reviewed and approved by the Ministries of Public Health and Public Works.

The detailed design plans, specifications, and tender documents will be prepared by either a qualified local architecture and engineering firm or by the Ministry of Public Works. All plans, specifications, and tender documents will be approved by USAID and the Ministry of Health.

The design will be a simple and practical one-story structure, compatible with conventional Government office buildings. The design will provide a durable, functional and aesthetically pleasing building without unnecessary ostentation.

3. Construction and Materials: The office building will be constructed by a qualified local contractor, who has experience in construction of the type and size of building in question. Given the size of the construction contract, USAID experience with similar construction has shown that no U.S. contractor will be interested in construction this size. The building will be constructed of locally available materials proven to be appropriate to the climate and construction techniques. Options to be considered are reinforced concrete with brick and plaster walls, or high-quality stabilized banco and other

appropriate materials. Special consideration should be given to efficiency in operating and maintenance costs, such as cooling and ventilation, lighting, duration of exterior and interior finish and floors, and cleaning.

4. Construction contract: Procedures for tendering and award of contract will follow regulations of the Ministry of Public Works and AID, with approval by AID and the Ministry of Health.

5. Implementation schedule: The estimated time required for the various steps in the design, tendering and construction of the planning center building is shown below:

(a)	Selection of architecture and engineering firm	2 months
(b)	Preparation and approval of final design, tender documents and invitation for bids . .	5 months
(c)	Bid preparation	2 months
(d)	Bid analysis and award	1 month
(e)	Construction	10-12 month
	Total	20-22 month

6. Supervision: Day-to-day supervision of construction will be p by qualified Ministry of Public Works staff, with periodic checks, as required, by USAID. As phases of construction are completed, vouchers may be approved by AID for payment. Upon completion of construction, the building will be inspected by AID for final approval and authorization for acceptance and final payment.

7. Cost of construction: The following cost-estimate is for construction of the office to house the DPOR. Cost of the equipment and furniture are listed in Annex I.

Estimated Construction Cost			
Item	Quantity (m^2)	Unit cost	Cost
Guard Room	6		
Library	32		
Conference Room	40		
Reproduction Room	12		
Storerooms (3)	16		
Secretarial Service	18		
Secretariat	20		
Logistical Supervisor	15		
Director	20		
Biostatistics	20		
Statistics	16		
Human Resources	16		
Monitoring and Evaluation	16		
Project Studies	17		
Planning and Programming	20		
Toilets (2)	16		
Sub-total	300	$ 450	$ 135,000
Covered walk and patio	350	200	70,000
Sub-total			205,000
Architecture & Engineering (7%)			14,350
			219,350
Inflation for 1983 construction (15%)			32,903
Sub-total			252,253
Contingencies (10%)			25,225
GRAND TOTAL			$ 277,478

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IV. FINANCIAL PLAN AND FINANCIAL ANALYSIS

A. Summary Cost Estimate and Financial Plan

AID funding in the amount of $ 4,000,000, of which $ 3,046,000 will be in foreign exchange and $ 954,000 will be in local currency, will cover the following:

- Technical assistance, for both long and short term;
- Training, for both long and medium term;
- Construction of a building to house the DPOR;
- Commodities;
- A portion of the operating costs (100% in Year 1, 80% in Year 2, 60% in Year 3, 40% in Year 4, 20% in Year 5) to cover, inter alia, office supplies, petroleum, oil and lubricants for vehicles and mobylettes, and per diem;
- Five operational research studies;
- Sixteen workshops and/or scientific conferences;
- Mid-term and final evaluations; and
- A locally hired, skilled French-speaking administrative secretary.

The GOUV contribution of approximately $ 824,000 will cover the following:

- Local staff salaries;
- Utilities;
- A portion of the operating costs (20% in Year 2, 40% in Year 3, 60% in Year 4, 80% in Year 5 and 100% in Year 6) to cover, inter alia, office supplies, petroleum, oil and lubricants for the vehicles and mobylettes and per diem;
- The land for the construction of the building to house the DPOR; and
- Office rent for a villa until the AID-financed building is constructed.

The total cost of this six-year project is $ 4,824,000

Tables IV and V provide a breakdown of the budget by year by category. All calculations are based on $1 = CFAF 300. It is assumed that the operational start of the project will be June, 1983 when the Chief-of-Party of the technical assistance team arrives.

TABLE IV. BUDGET OF AID FUNDS
(Planned Expenditures)
($ 000)

	Year 1*/	Year 2	Year 3	Year 4	Year 5	Total	%
Long-term technical assistance	$ 240	$ 600	$ 480	$ 180	$ 120	$1,620	56.4
Short-term technical assistance	39	45	42	45	-	171	6.0
Locally hired administrative secretary	18	18	18	18	18	90	3.1
Long-term training	7	15	7	-	-	29	1.0
Medium-term training	25	-	21	-	-	46	1.6
Workshops/ Conferences	6	8	8	6	4	32	1.0
Construction	289	-	-	-	-	289	10.2
Commodities	168	10	73	5	3	259	9.0
Operating costs	42	34	25	17	9	127	4.4
Evaluations	-	-	27	-	60	87	3.0
Travel of the Director, DPOR	3	-	-	-	-	3	0.1
Operational Research studies	-	30	50	40	-	120	4.2
Total	$ 837	$ 760	$ 751	$ 311	$ 214	$2,873	100.0
10% Contingencies	83	76	75	31	21	286	
Sub-total	$ 920	$ 836	$ 826	$ 342	$ 235	$3,159	
10% Cumulative Inflation	92	176	273	159	144	841	
GRAND TOTAL	$1,012	$1,012	$1,099	$ 501	$ 379	$4,000	
%	25.2	25.3	27.5	12.5	9.5	100	

*/ Project period October 1982 - September 1984.

TABLE V. BUDGET OF GOUV FUNDS
(Planned Expenditures)
($ 000)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Salaries	$ 59	$ 59	$ 59	$ 59	$ 59	$295
Utilities	35	30	30	30	30	155
Operating Costs	-	8	17	25	33	83
Land 1/	34	-	-	-	-	34
Office Rent 2/	12	-	-	-	-	12
TOTAL	$140	$ 97	$106	$114	$122	$579
10% Contingencies	14	10	10	11	12	57
Sub-total	$154	$107	$116	$125	$134	$636
10% Cumulative Inflation	15	21	36	56	60	188
GRAND TOTAL	$169	$128	$152	$181	$194	$824

1/ The land is not purchased by the GOUV as it is already allocated to the MOH. The price of the land is estimated based upon prices for an equivalent lot in the area (CFAF 4,000 per meter).

2/ The rental of an office in a villa will be necessary as the AID-financed building will not be constructed when the technical assistance team arrives. The MOH has to rent a villa for office space in order to start the planning activities under the World Bank Project Preparation Fund. The MOH has agreed that the villa will have space for at least 12 offices in order to give the two technical assistance teams (AID and the World Bank) enough space to work in.

TABLE VI. CASH FLOW OF FOREIGN EXCHANGE AND LOCAL CURRENCY
($ 000)

	AID		GOUV	Total
	FX	LC	LC	
Technical Assistance	$ 1,791			$ 1,791
Local salaries			$ 295	295
Locally hired administrative secretary		$ 90		90
Training	46	29		75
Workshops/Conferences		32		32
Construction		289		289
Commodities	249	10		259
Operating costs		127	83	210
Evaluations	87			87
Operational Research Studies		120		120
Land			34	34
Utilities and rent			167	167
Total	$ 2,173	$ 697	$ 579	$ 3,449
10% Contingencies	217	69	57	343
Sub-total	$ 2,390	$ 766	$ 636	$ 3,792
10% Cumulative inflation	656	188	188	1,032
GRAND TOTAL	$ 3,046	$ 954	$ 824	$ 4,824

Note: For a detailed breakdown of the budget by category, please see Annex I.

B. Financial Analysis

The project does not lend itself to being evaluated in terms of an internal rate of return. The Economic Feasibility (Section II A) discussed the cost-effectiveness of the investment of AID resources. The project will not result in any identifiable revenue flows. The total of $ 4,000,000 of AID funding will be obligated at one time.

The GOUV will not maintain the local currency accounting records for the project. Rather, the Chief-of-Party of the technical assistance team will maintain the accounting system, as described in Annex P.

V. IMPLEMENTATION PLAN

The project is scheduled to begin implementation on or about October 1, 1982. Formal training of the documentalist, health planner and epidemiologist/evaluator should commence as soon as possible. The following schedule of actions is illustrative and recognizes that there will be slippage. Presumably the technical assistance team will have modifications to recommend.

Schedule of Actions	
Month	**Activity**
A. Year 1 - October 1, 1982 through September 30, 1983 (FY 1983)	
1. October	GOUV meets Conditions Precedent to disbursement of funds; standard PILs are issued.
2. October	Architectural design for the DPOR building begins (estimated two months to draw up the plans).
3. October (or as soon as the next course begins)	Documentalist identified to head up the Office of Documentation & Archives of the DPOR; documentalist is sent to the Documentation Training Center in Dakar for a two-year training course in documentation.
4. October	Peace Corps to begin recruitment for PCV Documentalist.
5. October	Professional and support staff are selected and begin transfer to the DPOR.
6. November	Order equipment, furniture and supplies for the project (estimated time of arrival is 10 months from when the order is placed; therefore materials should be in Ouagadougou by August 1983).
7. November	Invitation for Bids (IFB) is issued for U.S. contractor to provide the long-term technical assistance team.
8. December	Architectural plans are ready; price is calculated for the construction; IFB is issued and bidding is open for maximum of 90 days.
9. March	The Director of the DPOR will travel to Washington to interview the top two or three candidates for the Health Manager and Health Planner positions.
10. March	The selected MD/MPH Voltaic Director of the Planning and Programming Service begins a six-month formal training course in Health Planning at the University of California at Santa Cruz.

Month	Activity
11. March	The selected CESSI Public Health Nurse, who will head the Office of Monitoring and Evaluation, begins a six-month formal training course in Public Health/ Epidemiology in Cotonou, Benin or Lome, Togo.
12. April	The contractor to construct the DPOR building is chosen and the contract is signed.
13. April	The contractor to provide the long-term technical assistance team is chosen and the contract is signed.
14. June	Chief-of-Party of the T.A. team (the Health Manager) should arrive in Ouagadougou.
15. June	Construction of the DPOR begins (construction should take nine months to complete).
16. August	First data-gathering field trip to two Departments for three staff members of the DPOR.
17. Septembe	CESSI Public Health Nurse returns from training in Cotonou or Lome to assume duties as head of the Office of Monitoring and Evaluation and counterpart to the Epidemiology/Evaluator contractor.
18. September	Health Planner Epidemiologist/Evaluator and Economist should arrive in Ouagadougou.
19. September	The Voltaic MD/MPH member of the DPOR staff returns to Ouagadougou from the training course at the University of California at Santa Cruz to become the Director of the Planning and Programming Service of the DPOR and the counterpart of the Health Planner contractor.
B. Year 2 - October 1, 1983 through September 30, 1984 (FY 1984)	
20. October	Special report on the current Upper Volta Health Status prepared by the DPOR based on the Health Program Development Document, Plan of Action for 1984, Health Statistical Analysis, and documents on finance, logistics, monitoring and evaluation.
21. October	The Voltaic Economist goes to Yaounde, Cameroon to begin one-year training course.
22. October	Review and simplification of the Health Information System (HIS) begins; it will take nine months to be set up and three months to be tested in Ouagadougou and three Departments of Upper Volta.

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Month	Activity
23. November	Second data-gathering field trip to three Departments for three staff members of the DPOR.
24. February	Short-term technical assistance consultant in Financial Analysis arrives in Ouagadougou for a period of eight weeks to work in Finance and Logistics.
25. February	Short-term technical assistance consultant in Record Systems Development arrives in Ouagadougou for a period of four weeks to work out an appropriate format for the HIS data collection.
26. March	Construction of the DPOR building is completed; the DPOR staff and technical assistance move into the new quarters.
27. April	Publication and distribution of Health Program Development Report No. 1 by the Director of the DPOR.
28. May	Preparation of a research protocol for the first operational research study on Primary Health Care.
29. June	Short-term technical assistance consultant in Systems Analysis arrives in Ouagadougou for a period of four weeks to work in collaboration with Health Management and Health Planning.
30. June	Short-term technical assistance consultant in Epidemiology arrives in Ouagadougou to work in epidemiology surveillance and collaborate in the development of operational research on Primary Health Care.
31. July	First national health conference organized by DPOR in Ouagadougou with MOH participants from the 11 Departments.
32. August	Attendance by two DPOR staff members at a workshop in an African country and observation visit by two other DPOR staff members to the Primary Health Care Programs in Senegal.
33. August	The testing of the new HIS begins in three Departments and Ouagadougou for a duration of three months.
34. September	Publication and distribution of the Health Plan of Action for 1985 prepared by the Planning and Programming Service of the DPOR.
35. September	Voltaic Statistician from the DPOR leaves for a one-year course of training in an African country.

Month	Activity
C. Year 3 - October 1, 1984 through September 30, 1985 (FY 1985)	
36. October	The Economist and the Documentalist return from their training and begin to work in the DPOR Office of Projects and Operational Research and Office of Documentation and Archives respectively and as counterparts to the technical assistance consultants in these fields.
37. October	Publication and distribution of the Health Program Development Report, No. 2, prepared by the Director of the DPOR.
38. November	Testing of the HIS ends. Discussions about the needed modifications get underway.
39. December	Mimeo-printing of the new data collection forms for the HIS and distribution for second testing trial in the same areas as the first trial, for a period of two months.
40. January	Begin data collection in the trial areas (two months).
41. February	Short-term technical assistance expert in Financial Analysis arrives in Ouagadougou for a period of eight weeks to work on financial and logistics activities in the DPOR.
42. February	Short-term technical assistance expert in Records Systems Development arrives in Ouagadougou for a period of four weeks to review the new data collection forms, to participate in their testing and to recommend improvements.
43. March	Printing and distributing country-wide HIS definitive formats with the corresponding instructions. An itinerant team will visit the remaining eight Departments in order to train the statistical officers in the appropriate collection and processing mechanisms. The Department statistical officers will train the responsible data collection individuals of the various health units. The new forms will be used throughout the country beginning July 1, 1985. A detailed training schedule should be developed, therefore, in preparation for the introduction of the new system.
44. April	Publication and distribution of the Health Program Development Report, No. 3, prepared by the Director of the DPOR.

Month	Activity
45. March	Development of an operational research protocol on the subject of integrated MCH/Nutrition.
46. June	Mid-point evaluation (three weeks) by an external team of four consultants (Health Manager, Health Planner, Social Analyst and Biostatistician).
47. July	First evaluation of the new HIS.
48. July	Second National Health Conference organized by DPOR in Bobo-Dioulasso, with MOH participants from the 11 Departments.
49. August	Third data-gathering field trip/study visit by three staff members of the DPOR.
50. September	Attendance at one workshop by three staff members of the DPOR.
51. September	Official presentation of the preliminary results of operational research studies Nos 1 and 2.
52. September	Publication and distribution of the Health Plan of Action for 1986, prepared by the Planning and Programming Service of the DPOR.
53. September	Technical assistance consultants in Economics and Epidemiology/Evaluation and their contracts with the project and leave Ouagadougou.
D. Year 4 - October 1, 1985 through September 30, 1986 (FY 1986)	
54. October	Voltaic statistician returns from training and resumes work as Director of the Statistical Service of the DPOR.
55. October	Publication and distribution of the Health Program Development Report No. 4, prepared by the Director of the DPOR.
56. November	Attendance at a workshop in an African country by three staff members of the DPOR.
57. December	DPOR Director travels to U.S. for a six-month formal training course in health management at the University of Michigan.
58. January	Second HIS evaluation.
59. January	GOUV presents to USAID a detailed plan to meet the recurrent costs when the project phases out.

Month	Activity
60. February	Short-term technical assistant consultant in Systems Analysis arrives in Ouagadougou for a period of four weeks to work in Program Development, Health Planning and Health Statistics-related activities.
61. February	Short-term technical assistance consultant in Epidemiology arrives in Ouagadougou for a period of eight weeks to work in epidemiological surveillance, to collaborate with the DPOR Office of Monitoring and Evaluation in the elaboration of a research protocol dealing with Primary Health Care.
62. March	Fourth data-gathering field trip/study visit for three staff members of the DPOR.
63. April	Publication and distribution of the Health Program Development Report, No. 5, prepared by the Acting Director of the DPOR.
64. April	Technical assistance consultant in Documentation ends contract with the Project and leaves Upper Volta.
65. June	Study visit of PHC Programs in Mauritania by three staff members of the DPOR.
66. July	The Director of the DPOR returns from his training in Health Management and resumes his work in the DPOR.
67. August	Third National Health Conference organized by the DPOR in Ouagadougou, with MOH participants from the 11 Departments.
68. September	Technical assistance consultant in Health Planning ends contract with the Project and leaves Upper Volta.
69. September	Publication and distribution of the Health Plan of Action for 1987, prepared by the Planning and Programming Service of the DPOR.
E. Year 5 - October 1, 1986 through September 30, 1987 (FY 1987)	
70. October	Publication and distribution of the Health Program Development Report, No. 6, prepared by the Director of the DPOR.
71. November	DPOR begins a three-month preparation of a policy proposal dealing with Primary Health Care.
72. December	Fifth data-gathering field trip/study visit for three staff members of the DPOR.

Month	Activity
73. February	Presentation of a Policy Proposal on Primary Health Care to the Higher Council of Public Health for its consideration and action.
74. April	Publication and distribution of the Health Program Development Report, No. 7, prepared by the Director of the DPOR.
75. May	DPOR begins a three-month preparation of a policy proposal dealing with integrated maternal and child health care and nutrition.
76. June	Attendance at a workshop by three staff members of the DPOR.
77. July	Fourth National Health Conference organized by the DPOR in Bobo-Dioulasso, with MOH participants from the 11 Departments.
78. August	Official presentation of the policy proposal on Integrated MCH/Nutrition to the Higher Council of Public Health for its consideration and action.
79. September	Publication and distribution of the Health Plan of Action for 1988, prepared by the Planning and Programming Service of the DPOR.
F. Year 6 - October 1, 1987 through September 30, 1988 (FY 1988)	
80. October	Publication and distribution of the Health Program Development Report No. 8, prepared by the Director of the DPOR.
81. November	DPOR begins a three-month preparation of a policy proposal on technical and administrative reorganization of the Ministry of Health to the Higher Council of Public Health for its consideration and action.
82. March	Presentation of the policy proposal on reorganization of technical and administrative aspects of the MOH to the Higher Council of Public Health for its consideration and action.
83. April	Publication and distribution of the Health Program Development Report, No. 9, prepared by the Director of the DPOR.
84. May	Preparation of the FINAL REPORT of the Project activities, with a chapter on "Lessons learned, final conclusions and recommendations".

Month	Activity
85. June	Final evaluation (four weeks) by an external team of five consultants (Health Manager, Health Planner, Biostatistician, Social Analyst and Public Health Nurse).
86. July	Official presentation of the Final Report dealing with the activities carried out during the life of the project. The presentation will be made by the Director of the DPOR who will distribute copies of the report to the appropriate GOUV, MOH and USAID offices.
87. July	Technical assistance in Health Management ends contract with the project and leaves Upper Volta.
88. September	Project ends. Possible post-project actions regarding AID support in the future, would undoubtedly have been discussed several months before the end of the project.

Please see Annex K for a detailed description of the activities and tasks of the DPOR staff members, the reports to be produced by each service and office, how often, etc., and the specific monitoring responsibilities of each party.

VI. EVALUATION ARRANGEMENTS

Project evaluation is an integral part of the development of the DPOR and it will be a continuous activity throughout the life of the project. The object of the evaluation is to verify the completion of scheduled activities, evaluate the quality and status of outputs and recommend modifications of project activities in order to ensure the achievement of the project purposes.

In addition to periodic Activity Reports and monitoring activities, formal evaluations will be carried out at the mid-point (June 1985) and at the end of the project (June 1988). The mid-point evaluation will be carried out by an external team composed of a health manager, a health planner, a social analyst and a biostatistician from the U.S. and two Voltaic evaluators, whose specialties will be defined. The U.S. members of the evaluation team will be selected by USAID and approved by the MOH; the Voltaic members of the evaluation team will be selected by the MOH and approved by USAID. The six members of the evaluation team will work together during the three weeks of the evaluation visit. The work of the U.S. evaluators will be facilitated by working with Voltaics familiar with the MOH; the Voltaics, in turn, will learn from working with professional evaluators.

If possible, the evaluators should receive pertinent information in advance of the start-up of the evaluation mission. Following is a list of some of the documents which the team members should focus upon and, if at all possible, review before the start-up of the evaluation: (a) Health Program Development Reports; (b) Project Paper; (c) Health Sector Analysis Reports; (d) Health Data Analysis Reports; (e) Financial/Logistical/Administrative Analysis Reports; (f) Operational Research Reports; (g) Planning and Programming Documentation Reports; and (h) AID Monitoring System Reports.

At a minimum, the Health Program Development Reports and Project Paper should be made available to the team members in Washington. The evaluation team will prepare a single report, copies of which will be submitted to the MOH and USAID.

In addition to verifying activities and examining project documents, the evaluation team will hold discussions with MOH officials and the U.S. technical assistance and Voltaic planning and programming staff of the DPOR. The recommendations made in this mid-term evaluation report will be used to adjust project activities (if necessary) in the final half of the project.

The <u>final evaluation</u> will be carried out by an external team composed of a health manager, a health planner, a biostatistician, a social analyst and a public health nurse (selected by USAID and approved by the MOH), and three Voltaic evaluators nominated by the MOH and approved by USAID. The eight members of the evaluation team will work together during the four weeks of the evaluation and will produce a single report, copies of which will be submitted to the MOH and USAID. The final evaluation should include field visits and interviews with the patients and the general community in order to assess positive behavioral changes and satisfaction aspects with the services provided. This will be particularly important in the rural areas in the Primary Health Care Programs.

VII. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

A. Conditions Precedent to Disbursement

1. First disbursement

Prior to any disbursement of funds or the issuance of any commitment documents under the Grant (except for commodities, equipment, training, the preparation of construction plans and specifications, and as USAID may otherwise agree in writing), the Grantee shall furnish in form and substance satisfactory to USAID:

(a) Written assurance by the Minister of Health, including detailed implementation plans satisfactory to USAID, that the MOH personnel listed in this Agreement to be provided by the Grantee will be provided and in place by June 1, 1983. The Grantee understands that failure to comply by the said date with such assurance and plans may result in the termination of funding for the Project by USAID.

(b) The name and specimen signatures of the Minister of Health, the MOH official who will be assigned to act as the Grantee's Project Manager and who will be the counterpart and primary contact for the USAID Project Manager, and the MOH officials who will be assigned to act on behalf of each of the above-named officials in their absence.

2. First disbursement for construction

Prior to the first disbursement of funds or the issuance of any commitment documents under the Grant for the construction activity financed by AID under the Project (except for disbursement of funds for the preparation of construction plans and specifications, and as USAID may otherwise agree in writing), the Grantee shall furnish, additionally, in form and substance satisfactory to USAID:

(a) Detailed plans, specifications and construction schedules with respect to such activities;

(b) A description of the arrangements made to provide construction services for such activities; and

(c) A description of the arrangements made to provide engineering supervisory services for such construction activities.

3. Disbursement for equipment and commodities

(a) Prior to the disbursement of funds or the issuance of any commitment documents under the Grant for the procurement of any item or items of equipment and/or commodities financed by USAID under the Grant, the Grantee shall furnish in form and substance satisfactory to USAID detailed specifications for such equipment and/or commodities;

(b) Prior to the disbursement of funds or the issuance of any commitment documents under the Grant for the procurement of equipment and

commodities from sources other than Upper Volta financed under the Grant by USAID, the Grantee shall furnish, additionally, in form and substance satisfactory to USAID an executed contract for the services of a procurement agent or other arrangements satisfactory to USAID for providing such services.

B. Special Covenants

1. Grantee responsibility

(a) The MOH shall have overall responsibility for the Project.

(b) No later than January 15, 1986, the Grantee in cooperation with the U.S. technical assistance team financed under the Grant, shall develop and present to USAID a detailed plan to cover recurrent costs after AID financing ends.

(c) The MOH personnel sent for training in excess of six months under this Project shall be required to return to their jobs in the DPOR for a minimum of three years. The Grantee understands that failure to comply with this covenant may result in the issuance of a bill of collection for costs incurred by AID and for training.

(d) The terms of the accounting system as described in Annex P shall be adhered to, such that:

(i) Local currency expenditures will be paid directly by USAID until the arrival of the Chief-of-Party of the long-term technical assistance team; and

(ii) Upon the arrival of the aforementioned Chief-of-Party, he or she will be responsible for maintaining the check-book for the Project, although it will be the Grantee's Project Manager and another MOH official who will co-sign the checks.

(e) Prior to the release by USAID of any funds to a checking account set up by the Grantee for the Project, the Grantee shall furnish in form and substance satisfactory to USAID the name and specimen signature of a second official of the MOH who will co-sign checks with the Grantee's Project Manager.

2. Grantee and AID responsibility

The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

(a) Evaluation of progress toward attainment of the objectives of the Project;

(b) Identification and evaluation of problem areas of constraints which may inhibit such attainment;

(c) Evaluation, to the degree feasible, of the overall development impact of the Project

ANNEX A

Life of Project :
From FY 82 to FY 88
Total US Funding : $4,000,000
Data prepared : August 11, 1982

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project title and number : STRENGTHENING HEALTH PLANNING CAPACITY (686-0251)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal : the broader objective to which this project contributes : Improve health status of Voltaic population by increasing delivery of health services to rural areas.	Measures of Goal Achievement : 1. Increase coverage of the population, particularly of the rural areas. 2. Decreased unit costs for basic health care delivery. 3. Absolute and relative increase of health budget. 4. Increase in operating funds. * Quantitative measures will be established following the mid-point evaluation.	1. MOH monthly and annual reports 2. MOH policy papers 3. MOH records and budget. 4. Health budget as a % of the GDP and as a % of GOUV national budget 5. Health budget : % of non personnel costs in the budget.	Assumptions for achievin goal targets : 1. MOH commitment to primary health care in rural areas. 2. Increased funds for health services and activities coming from US and other donations or loans. 3. Increased national budget resources available for health 4. Continued GOUV priorities on health.
Project purpose : To strengthen the Directorate of Planning and Operational Research (DPOR) of the MOH for the systematic analysis of health needs	Conditions that will indicate purpose has been achieved : End of Project Status.	Verifiable indicators: 1.project mid-term and final evaluation. 2.inspection of central and departmental files of the health information system.	Assumptions for achievin purpose: 1.GOUV gradually assumes funding and recurrent costs of DPOR planning and programming operations.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
and resources, the development of health strategies and programs and to provide a more effective MOH contribution to national planning efforts.	A functioning Directorate of Planning and Operational Research within the MOH, staffed by at least 5 Voltaic trained staff in health planning and programming areas, which can: 1.produce an annual well-documented Plan of Action based on the analysis of priority health needs of the population and actual available health resources; 2.present health policy options in an effective way to MOH decision-makers; 3.analyze the data produced by the health information system and present them in an integrated way; 4.plan and evaluate health programs and project proposals; 5.coordinate operational research activities in areas of potential importance to rural health; 6.set standards for MOH personnel in the various health services categories for logistics and supply systems.	3.MOH records at the different levels; 4.reports from the DPOR to the Minister, the Commission for Planning and Research and to other MOH Directorates; 5.project T.A.team reports; 6.regular statistical and analytical reports on health and program data; 7.MOH annual reports.	2.GOUV and MOH willing to act and to take into consideration DPOR recommendations; 3.cooperation of the various levels of MOH for data collection and data processing; 4.health-related organizations willing to regularly communicate with DPOR; 5.GOUV personnel available and motivated to improve planning and programming and delivery of services; 6.planning approaches and activities do not create resistance within MOH.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs : 1.DPOR staff trained in health management, planning, evaluation, statistical analysis and logistic planning and programming. 2.Health Information System established, which comprehensively collects data on population, vital statistics, health status, health service activities, donor and PVO activities in health and which is periodically updated. 3.DPOR staff has regular regional and national contact exchanges, including field visits and conferences. 4.DPOR office built and equipped. 5. effective management and planning administration in MOH functioning.	Magnitude of Outputs : 1.5 MOH staff trained. 2.Construction of one 9-office and supporting services building for DPOR. 3.Health information system and data bank organized and functioning; 4.5 yearly health plans of action produced ('84, '85, '86, '87 and '88). 5.4 annual national conferences 6.5 regular data gathering and supervision field trips by DPOR staff members 7.3 operational research projects of potential importance to rural health planning and management coordinated 8.3 policy proposals prepared and submitted to MOH for consideration	Verifiable indicators: - training reports - site visits - field trip reports - regular project reports - policy projects submitted - inspection of files and data bank - technical reports - operational research documents.	Assumptions for achieving outputs : 1. T.A. personnel establish good working relationships with counterparts 2. MOH cooperates with and gives support to DPOR

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs : A - USAID	Implementation target (Type and Quality) :	Verifiable indicators:	Assumptions for providing inputs :
1. long-term technical assistance	162 person months	Project implementation documents	1. competent French-speaking technicians available for TA
2. short-term technical assistance	14.2 person months		2. suitable participant trainees are available
3. local hire administrative secretary	60 person months		3. GOUV provides MOH personnel in a timely manner
4. long-term training	48 person months		
5. medium-term training	18 person months		
6. workshops and/or scientific conferences	16 workshops and/or conferences		
7. construction building	300m2 construction area		
8. commodities	office furniture and generator		
9. vehicles and mobylettes	4 vehicles and 2 mobylettes		
10. operating costs	50% cost during 5 years		
11. evaluations	6.8 person months		
12. operational research studies	5 special studies		
B - GOUV			
1. local staff salaries	1,140 person months		
2. utilities (electricity, water, telephone)	100% cost during 5 years		
3. operating costs	50% cost during 5 years		
4. land for construction of building	1,600 m2		
5. office rent before building construction	100% cost before building finished.		

APPENDIX B - ALL PROJECT STATUTORY CHECKLIST

Introduction

A. The statutory checklist is divided into three parts: 5C (1) - Country Checklist, 5C(2) - Project Checklist, and 5C(3) - Standard Item Checklist.

B. The Country Checklist, of items affecting the eligibility of the country as a whole, etc., is to be prepared annually, at the time of the first project paper (PP) for the country in a fiscal year. The checklist is then referenced in subsequent PP's, where, in addition, items which have changed are to be brought up to date.

C. The Project Checklist focuses on statutory items which bear directly on the project and are to be included in all PP's.

D. The Standard Item Checklist is intended as a working tool, rather than for inclusion in a project paper. It provides condensed coverage, in checklist form, of statutory matters routinely covered in the project agreement (e.g., 50/50 shipping, etc.). Items from this list should be noted in the PP or added to the project checklist when they require or warrant special treatment or concern.

E. As indicated by their subdivisions, these Checklists are intended for projects funded from Development Assistance and the Economic Support Fund.

*F. These Checklists include the applicable statutory criteria from the Foreign Assistance Act of 1961, as amended ("FAA"), the International Security and Development Cooperation Act of 1981 ("ISDCA of 1981"), and the Foreign Assistance and Related Programs Appropriations Act, 1982, P.L. 97-121 ("FY 1982 Appropriation Act").

G. These Checklists do not purport to list every conceivable statutory provision which might be relevant, but are intended to provide a convenient reference for provisions which may be of more frequent or more significant relevance.

H. Space has been provided at the right of the Checklist questions for responses and notes. Extra copies of the appendix may be requisitioned from SER/MO/PAV for use in project development and drafting.

*Revised

B - COUNTRY CHECKLIST

Listed below are statutory criteria applicable generally to FAA funds, and criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481. Has it been determined that the government of the recipient country has failed to take adequate steps to prevent narcotic drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully? NO

2. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? NO

3. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? NO

4. FAA Sec. 512(c), 620(a), 620(f), 620(j); FY 1982 Appropriation Act Secs. 512 and 513. Is recipient country a Communist country? Will assistance be provided to Angola, Cambodia, Cuba, Laos, Vietnam, Syria, Libya, Iraq, or South Yemen? Will assistance be provided to Afghanistan or Mozambique without a waiver? NO

5. ISDCA of 1981 Secs. 724, 727, 728 and 730. For specific restrictions on assistance to Nicaragua, see Sec. 724 of the ISDCA of 1981. For specific restrictions on assistance to El Salvador, see Secs. 727, 728 and 730 of the ISDCA of 1981. N/A

6. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property? NO

7.	FAA Sec. 620(k). Does the program furnish assistance in excess of $100,000,000 for the construction of a productive enterprise, except for productive enterprises in Egypt that were described in the Congressional Presentation materials?	NO
8.	FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC?	N/A
9.	FAA Sec. 620(o); Fisherman's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters?	N/A
	(b) If so, has any deduction required by the Fisherman's Protective Act been made?	N/A
10.	FAA Sec. 620(q); FY 1982 Appropriation Act Sec. 517. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill appropriates funds?	N/A

11.	FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? Reference may be made to the annual "Taking into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	N/A
12.	FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	NO
13.	FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?	1981 not in arrears

14. FAA Sec. 620A; FY 1982 Appropriation Act Sec. 512. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed a war crime? NO

15. FAA Sec. 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? NO

16. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device, after August 3, 1977? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) NO

27. FAA Sec. 730. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Session of the General Assembly of the U.N. of Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? N/A

28. FAA Sec. 721. See special requirements for assistance to Haiti. N/A

E. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria. NO

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

2. Economic Support Fund Country Criteria N/A

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally

recognized human rights? If so, has the country made such significant improvements in its human rights record that furnishing such assistance is in the national interest?

b. FAA Sec. 620B. If ESF is to be furnished to Argentina, has the President certified that (1) the Govt. of Argentina has made significant progress in human rights; and (2) that the provision of such assistance is in the national interests of the U.S.? N/A

c. ISDCA of 1981, Sec. 726(b). If ESF assistance is to be furnished to Chile, has the President certified that (1) the Govt. of Chile has made significant progress in human rights; (2) it is in the national interest of the U.S.; and (3) the Govt. of Chile is not aiding international terrorism and has taken steps to bring to justice those indicted in connection with the murder of Orlando Letelier? N/A

B - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects under the FAA and project criteria applicable to individual funding sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 653(b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;	On September 10, 1982 AID notified Senate and House authorizing and appropriations committees by means of a Congressional Notification (CN) of its intent to authorize and obligate funds for this project.
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that amount)?	Yes

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000 will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

	Yes
	Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No legislative action is required

4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973?

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

NO

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	N/A This project will strengthen the country's health planning capacity. N/A N/A N/A N/A N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	U.S. firms will provide technical assistance outlined in the Project Paper
9. FAA Sec. 612(b), 636(h); FY 1982 Appropriation Act Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	Upper Volta will be contributing a total of $ 824,000 to meet local currency costs for salaries, utilities, initial office space rental and a portion of other operating costs (POL, per diem, supplies) on a progressive basis.

10.	FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	NO
11.	FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes
12.	FY 1982 Appropriation Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	N/A
13.	FAA 118(c) and (d). Does the project take into account the impact on the environment and natural resources? If the project or program will significantly affect the global commons or the U.S. environment, has an environmental impact statement been prepared? If the project or program will significantly affect the environment of a foreign country, has an environmental assessment been prepared? Does the	The Project takes into account the project's impact on the environment and natural resources as stated in Section III-E of the Project Paper. The IEE recommended a negative determination.

project or program take into consideration the problem of the destruction of tropical forests?

es, AA/AFR determined on eptember 1, 1982 that the ost country has an adequate ystem for project financial ccounting.

14. FAA 171(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward

The project objective is to strengthen the planning capacity of the Ministry of Health (MOH). In achieving this objective, the health needs of the poor will be more effectively and efficiently addressed. Over the long-term, improved health among the population will help to foster a wide participation of the nation's populace in developmental activities.

N/A

better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?	(c) Same as (a) above (d) Women will be both direct and indirect beneficiaries of the project. Their status will be enhanced as women occupy important field positions in the MOH, departmental hospitals and other health centers and benefit from improved management and opportunity to participate in the work of the Directorate of Planning & Operational Research (DPOR). (e) N/A
b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?	Yes
c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activitiy with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	No, Upper Volta is a relatively least developed country

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?	Yes, Upper Volta is a relatively least developed country, and revised Delegation of Authority n° 140 authorizes approval of projects with length of more than three years.
f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	Yes
g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective particpation in governmental processes esential to self-government.	The project was developed in close consultation with the Ministry of Health and is tailored to address its expressed needs to strengthen its health program planning capacity. By providing trained staff, facilities, equipment and operating funds to the MOH, this project will directly assist the GOUV in carrying its policy and attaining the goal of making health care available to all Voltaics by the year 2000. MOH counterpart personnel will be encouraged to adapt assistance provided under this project to enhance its institutional development.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of	N/A

the country to repay the loan, at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? N/A

c. ISDCA of 1981, Sec. 724 (c) and (d). If for Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)? N/A

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will his assistance promote conomic or political tability? To the extent ossible, does it reflect he policy directions of AA Section 102? N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? N/A

c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance N/A

of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A

B - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? — yes

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him? — yes

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? — N/A

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be — N/A

financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

5. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates? N/A

6. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? yes

7. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — yes

8. FY 1982 Appropriation Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — yes

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, the engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interests? — N/A

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — yes

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million? — N/A

x ok

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? — N/A

FAA SEc. 301(d). If fund is established solely by U.S. contributions and administed by an internatioal organization, does Comptroller General have audit rights? — N/A

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? — yes

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1982 Appropriation Act Sec. 525: (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which

(1) yes
(2) yes
(3) yes
(4) yes

relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?

b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? — yes

c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? — yes

d. FAA Sec. 662. For CIA activities? — yes

e. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? — yes

f. FY 1982 Appropriation Act, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? — yes

g. FY 1982 Appropriation Act, Sec. 505. To pay U.N. assessments, arrearages or dues? — yes

h. FY 1982 Appropriation Act, Sec. 506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to — yes

X.06

multilateral organizations for lending)?

i. FY 1982 Appropriation Act, Sec. 510. To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields? — yes

j. FY 1982 Appropriation Act, Sec. 511. Will assistance be provided for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? — yes

k. FY 1982 Appropriation Act, Sec. 515. To be used for publicity or propaganda purposes within U.S. not authorized by Congress? — yes

ANNEX "C"
1 Sec

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM : AFR/SWA, Frederick E. Gilbert

SUBJECT: Upper Volta Strengthening Health Planning Capacity Project (686-0251

RE : Delegation of Authority No. 144

Problem: Section 121(d) of the Foreign Assistance Act of 1961, as amended, (the "FAA") precludes any new obligation of Sahel Development Program funds for disbursement by a foreign government until the Administrator has determined "that the foreign government will maintain a system of accounts with respect to those funds which will provide adequate identification and control over the receipt and expenditure of those funds." On January 6, 1982, the Administrator delegated the authority to make this determination to you in Delegation of Authority No. 144.

Discussion: In anticipation of this requirement, the Africa Bureau, at the beginning of FY 1982, initiated a process of "Certification Review" and "Certification" by Mission Directors and Office Heads. This review is designed to establish the adequacy of host country accounting systems. The Certification requirements are spelled out in STATE 278344 dated October 20, 1981 (Attachment A). This cable was followed by STATE 313799 dated November 25, 1981 (Attachment B), which was prepared by the Office of Financial Management, and established for the Missions the minimum standards for host country accounting systems which must be met prior to certification.

In accordance with this process, Upper Volta has certified (Ouagadougou 4417, Attachment C) that the accounting system of the Government of Upper Volta's institutions handling the USAID funded local currency accounts will meet the criteria outlined in paragraph two, STATE 313799 (attachment B) prior to any disbursement of funds for local cost financing under subject project. Consequently, based on this certification, it appears that the GOUV will maintain a system of accounts that provides adequate identification and control over the receipt and expenditure of Sahel Development Program funds for this project.

Recommendation: That the AA/AFR make a determination that the Government of Upper Volta system of accounts with respect to these funds will meet the requirements of Section 121(d) of the FAA.

Approved ✓

Disapproved _____

Date SEP 1 1982

a8

ANNEX "D"

UNITED STATES GOVERNMENT

memorandum

DATE: August 16, 1982

REPLY TO ATTN OF: Dan Jenkins, REDSO/ENG

SUBJECT: RURAL HEALTH PLANNING AND MANAGEMENT PROJECT: 611(A) CERTIFICATION FOR OFFICE BUILDING CONSTRUCTION

TO: Patricia J. Lerner, Project Development Officer

During the week of August 9, 1982, I have reviewed the proposed floor plans and cost-estimates for the project building, and also visited the site. Unit cost-estimates were checked with local construction firms, the Ministry of Public Works and contract prices of similar buildings presently under construction. It is my judgement that the project paper cost estimate of $277,000 for a 1983 construction of the proposed office of 300 net square meters is adequate and reasonable for issuance of 611(A) approval.

It is also my judgement that the Public Works Ministry, as well as local private A&E firms, are capable of preparing design, specifications and bid documents for the proposed building. There are also local firms which can construct the office to the necessary quality and standards.

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

LAB/YJ

REPUBLIQUE DE HAUTE-VOLTA
Unité - Travail - Justice

Ministère des Affaires Etrangères et de la Coopération

ANNEX "E"

AMB
DCM
AID

ACTION COPY

N° 102558 AEC/SG/SI DGCI/CB

Le Ministère des Affaires Etrangères et de la Coopération de la République de Haute-Volta présente ses compliments à l'Ambassade des Etats Unis d'Amérique et a l'honneur de lui faire parvenir ci-joint à l'attention de Son Excellence l'Ambassadeur, la lettre n°1740/SP/SG/DEP du 19 Août 1982 relative à une demande d'assistance financière auprès de l'USAID.

Le Ministère des Affaires Etrangères et de la Coopération saisit cette occasion pour renouveler à l'Ambassade des Etats Unis d'Amérique les assurances de sa haute considération.

OUAGADOUGOU, le 27 AOUT 1982

MINISTERE DES AFFAIRES ETRANGERES ET DE LA COOPERATION

AMBASSADE
DES ETATS UNIS D'AMERIQUE
- OUAGADOUGOU

USAID/OUAGADOUGOU
143
ACTION: CPR
INFO: AMB, AID
ACTION REQUIRED:
DATE RECEIVED: 9/10/82

x 100

CABINET DU MINISTRE

N° 1740 /SP./SG/DEP

Ouagadougou, le 19 AOUT 1982

Le Ministre de la Santé Publique

Monsieur son Excellence Monsieur
l'Ambassadeur des Etats-Unis
en Haute-Volta

s/c de Monsieur le Ministre des Affaires Etrangères

- OUAGADOUGOU -

Excellence,

La réorganisation de mon département a conduit à la création de nouvelles directions centrales et plus particulièrement la Direction des Etudes et de la Planification. Cette direction dont l'importance n'est plus à prouver dans le cadre de la réalisation de notre plan de santé, aura pour principales tâches :

- La centralisation, l'analyse des informations statistiques nécessaires à une planification d'ensemble des activités du ministère ;

- L'élaboration des plans et projets d'action en application de la politique sanitaire ;

- Le suivi de l'exécution et l'évaluation des projets.

- Très tôt, l'USAID s'est préoccupé de la mise en place d'une telle direction et ce, dès 1979-1980.

Aussi est-ce avec plaisir que par la présente, je sollicite auprès de cet Organisme de Développement une aide de quatre millions de dollars (4.000.000 dollars US) pour le financement de ce projet.

L'ensemble de ce financement étalé sur cinq (5) ans sera utilisé pour :

MINISTERE DES AFFAIRES ETRANGERES
DE LA HAUTE-VOLTA
Arrivée N° 2485 AET/CAB
OUAGADOUGOU, le 19 AOUT 1982

- Le financement de l'Assistance Technique sollicitée aussi auprès de l'USAID, pour le renforcement des activités de la direction ;

- La construction et l'équipement du bâtiment devant abriter les bureaux de la direction ;

- La formation des homologues voltaïques ;

- Le financement de quelques coûts de fonctionnement locaux.

Pour marquer l'importance du projet, le gouvernement prend le ferme engagement de :

- Mettre à la disposition de l'USAID le terrain nécessaire à la construction du bâtiment ;

- Prendre en charge le salaire du personnel national mis à la disposition de la direction, ainsi que les charges locatives du bâtiment (Eau, Electricité, Téléphone) ;

- Participer progressivement au fonctionnement de la direction pendant la durée du projet et d'en assurer la continuité à la fin du projet.

Les coûts recurrents totalement en charge de l'USAID durant la première année du projet seront progressivement assurés par le gouvernement à raison de 20% l'an à partir de la 2è année.

Cette contribution du gouvernement pendant la durée du projet est estimée à environ sept cent cinquante quatre mille quatre cent soixante dix (754.470) dollars U.S.

Enfin je me permets de vous informer que la Banque Mondiale dans le cadre de la préparation d'un Projet santé a sollicité le concours technique de la Direction des Etudes et de la Planification pour la réalisation d'un tel projet. A cet effet une assistance financière ponctuelle initiale a été consentie pour permettre à la Direction d'être immédiatement opérationnelle.

Vous sachant d'ores et déjà gré de la suite qu'il vous plaira de réserver à ma requête je vous prie de croire, Monsieur le Directeur, en l'assurance de ma haute considération.

Dr. Maximin OUOBA.

LE MINISTRE

ANNEX "F"

AID
AMB
DCM
ADM
CHRG

0 43

USAID/OUAGADOUGOU
ACTION: OPR
INFO: OFM, OHR, ORD
DATE ACTION REQUIRED:
NAN:
DISTRIBUTION:
DIR

DAD453EHW966
PP RUFHOC
DE RUEHC #7357 2600839
ZNR UUUUU ZZH
P 170619Z SEP 81
FM SECSTATE WASHDC
TO AMEMBASSY OUAGADOUGOU PRIORITY 9370
BT
UNCLAS STATE 247357

AIDAC

E.O. 12065: N/A

TAGS:

SUBJECT: RURAL HEALTH PLANNING (686-0251) PID REVIEW.

REMARKS:

1. SUBJECT PID WAS REVIEWED AND RECOMMENDED FOR APPROVAL BY THE PROJECT COMMITTEE (PC) ON AUGUST 26, 1981. AND THE IEE WAS APPROVED BY THE BUREAU ENVIRONMENTAL OFFICER. THE AA/AFR HAS SUBSEQUENTLY AUTHORIZED USAID/OUAGA TO PROCEED WITH DEVELOPMENT OF THE PP. IN ADDITION TO THE ISSUES RAISED BY USAID IN THE PID, THE FOLLOWING POINTS SHOULD BE ADDRESSED IN DETAIL DURING PROJECT DESIGN:

A. THE PP TEAM SHOULD REEXAMINE THE SKILLS NEEDED BY THE TECHNICAL ASSISTANCE STAFF AND THEIR VOLTAIC COUNTERPARTS TO INSURE THAT THEY ARE COMPATIBLE WITH PROJECTS NEEDS.

B. THE PID DID NOT DESCRIBE THE EXISTING STRUCTURE OF HEALTH SERVICES AND INFRASTRUCTURE WHICH WILL BE RELIED UPON TO FUNNEL DATA TO THE PLANNING OFFICE (PO) FOR-ANALYSIS. THE PP DESIGN TEAM SHOULD ASSESS AND ANALYZE EXISTING DATA SOURCES, AND REVIEW THE IMPLICATIONS WHICH -DATA DEFICIENCIES MIGHT HAVE FOR CARRYING OUT OF PLANNING ANALYSIS BY THE PO. THE PP TEAM SHOULD INDICATE THE MEASURES NECESSARY TO PROVIDE SUFFICIENT DATA TO THE PO FOR SOUND PLANNING.

C. THE PP SHOULD IDENTIFY THE PRIORITY AREAS IN WHICH PLANNING CAPABILITY MUST BE IMPROVED. SKILLS REQUIRED OF THE TECHNICAL ASSISTANCE TEAM AND COUNTERPARTS SHOULD REFLECT THOSE NECESSARY FOR THE PRIORITY TASKS IDENTIFIED, AS SHOULD THE TYPE OF TRAINING PLANNED FOR COUNTERPARTS.

D. IT IS NOT CLEAR WHERE CANDIDATES FOR POSITIONS IN THE PLANNING OFFICE WILL BE FOUND. IF THEY ARE TAKEN FROM THE OTHER OFFICES IN MOH, THIS WILL FURTHER DECREASE THE MINISTRY'S ABILITY TO CARRY OUT ITS RESPONSIBILITIES.

E. THE COMMITTEE UNDERSCORED THE IMPORTANCE OF FINANCIAL ACCOUNTABILITY AT THE PROJECT LEVEL, AND DIRECTED THE PP DESIGN TEAM TO DETAIL THE STEPS THAT WILL BE TAKEN TO ASSURE THAT ADEQUATE ACCOUNTABILITY FOR AID RESOURCES IS REALIZED.

2. AFTER ABOVE CONCERNS ARE ADDRESSED IN THE PP, MISSION MAY AUTHORIZE PP IN ACCORDING WITH ITS DELEGATION OF AUTHORITY. MISSION SHOULD BE AWARE THAT FY 82 AND FY 83 BUDGETS ARE NOT YET FIRM AND FUNDING LEVELS HAVE NOT YET BEEN DETERMINED. MISSION SHOULD PROCEED WITH THE PREPARATION OF THE PP, BUT MAY WISH TO APPRISE THE GOUV THAT FUNDING LEVELS ARE STILL UNCERTAIN. WE RECOGNIZE THAT THIS PROJECT WAS INCLUDED IN THE MISSION'S MINIMUM LEVEL IN THE FY 1983 ABS. IN THE DISCUSSION OF FUNDING CONSTRAINTS DURING THE PID REVIEW MEETING, THE COMMITTEE DISCUSSED THE FEASIBILITY OF FUNDING BOTH THIS PROJECT AND A HIGH PRIORITY AG SECTOR PROJECT, AND AS ONE OPTION TO ACCOMMODATE BOTH PROJECTS, SUGGESTED SPREADING FUNDING FOR HEALTH PROJECT OVER THREE YEARS RATHER THAN TWO. THE DESIGN TEAM SHOULD ASSESS THE FEASIBILITY OF THIS OPTION.

3. THE PROJECT COMMITTEE ALSO SUGGESTS THAT THE MISSION PURSUE WITH OTHER DONORS THE POSSIBILITY OF CO-FINANCING THE PROJECT SHOULD THE BUDGET PICTURE DIM FURTHER. WE WILL KEEP YOU ADVISED OF DEVELOPMENTS CONCERNING THE SIZE OF YOUR FY 82 ASSISTANCE BUDGET. HAIG

BT
#7357

NNNN

ANNEX G

INITIAL ENVIRONMENTAL EXAMINATION

Project Country: UPPER VOLTA

Project Title: Rural Health Planning (686-0251)

Funding: FY(s) 82-83 $3,500,000

Period of Project: 1982-1987

I.E.E. Prepared by: Ray Fontaine **Date:** March 10, 1981

Environmental Action Recommended: Negative Determination

Concurrence: Richard C. Meyer

Richard C. MEYER
USAID Mission Director

Assistant Administrator Decision:

_____
Approved

_____
Disapproved

_____
Date

ANNEX G

I. Project Description

The overall goal of the project is to extend health care coverage and improve the health status of rural Voltaics. The purpose of the project is to develop a planning capability in the Ministry of Health.

At the end of the project, a competent health planning unit will have been established and staffed by personnel who will have received both academic and on-the-job training in various aspects of health planning. Having this capability will enable the MOH to set priorities, allocate judiciously scarce resources and elaborate plans for the implementation of Rural Health Delivery System. Detailed plans and implementation priorities will be reflected in proposals for assistance submitted to donor countries, international loan institutions and private voluntary and non-government organizations.

To attain the above, the project will finance technical assistance, the training of a Voltaic staff and the construction and furnishing of one office building.

II. Identification and Evaluation of Environmental Impacts

The ultimate objective of the project is to improve the health of the rural population. As this happens, the effect upon the environment will be beneficial.

The provision of technical assistance and health training to staff members of the Planning Office will not impact adversely upon the environment. The planned pilot studies are small-scale research activities and will be carefully monitored by the PH nurse on the technical assistance team. As such these activities do not require preparation of environmental documents.

The only possible impact will be the construction of a small one-story office building for the permanent staff of about six persons. The construction will take place near the present building of the Ministry of Health. The only alteration of the natural environment will be the excavation for the foundation and some minor landscaping around the building. Project construction will be supervised by the USAID engineer who will provide necessary guidance to the builder to mitigate any potential negative impact on the environment. The proposed construction will not jeopardize an endangered or threatened species nor will it adversely modify a critical habitat.

Recommendation: In light of the above, it is concluded that the environmental impact of the construction will not be significant whereas the ultimate health impact of the project upon the population will be beneficial. Therefore, a negative determination is recommended.

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas and Sub-Areas	Impact Identification and Evaluation[1]
A. LAND USE	
1. Changing the character of the land through:	
a. Increasing the population	N
b. Extracting natural resources	N
c. Land clearing	L
d. Changing soil character	N
2. Altering natural defenses	N
3. Foreclosing important uses	N
4. Jeopardizing man or his works	N
5. Other factors	N
Increased food production	N
B. WATER QUALITY	
1. Physical state of water	N
2. Chemical and biological states	N
3. Ecological balance	N
4. Other factors	N

1/ Key to symbols: -
N - No environmental impact
L - Little (low) environmental impact
M - Moderate environmental impact
H - High, significant environmental impact
U - Unknown environmental impact
+ - Indicates impact is positive
- - Indicates impact is negative

IMPACT IDENTIFICATION AND EVALUATION FORM

C. ATMOSPHERIC

1. Air additives..... N
2. Air pollution..... N
3. Noise pollution..... N
4. Other factors..... N

D. NATURAL RESOURCES

1. Diversion, altered use of water..... N
2. Irreversible, inefficient commitments..... N
3. Other factors..... N

E. CULTURAL

1. Altering physical symbols..... N
2. Dilution of cultural tradition..... N
3. Other factors

   Increased self-esteem for rural producers..... N

F. SOCIOECONOMIC

1. Changes in economic/employment patterns..... N
2. Changes in population..... N
3. Changes in cultural patterns..... N
4. Other factors

   Increased purchasing power for rural farmers..... N

G. HEALTH

1. Changing a natural environment..... N
2. Eliminating an ecosystem element..... N
3. Other factors

   Improved Nutrition..... +

IMPACT IDENTIFICATION AND EVALUATION FORM

H. GENERAL

1. International impacts..... N

2. Controversial impacts..... N

3. Larger program impacts..... N

4. Other factors..... N

I. OTHER POSSIBLE IMPACTS (Not Listed Above)

_____

_____

_____

SOCIAL SOUNDNESS ANALYSIS

Physical Setting, Climate, Soils, Vegetation

Upper Volta is located in West Africa, covering approximately 274,122 Km2. It is landlocked and surrounded by Mali, Niger, Benin, Togo, Ghana, and Ivory Coast (see map 1)[1]. The land surface varies between an average 250 and 350 meters above sea level. There are three major ecological zones: the south sudanian, north sudanian, and the sahelian zones (see map 2). These roughly correspond to the southwest, central, and northern regions of the country. The principal change is from a longer and more abundant rainy season and lower temperatures to a longer dry season and higher temperatures moving from southwest to north. For all of Upper Volta, there are two basic prevailing wind patterns, the monsoon bringing humid air from the south during the rainy season, and the harmattan, bringing dry air from the north during the dry season.

The south sudanian zone is located south of 11° latitude north, with an average annual rainfall between 1,000 and 1,300+ mm. The rainy season begins, on average, between April 15 and May 1 and ends between September 25 and October 5. Annual average temperatures are 27° C, varying from 24° in August to 29° in April.[2] Diurnal-nocturnal variation ranges from 8° in August to 14° in January.

The sahelian zone is located north of the 14° latitude with annual average rainfall of less than 650 mm. The rainy season begins, on average, between June 15 and July 1 and ends between September 1 and 15. Average annual relative humidity is no more than 43%. Average annual temperature is 28°, varying from 23° in January to 34° in May. Diurnal-nocturnal variation ranges from 10° in August to 19° in January.

The climate and geographic setting have important effects on the health of the people of Upper Volta. Extreme heat is related to dehydration, circulatory difficulties, loss of important minerals and salts, heat stroke and heat cramps. Intense solar radiation is a cause of skin disease. Strong, dry winds are a factor in eye disease, in particular, conjunctivitis, and also in trachoma and meningitis. Relatively low temperatures in the dry season are related to respiratory illness.[3]

1/ Much of following derived from: Pallier, Ginette (1981), Geographie Générale de la Haute-Volta, 2nd edition, Université de Limoges and Centre National de la Recherche Scientifique - Limoges.

2/ Pallier (1981), Table II, page 207

3/ Tourne, F. and L. Monjour, Problèmes de Santé en Milieu Sahelien - Presses Universitaires de France. Paris (1980).

Water resources in Upper Volta reflect closely the variation in seasons. There are four major basins: the Banafing, the Voltas (Red, White, and Black), the Comoe, and the Niger (see map 3). The only major river to flow throughout the year is the Black Volta.

The variation of seasons and the consequent variation in water sources have important consequences for human health. Presence of slow or non-moving water sources during the rainy season provide the ecological setting for parasites and disease vectors, especially important for particular periods of their transmission and life cycles. Three vector-born diseases most closely tied to seasonal variation in water sources are malaria, schistosomiasis, and onchocerciasis. Scarce and concentrated water sources during the dry season also contribute to disease transmission. Non-vector born diseases, particularly bacterial, are tied to the increase during the rainy season of surface runoff. According to Tourne and Monjour, "in the months of August, September, and October, gastro-enteritis diseases are the principal cause in child mortality in the Sahel".4/ The hot, dry, and windy months are those in which dehydration, measles meningitis, and severe nutritional stress due to exhaustion of stored grains, combine as factors in mortality and morbidity. Further, the seasonality and irregularity of water supply result in the storage of water in non-sterile containers for long periods of time and consequent growth of colibacilles.

The relief and soil resources of Upper Volta are closely tied to both the distribution of vegetation and to climatic variation. The southwest in general has ferruginous soils, except for the river basins which have hydromorphic soils. The vegetation is savannah forest, with river valley gallery forest and a small sudanian-guinean area of dense forest (see map 4). The Central Plateau covers a large portion of the center of the country. It is covered almost completely by ferruginous soils of uniformly poor quality. The sudanian vegetation is bush-forest savannah with sahelian species appearing toward the northern edge. The northern sahelian zone includes sub-arid mineralized soils and solonetz soils. The sahelian vegetation is characterized by brush-spiny tree, with pockets of impenetrable "brousse tigrée". Towards the north, sandy soils and steppe vegetatic appear. Several trees are cultivated, or at least maintained, for their commercial and or nutritive value such as the karite (from whicl shea butter is derived) and the parkia and baobab.

Population Distribution, Ethnicity and Demography

The population of Upper Volta, at the time of the last national census in 1975 was 5,638,203 and an estimate of mid-1982 population is 6,200,000.5/ Average population density was 22 inhabitants per square kilometer in 1981. There is a great deal of variation in

4/ Pallier, 1981, page 32.

5/ World Bank Basic Population and Health Indicators, Health and Nutrition Sector Review, July 1982.

density as shown for 1975 in Table I, and Map 5. The crude birth rate per 1 000 population is estimated to be around 48 and the crude death rate around 24 per 1 000. Rate of natural increase is around 2.4, with a doubling time of 29 years.

TABLE I

POPULATION DENSITY BY DEPARTMENT

IN 1975

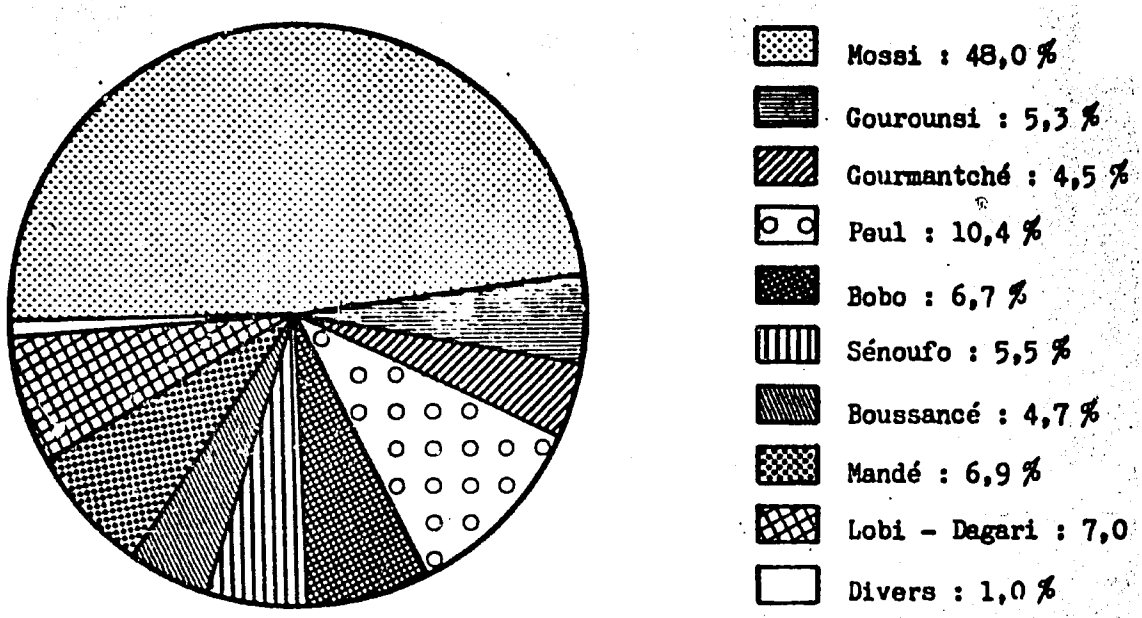
DEPARTMENTS	POPULATION in 1975	AREA (in Km2)	DENSITY (hab./Km2)
CENTRE	944 706	21 952	43,03
CENTRE-EST	404 602	11 266	35,91
CENTRE-NORD	632 285	21 578	29,30
CENTRE-OUEST	788 962	26 324	29,97
EST	407 215	49 992	8,14
HAUTS-BASSINS	582 810	43 172	13,49
NORD	530 192	12 293	43,12
SAHEL	354 079	36 869	9,60
SUD-OUEST	357 592	17 448	20,49
VOLTA NOIRE	635 760	33 106	19,20
T O T A L	5 638 203	274 000	20,5

The variation in density has many causes, among which the most important are: distribution of soils of varying qualities, rainfall, water sources, disease vectors (especially those related to onchocerciasis and trypanosomiasis), and cultural and historical phenomen including inter-ethnic group warfare, invasion by different ethnic groups, and slave-taking expeditions.

Ethnicity is a major factor in population distribution in Upper Volta, Map 6 indicates this distribution and Table II illustrates the division of the population between the nine major ethnic groups (Touareg, Bella, and Songhoi included in Divers). The Mossi are the largest ethnic group, and have occupied most of the central plateau since the 12th Century A.D. The high density of the population is attributable to their highly developed political organization

which provided for intensive production under an organized and militarily powerful state. They continue to expand the area they occupy. The Gourmantche (4.5%) settled in the southeast of present day Upper Volta.

TABLE II



The Peulh (Fulani or Foula) is the second largest ethnic group with 10.4% of the population. They are found throughout the country with concentration in the north, where the Touareg, Bella, and Songhai are also found.

The Gourounsi (5.3% of the population) were displaced by the Mossi and moved to their present location in the southwest of the central plateau. The Bobo, (6.7% of the population) have inhabited the western border area longer than any other ethnic group. Successive invasion, wars, and complex migrations resulted in the settling

of Mande (6.9%), Senoufo (5.5%), Boussance (4.7%), and Lobi-Dagari (7%) ethnic groups in their present territory.

Among the ethnic groups, many languages are spoken, but they can be grouped largely into the Voltaic (More, Dagari, Gourmantche, Lobi, Gourounsi, Senoufo), Mande (Dioula, Marka, Samo, Bobo-Fing, Bissa), West Atlantic (Peulh or Fulbe) and berber. One estimate states that only 10-15% of the population speak French, but there is a wide range in comprehension and ability to use it. The principal lingua francas are More, Dioula, and Fulbe. In terms of major religions, while there may be a large and growing adherence to Islam, Table III indicates this varies greatly according to ethnic groups. The population is much less Islamicized than its closest sahelian neighbors, Mali and Niger. Urban populations are comparatively more ready to identify themselves as Islamic. In 1968, a survey among Ouagadougou residents showed that 50.4% of the people identified them selves as Moslems, 44.2% Christians, and only 4.7% animists. In contrast, 1960-61 survey evidence indicated that 69.6% of rural residents identified themselves as animist, 26.8% Moslem, and 3.8% Christian. The differences in religious identification between rural and urban areas is related to the major phenomenon of urbanization.

TABLE III

ETHNIC AND GEOGRAPHICAL DISTRIBUTION

POPULATION OF UPPER VOLTA

(a) Density of the Population by Stratum 1960

STRATUM	AREA (SQ. MILES)	POPULATION (THOUSANDS)	DENSITY (PERSONS PER SQ. MILE)
(A) North	15,700	245	16
(B) Yatenga	4,600	540	117
(C) Mossi	20,000	715	36
(D) Bissa	2,800	238	85
(E) Gourma	18,600	215	12
(F) Gourounsi	9,200	287	31
(G) West	18,800	737	39
(H) Sénoufo	7,600	281	37
(I) Lobi	8,700	229	26
Total[a]	106,000	4,487	42

TABLE III Cont'd

(b) Percentage Distribution of the Population by Major Ethnic Group, 1960[b].

(I) Mossi (& related)	48.0
(II) Bissa	4.7
(III) Gourmantché	4.5
(IV) Bobo	6.7
(V) Mandé (e.g., Marka)	6.9
(VI) Gourounsi	5.3
(VII) Sénoufo	5.5
(VIII) Lobi, Dagari	7.0
(IX) Fulani (Peul)	10.4
(X) Others	1.0
Total[b]	100.0

(c) Percentage Distribution of Major Ethnic Groups, by Religion

GROUP	ANIMISTS	MOSLEMS	CHRISTIANS	TOTAL
Mossi	75.3	21.9	2.8	100.0
Bissa	76.5	19.0	4.5	100.0
Gourmantché	94.5	4.8	0.7	100.0
Bobo	84.6	5.0	10.4	100.0
Mandé	44.6	49.5	5.9	100.0
Gourounsi	91.8	5.8	2.4	100.0
Sénoufo	90.5	9.1	0.4	100.0
Lobi, Dagari	81.8	4.4	13.8	100.0
Fulani (Peul)& Tuareg	3.2	96.8	0.0	100.0
Others	1.3	95.1	3.6	100.0

Source: 1960 Census.

[a]The total includes Ouagadougou and Bobo-Dioulasso.

[b]Not including the cities of Ouagadougou and Bobo-Dioulasso.

As of 1975, Upper Volta was administratively divided into 10 departments, 44 sous-prefectures, 97 arrondissements, and approximately 7,500 villages (see map 7). Since 1975, administrative changes, population growth and migration have increased the numbers of some of those units.

Infant mortality estimates range from a low of 161 per 1,000 live births in a 1976 post enumeration survey to 211 per 1,000 (1982 World Population Data Sheet). The proportion of child mortality below the age of 5 years is approximately 270 per 1,000 children 0 - 5 years. The total fertility rate is 6.5 live births per woman. Life expectancy at birth ranges from 35 to 40 years.

There are two significant features of the demographic structure which affect health planning. First, it is a young and expanding population, and second, migration of a selected segment of the active adult population, males between 19 and 42 is pronounced. The age structure of the population demonstrates that it is a young and expanding one (see Figure 1 and 2). From 1961 to 1975, the percentage of individuals below the age of 15 increased from 42% to 45%. Health care delivery, thus, focused primarily on pre-natal infant, child, and maternal-child problems. Further, with high fertility and high infant and child mortality, family planning is an important element for health care delivery.

The population structure also reflects the migration of young adult males, especially evident in Figures 1 and 2, as evidenced by the excess of females over males between the ages of 20 and 40 years. Migration includes internal or rural to rural migration, rural to urban migration, and migration to foreign countries.

Internal migration or movement from rural areas to other rural areas, other than the traditional movement related to exogamous marriage and residence rules, was that of the Mossi towards the west and south of the central plain, towards the departments of High Basins and the Black Volta. People are migrating in order to find more fertile, or at least previously underutilized land. However, this is not a major factor in relation to overall migration; in terms of growth of rural population it makes up only 3.5%.6/

Rural to urban migration is a more significant phenomenon, in terms of numbers. However, Upper Volta is still one of the least urbanized countries in the world with only between 6% and 10% (depending on the definition of urban) of its population living in urban areas. Even if all population centers over 5,000 were considered, they would still be only 15% of the population.

Annual growth rates of the two largest urban places, Ouagadougou and Bobo-Dioulasso were 8.9% and 4.9% respectively in 1975. Natural

6/ Conde, Julien (1980), Migration in Upper Volta in Zacharian, Conde and Nair. Demographic Aspects of Migration in West Africa, Vol II, World Bank Staff Working Paper No. 415, World Bank, Washington, D.C.

Figure 1.

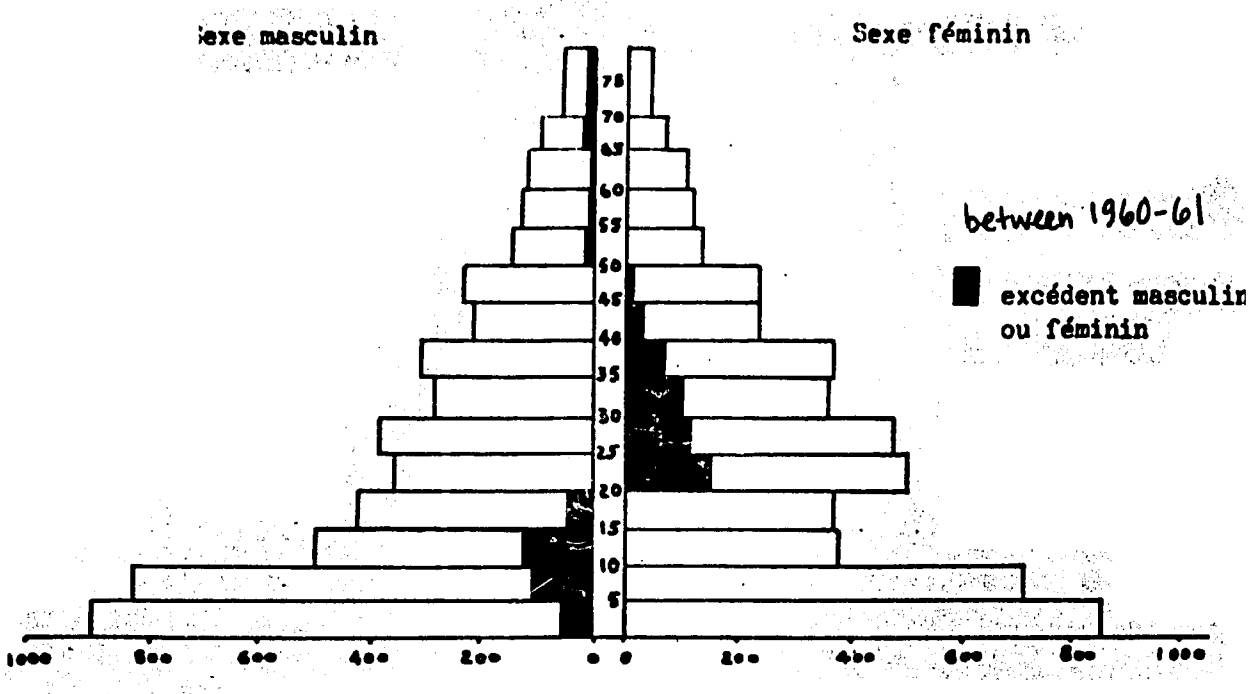
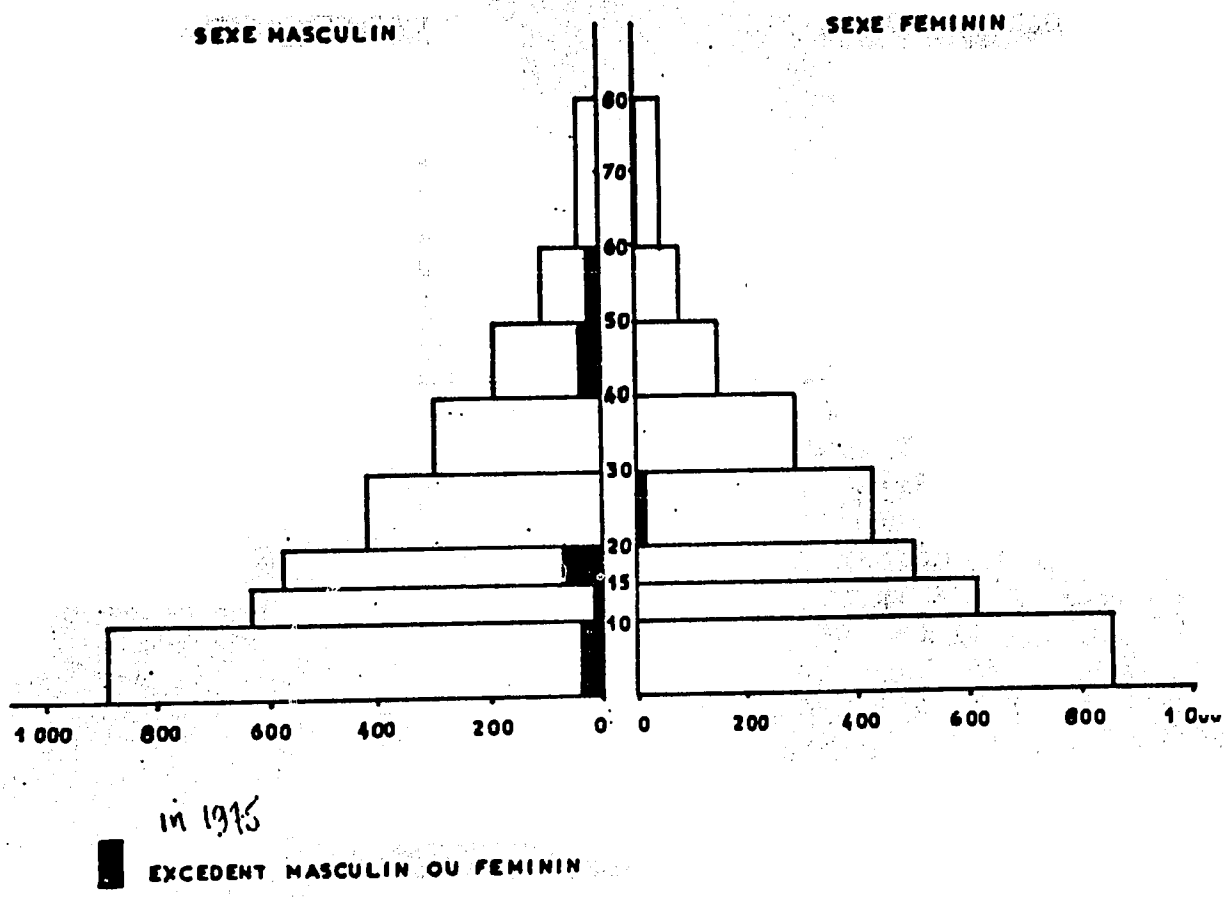


Figure 2.



increase was a major factor in this growth, along with migration from surrounding areas of the same department. There was substantial migration from other departments, but the greatest portion of people migrating in Upper Volta are those who go to other countries.

The 1975 census found 335,000 nationals living outside the country, or 6% of the population.7/ However, this was considered an underestimate and Conde calculated the following for 1975:

TABLE IV

Upper Volta nationals abroad in	Ivory Coast Ghana Other Countries	726,000 146,000 131,000
	Total	1,000,000
Upper Volta-born persons abroad in	Ivory Coast Ghana Other Countries	521,000 83,000 96,000
	Total	700,000

Upper Volta nationals abroad represented approximately 19% of the resident population. Emigration has been increasing since 1960, and one calculation of annual emigrating minus returning people shows that approximately 30% of annual population increase is offset by emigration.

Emigration is a selective process. Pool and Couvel have shown that, out of Voltaic males aged 20-29 years, one in five is absent in a foreign country at any given time. Further, between 20% and 25% of all migrants will migrate more than one time during their life. Table V illustrates the percentages of migrants from various ethnic groups and by sex, and Table VI the sex ratios of absent household members divided by ethnic group. While representing 48% of the population, 55% of those who had emigrated to other countries were Mossi. Emigration is becoming more a movement of families and of individual women. Women were 13% of total emigrants in 1960 or 30% of total emigrants in 1975. Child emigrants increased from 6.6% of total emigrants in 1960-61 to 18.8% in 1975. Males remain the most significant element of the flow to other countries. In 1975, rural residents represent 97.4% of the emigrant population. Emigration is rarely a life-time movement, rather durations average between one and three years depending on the country of destination. There is a trend towards longer periods of emigration.

7/ Ibid

TABLE V

Sex ratios of absent household members by tribe, 1960 (females per hundred males).

Fulani (Peul)	7.4
Mossi	6.9
Bissa	29.3
Gourmantché	5.3
Mandé	21.9
Bobo	29.1
Gourounsi	22.9
Sénoufo	50.3
Lobi	16.9
Other	24.9
Together	15.5

Source: 1960 census (Q.I.).

TABLE VI

Percentage distribution by tribe of absent household members subdivided by country of destination, 1960.

Sex and Ethnic Group	Ivory Coast	Ghana	Mali	Other Countries	All Countries	Distribution of total Population of Upper Volta
Males						
Mossi	63.3	50.3	54.2	19.7	53.3	48.0
Bissa	3.0	10.3	--	8.6	5.7	4.7
Gourmantché	0.5	2.9	--	7.2	1.8	4.5
Bobo	5.5	1.0	6.0	17.6	5.0	6.7
Mandé	8.1	1.6	10.5	8.2	6.0	6.9
Gourounsi	4.9	11.3	1.9	4.6	6.9	5.3
Sénoufo	5.4	--	5.3	14.2	4.3	5.5
Lobi-Dagari	6.4	16.5	4.5	12.2	10.1	7.0
Fulani	2.4	3.5	16.5	4.8	3.3	10.4
Others	0.5	2.6	1.1	4.9	1.6	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Females						
Mossi	40.6	13.5	18.9	18.9	31.0	47.8
Bissa	5.8	30.0	2.5	2.5	10.8	4.7
Gourmantché	--	0.9	3.0	3.0	0.7	4.4
Bobo	9.1	--	9.1	9.1	7.0	6.7
Mandé	16.3	--	8.7	8.7	11.3	7.0
Gourounsi	6.2	26.9	1.6	1.6	10.1	5.1
Sénoufo	13.2	--	36.6	36.6	13.9	5.7
Lobi-Dagari	7.6	25.4	3.3	3.3	11.0	7.1
Fulani	1.1	--	5.5	5.5	1.6	10.5
Others	0.1	3.3	10.8	10.8	2.6	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: 1960 Census (Q.I.).

The history of emigration from the colonial period through that of independence illustrates a transition from involuntary movement related to forced labor and military service to "voluntary" movement to find opportunities to earn money (see Table VII). Ivory Coast (57% in 1961) and Ghana (31% in 1961) were the destinations of the majority of emigrants, 57% and 31% respectively of 1961 total emigrating population. Agricultural labor has been the occupation of 60% to 65% of emigrants, and industry and commerce for 27% to 30% of emigrants.

TABLE VII

Reasons for migration, by period

Years	Recruited for Labor	Military & Police Service	Need for Money	Other	Total
Up to 1923	12.8	67.4	18.5	1.3	100.0
1924 - 1932	11.3	58.5	28.2	2.0	100.0
1933 - 1939	18.7	49.2	31.1	1.0	100.0
1940 - 1945	35.6	26.7	35.2	2.5	100.0
1945 - 1950	15.9	13.2	67.1	3.8	100.0
1950 - 1955	1.5	4.7	90.6	3.2	100.0
1955 - 1960	0.4	2.8	94.9	1.9	100.0
All periods	10.2	18.4	69.0	2.4	100.0

Source: 1960 census (D).

Health planning in Upper Volta is affected in several ways by migration. First, rural to rural migration may result in permanent lowering or increase of populations in sending and receiving areas within Upper Volta. Health data gathering and service planning and delivery must taken account of these movements. Second, rural to urban migration may affect planning in the same way, and if it increases faster than other forms of migration, it may mean that the present plans for emphasis on rural health delivery may have to be adjusted to include semi-urban and urban poor population.

Finally, emigration to other countries must be considered in health planning because needs of rural communities will differ depending upon the composition of its residents and its absent members. Most importantly, when health care delivery is being planned, and training needs and potential personnel recruited at the village are being identified, the absence of a selected group of the community, males between 20 and 35, may very well necessitate the modification

of plans. Further, the individuals who migrate may have the characteristics most desirable for village health workers, including literacy and initiative. Knowledge of the rate of emigration and return movement, and profiles of the kinds of people emigrating would be very useful for the work of the DPOR.

Economic Activity - Production and Nutrition

The economic activity most important for at least 90% of the population of Upper Volta is agriculture and animal-raising. One estimate is that 82% of the labor-force is involved in agriculture. The general trend in Voltaic agriculture is towards cash crop production and the sale of surplus food crops, if this exists, to the market supplied by the growing urban populations. The earlier discussion of climate, soils, and hydrology illustrated that physical conditions for agricultural production and animal raising are difficult for most of the country. In particular, the Volta valley, an area of well-watered and relatively fertile soils, is also a favorable ecological setting for the simulium or black fly, the vector for onchocerciasis. Recent development activities have begun to allow occupation of the area, but effective fly control will have to be continued.

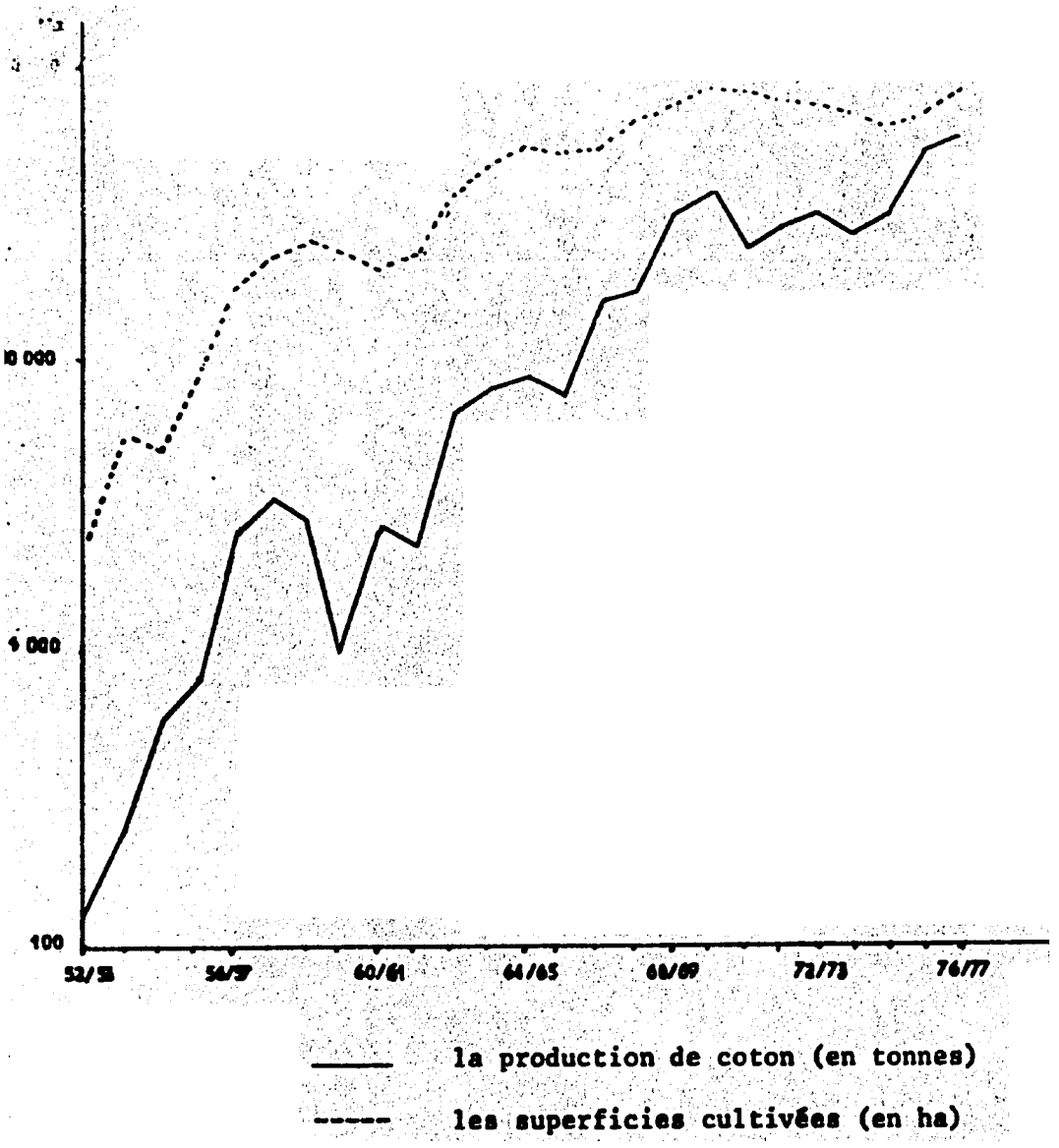
Besides generally unfavorable physical settings, agriculture and animal raising are limited by lack of improved tehcniques and technology. Despite a research and extension activity, production continues to be constrained by lack of improved seed, physical inputs, and machinery. Shifting field cultivation, characterized by leaving fields in fallow for varying amounts of time, is the predominant form of production. One estimate is that about two million hectares of land of a potential nine million hectares are exploited each year.[8/] Approximately 25,000 hectares of irrigated perimeters are exploited. Principal food crops are millet, sorghum, corn, fonio, rice, karite nut (for shea butter), tubers, manioc, and various vegetables and fruits. The principal cash crop is cotton. The rapid increase of cotton production since 1952 is indicated in Table VIII. Sugar cane and tobacco are other, less important cash crops.

Animal raising can be divided into two basic categories, cattle-raising and small runimant production. Poultry are also part of this kind of economic activity. The principal economic activity of the Peulh and other ethnic groups of the north is cattle raising, though people in other ethnic groups raise cattle as an additional facet of production. Often Peulh herders take care of cattle owned by farmers of other ethnic groups.

The key inter-relationship of economic activity and health for Upper Volta is the area of nutrition. Undernutrition is a condition in which an individual is not consuming a sufficient quantity of food. Nutritional needs vary greatly between individuals according to age, sex, level and kind of activity, climate, and other factors.

8/ Pallier, 1981, p. 120

TABLE VIII


10 000
100
52/53
56/57
60/61
64/65
68/69
72/73
76/77
la production de coton (en tonnes)
les superficies cultivées (en ha)

In Upper Volta, under-nutrition is cause by seasonal shortages and yearly variations in foodstuffs produced. The lwo level of improved techniques and technology in agriculture production means that production is directly dependent upon rainfall, unimproved soil qualities, and labor available to the producer. Most families suffer during periods of the year when reserves are expended. Often, this is during the period of intense physical activity, the clearing of land and planting of the next crop which intesifies undernutrition. Further, in general, food is alloted within the family in a way which provides for adult males first, followed by children and women. A poorly balanced diet is the other factor of nutritional difficulties; it is usually associated with a shortage of vitamins and minerals in addition to protein deficiency. Protein needs are supplied among rural families, for at least part of the year, by the grain they produced. However, the average quantity of protein from animal origin is generally low in the Voltaic population, except the Peulhs. Other nutritional deficiencies are avitaminose "A", anemia and goiter.

While nutritional deficiencies and imbalances affect rural populations, the children are the most affected. Marasmus is one of the results; it affects especially children from 1 to 3 years. Kwashiorkor affects severely a good number of children. Small children after weaning are particularly susceptible to nutritional deficiencies.

Nutritional shortages and imbalance are serious problems in themselves, but are perhaps even more grave because of their inter-relationship with other diseases, particularly infectious diseases. For example, gastro-enteritis aggravates a poor state of nutrition by causing loss of appetite, a lowering of intestinal absorption of nutrients, and a change in digestive flora. Malnutrition acts in a synergistic way to increase the severity of diarrhetic disease. Another particularly dangerous inter-relationship is malnutrition and measles, as fever and diarrhea work along with malnutrition to lower resistance and ability to survive infection. Nutritional shortage and imbalance act, in the case of most of the parasitic, bacterial, and viral infections, as a substrate which weakens resistance and exacerbates the difficulties affected individuals suffer.

Health Care Delivery - Traditional and Modern

The information above has provided an introduction to the situation of the population of Upper Volta. The implications for health planning of their situation have been sketched. The remainder of the discussion will turn to: 1) traditional health care delivery; 2) the role of the MOH DPOR in improving the modern health care delivery system; 3) the benefits of the project to strengthen the MOH DPOR and how they will be distributed; and 4) the specific means of structuring participation of people from all levels of the health care delivery system, especially villagers, in health planning and of adapting modern health care delivery to the realities faced by rural Voltaics.

The traditional health care system is based on beliefs, techniques and pharmacology which have evolved through time as a means of meeting physical and psychological stresses from the natural and social environment. There are two basic categories of practitioners, healers, who are most often male, and traditional birth attendants, who are most often female. As seen above, there are a number of major and minor ethnic groups in Upper Volta, with variation in their systems of traditional medicine. The following discussion will therefore be very general focusing on common features.

Illness is believed to be caused by spells cast by others, punishment for offenses to spirits, and as in a specific case of the latter, the sanction for not respecting taboos or socially proscribed behavior.9/ The traditional healer, in general, is a specialist who treats the sick person, not the disease. Disease is viewed in an environmental context. Diagnosis and treatment focus on the social and spiritual setting and only secondarily on physical symptoms. In modern terms, traditional medicine is focused on psychosomatic disorders. Diagnosis can be done by the healer through entering a trance state, sometimes using incantations. In other cases, physical examination and questioning are used. Healers most often prescribe plants they have gathered as treatment, either rubbed on the ailment or ingested. Healers also make use of traditional prosthetic devices such as splints for binding a broken arm.

The process of learning the practice of traditional medicine generally is one in which young people work for and with older practitioners. However, the concept of training is not the same as that of the Western sense of the word. The basis of being a healer is the receipt of a gift, most often inherited from one's ancestors. In explanation of the handing down of healing abilities, two practitioners recalled their ancestors' encounters with supernatural entities. The power of the inheritance of healing was attested to by a physician, who is a public health doctor in western Upper Volta, when he said that he stayed away from healing ceremonies for fear of being called by supernatural forces to become a traditional healer.

In the absence of any major nation-wide study of traditional health care, it is apparent that the system is ubiquitous and supported by Voltaies, urban and rural, educated and illiterate. A recent article in l'Observateur" concerning a very popular healer in Ouagadougou, stated that "we have even seen a few times, intellectuals bringing their relatives and friends (to the healers) and some expatriates" were seen to be consulting the healer 10/. In the cases of three practitioners, consultations ranged from 10 to 30 FCFA. Often, if treatments produce desired results, patients provide further remuneration to the practitioner.

There are indications that traditional medicine is growing in its acceptance by educated people and government agencies. A research organization, the Institute for Research on Natural Substances, was

9/ Tapsoba, Clement, 1982, Medecine et Pharmacopée Africaines Traditionelles, Carrefour Africain, No. 735.

10/ "Le Guerisseur de Bassunko" July 1, 1982 - L'Observateur, No. 2372.

established in 1978 as part of the National Scientific and Technological Research Center. It has held seminars, conducted research, and may begin a program of publications. One major publication on Herbal Remedies has been published by CEESAO.11/

Traditional birth attendants are women from the extended family or village of the woman giving birth. They are most often the eldest woman or at least an older woman aged 30-60 years. Training is based on experience with childbirth; there is little or no instruction in the modern sense. TBA's receive remuneration for their work, usually in the form of an animal or produce, sometimes in cash.

Acceptance of the utility of traditional medicine by those involved in modern medicine and vice versa seems, in general, to exist. Various government, donor, and NGO programs and projects have included the participation of traditional health practitioners. In at least two cases of primary health care projects, healers have been selected by villagers to be trained as village health agents. TBA's have been trained in projects financed by UNESCO, UNDP, and other agencies.12/ There are numerous other projects currently being planned and implemented, but no central record of all of them exist. Traditional healers reportedly counsel clients to consult modern practitioners and use modern drugs.

Two problems would exist if there were to be a comprehensive effort to integrate the traditional and modern health sectors. First, the concept and process of learning the methods and performing services are not readily compatible. Inspiration, possession, clairvoyance, and spirit mediation are conceptually different than two-week training classes utilizing Western pedogogical models. The idea of learning a set of procedures to be used and repeated, based on a theory of disease etiology and transmission developed by western medical science, cannot easily be amalgamated with traditional practice. Secondly, the self-identification process and the pursuit of healing powers and knowlege which others do not have is different from the village-wide or village committee selection of agents and their training in groups in a classroom environment, both characteristic of PHC programs. Healers are often different from other people in the village and they often desire to maintain that difference with their exclusive knowledge and power.

This is not to say that traditional medicine should be suppressed or denigrated. It is a system which seems to have no problem perpetuating itself and which seems to have a capacity to help people. However, integration should not be glibly advocated. Rather, in areas of modern health service delivery system planning and implementation, traditional medicine should be considered as a separate resource and one with which modern practice can co-exist.

11/ Forgues, Marcel, (1980), Quelques Remedies Simples Utilises en Haute-Volta, Centre d'Etudes Economiques et Social de l'Afrique Occidentale, Bobo-Dioulasso.

12/ Jett, Joyce (1977), The Role of Traditional Midwives in the Modern Health Sector in West and Central Africa, USAID/REDSO/WA, Abidjan. (Contract No. REDSO/WA-76-81).

X 176

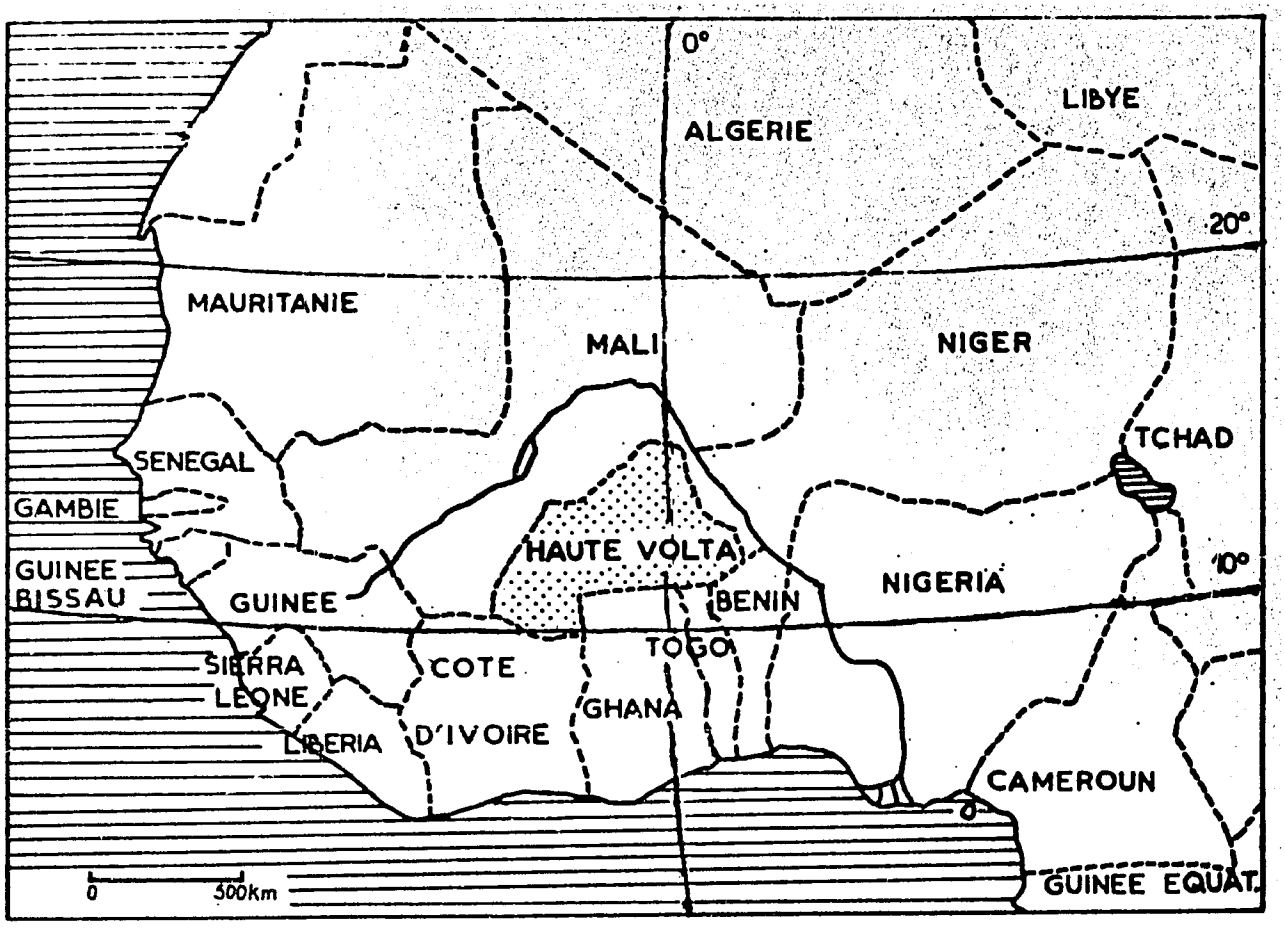
The modern health care delivery system has been described in other parts of this documents, but for the purpose of social analysis, several aspects require discussion. The system can be characterized as preventive and hospital and urban-biased in its care, centralized in its planning and management, and chaotic and ineffective in its record-keeping and drug delivery. In principle, the structure of the system includes eleven departmental hospitals, a medical center (CM) in each prefecture, a health and social promotion center (CSPS) in each sub-prefecture, and numerous health posts (PS) and maternities for lower political divisions. In many parts of Upper Volta, personnel, drugs, and medical attention are not available despite the existing structure. In one area visited by the design team, shortages of personnel, drugs, transport, electricity, and even potable water were found at the deparmental hospital and other levels. There are areas where dedicated personnel are providing services, especially where donor and NGO personnel activities and funds augment the limited resources available from GOUV budget allocations.

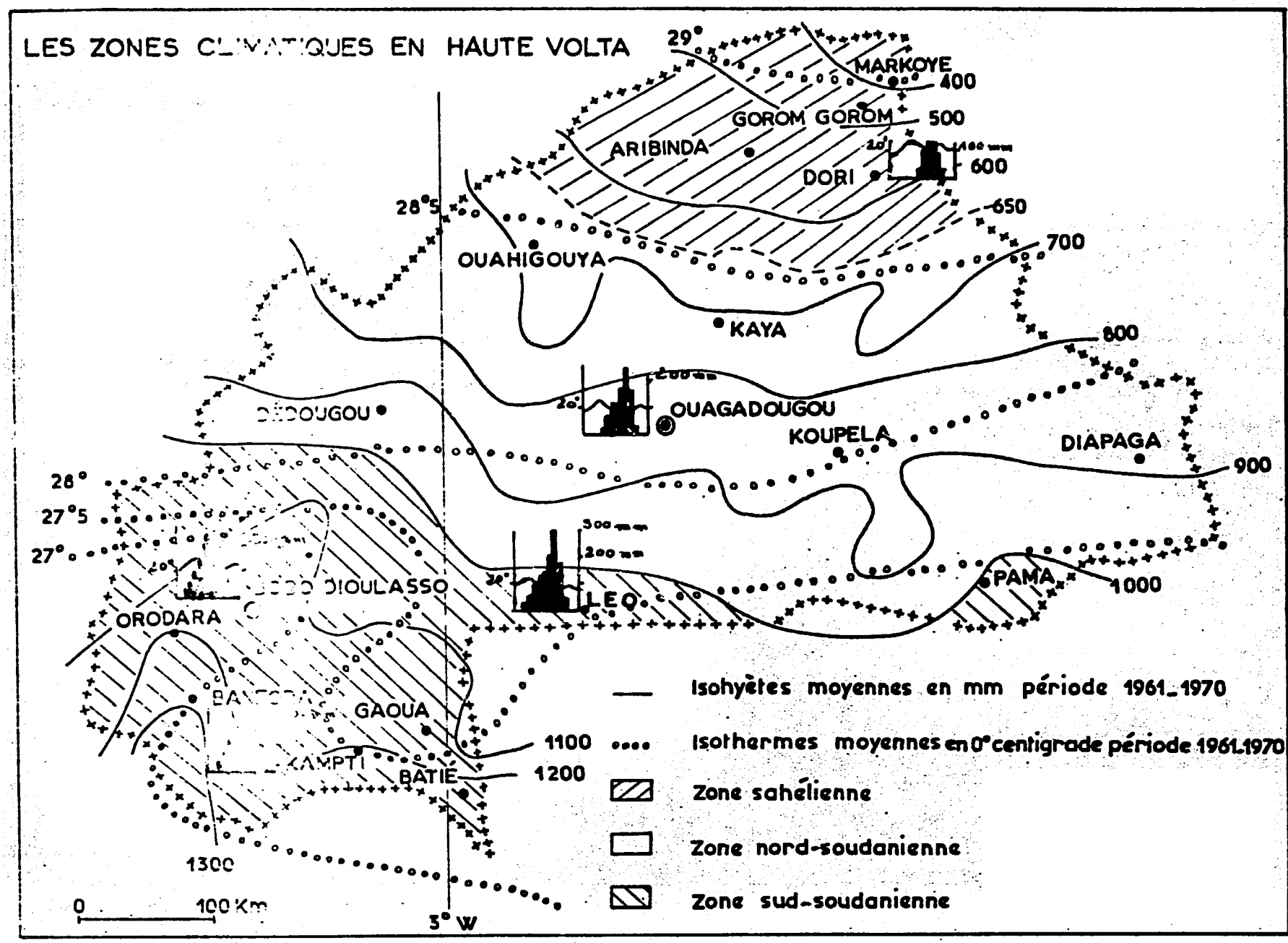
In this last category fall numerous primary health care delivery pilot projects. In limited areas, the design and testing stage has been completed and MOH personnel are operating a primary health care system based on preventive care and villager participation in system management through village health committees and selection and training of village health care workers and birth attendants. One of the major tasks of the DPOR will be to organize all existing information on these PHC programs and projects, analyze their progress and advise MOH decision-makers on lessons learned and alternative directions for development of an effective PHC system. Especially crucial for judging social viability of these projects will be the comparison of how participation is elicited, what decisions are shared by higher levels in the system or left to village health committees, the kind and degree of support given health workers and birth ttendants by villagers during their training and their work in the village, and the ability of village health committees to manage crises such as health worker absence, poor performance, and resignation.

Women are involved in health care in the traditional and modern systems as consumers and practitioners. Consumption involves principally obtaining care for child bearing and securing care for children. In villages, older women provide care traditionally as birth attendants or midwives. The PHC projects in Upper Volta commonly provide training to improve hygienic practices and techniques of these women.

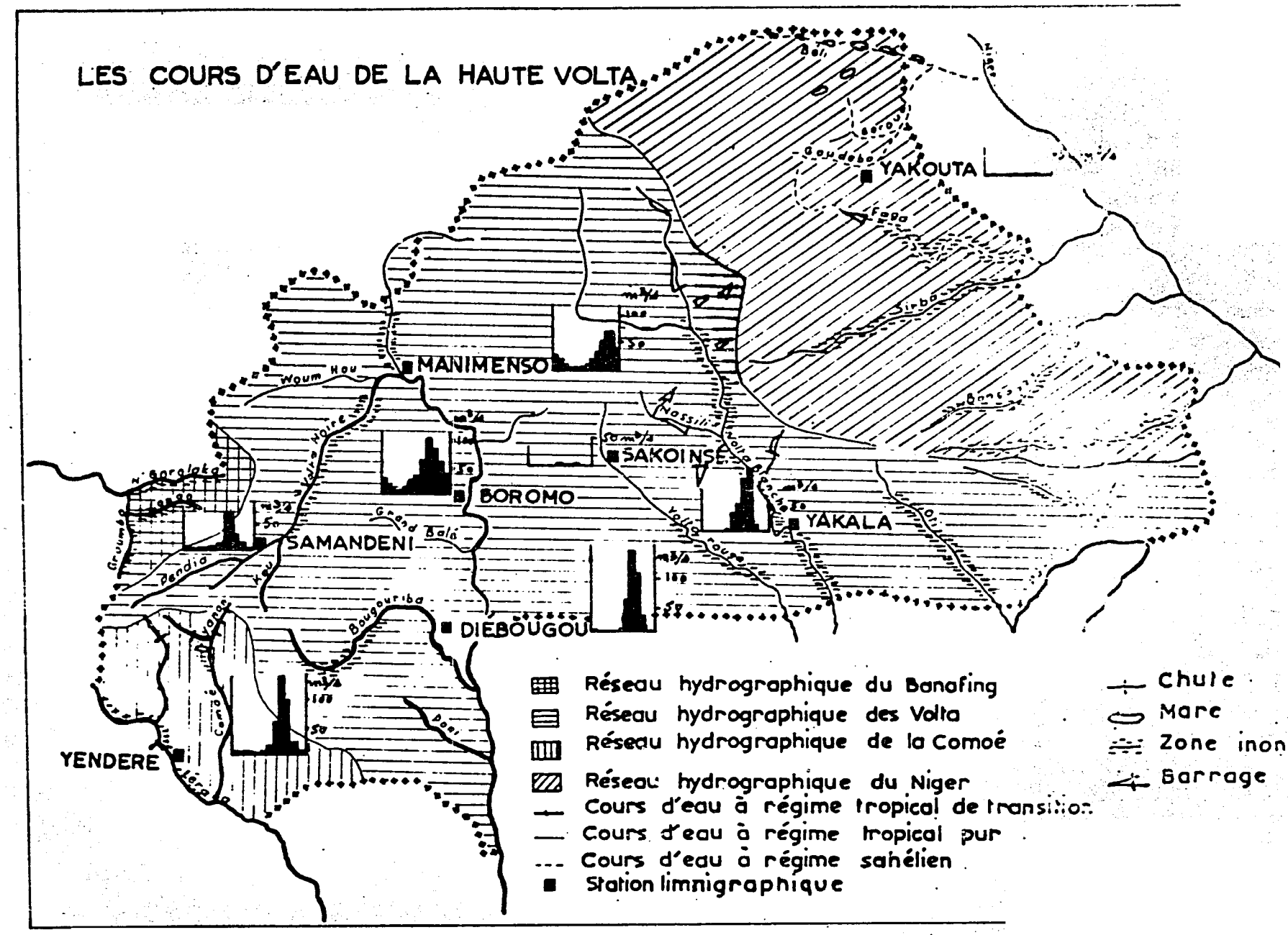
MAP 1

LA SITUATION DE LA HAUTE VOLTA



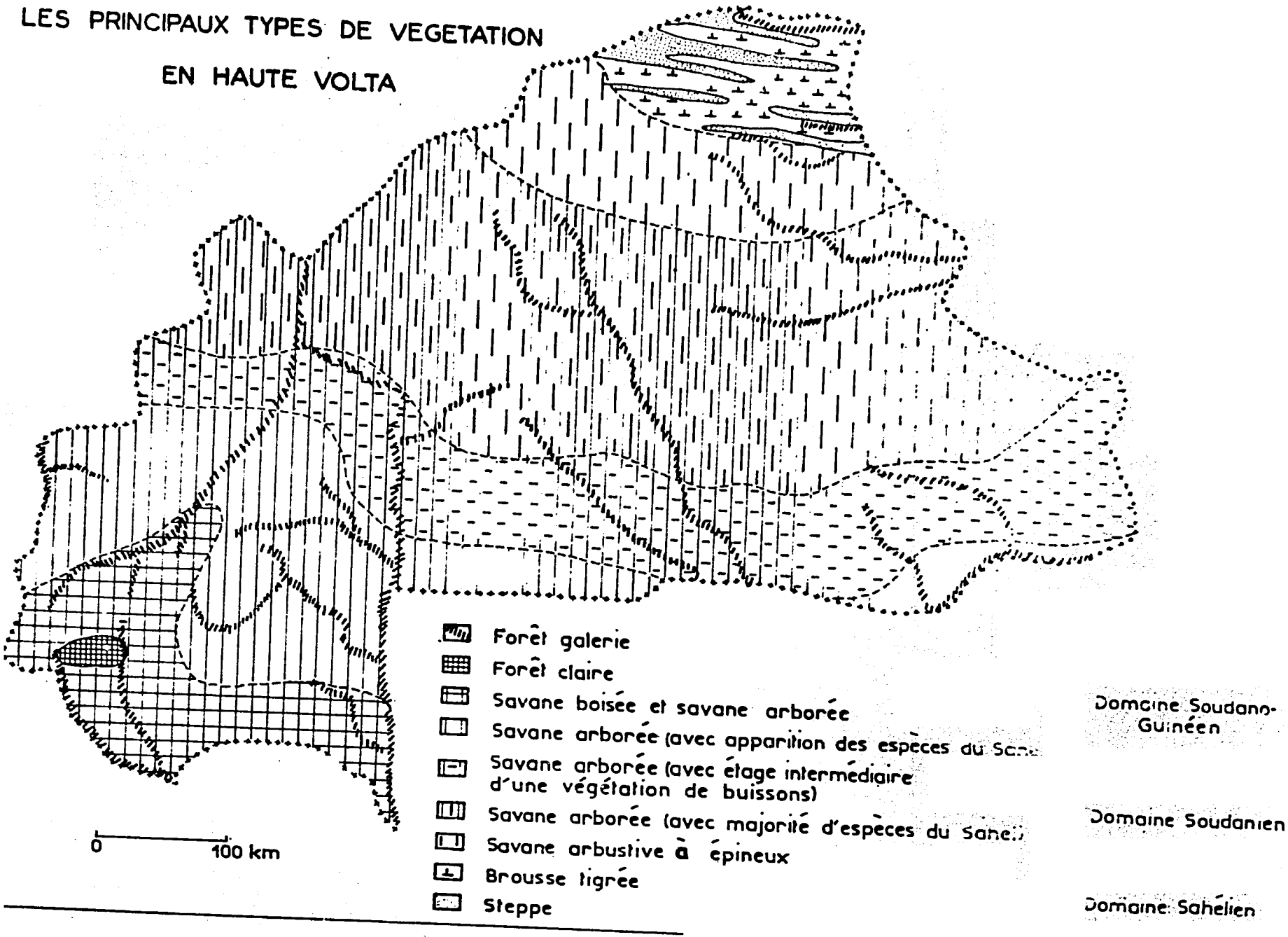

LES ZONES CLIMATIQUES EN HAUTE VOLTA
29°
28°5
28°
27°5
27°
3° W
MARKOYE
400
GOROM GOROM
500
ARIBINDA
DORI
600
650
700
OUAHIGOUYA
KAYA
800
OUAGADOUGOU
KOUPELA
DIAPAGA
900
DIOULASSO
ORODARA
LEO
PAMA
1000
GAOUA
1100
KAMPTI
BATIE
1200
1300
0
100 Km
Isohyètes moyennes en mm période 1961_1970
Isothermes moyennes en 0° centigrade période 1961-1970
Zone sahélienne
Zone nord-soudanienne
Zone sud-soudanienne

MAP 2


LES COURS D'EAU DE LA HAUTE VOLTA
YAKOUTA
MANIMENSO
SAKOINSE
BOROMO
YAKALA
SAMANDENI
DIEBOUGOU
YENDERE
Réseau hydrographique du Banafing
Réseau hydrographique des Volta
Réseau hydrographique de la Comoé
Réseau hydrographique du Niger
Cours d'eau à régime tropical de transition
Cours d'eau à régime tropical pur
Cours d'eau à régime sahélien
Station limnigraphique
Chute
Mare
Zone inondable
Barrage

MAP 3

LES PRINCIPAUX TYPES DE VEGETATION EN HAUTE VOLTA

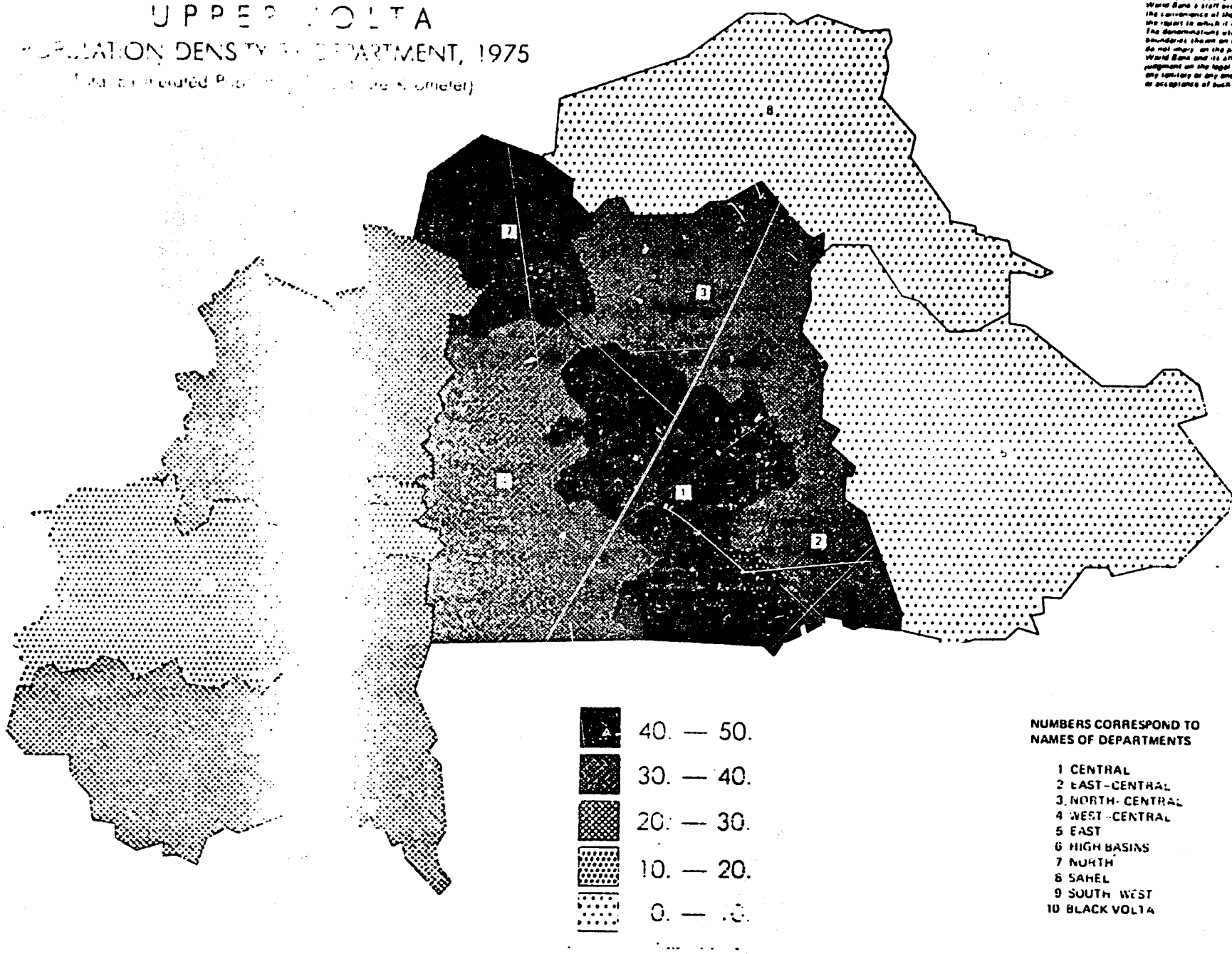


MAP 4

UPPER VOLTA

POPULATION DENSITY BY DEPARTMENT, 1975

(Inhabitants per Square Kilometer)

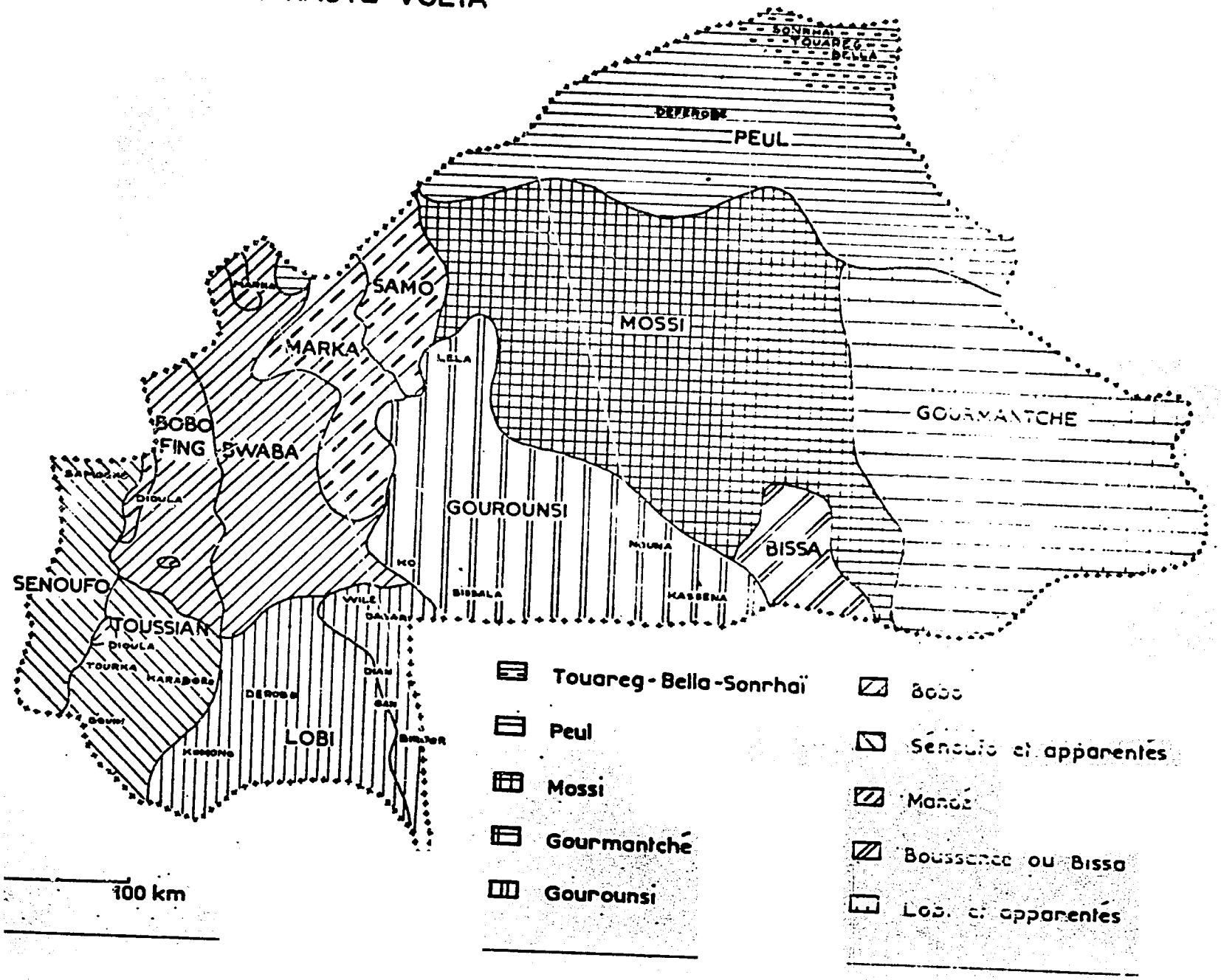


NUMBERS CORRESPOND TO NAMES OF DEPARTMENTS

1 CENTRAL
2 EAST-CENTRAL
3 NORTH-CENTRAL
4 WEST-CENTRAL
5 EAST
6 HIGH BASINS
7 NORTH
8 SAHEL
9 SOUTH WEST
10 BLACK VOLTA

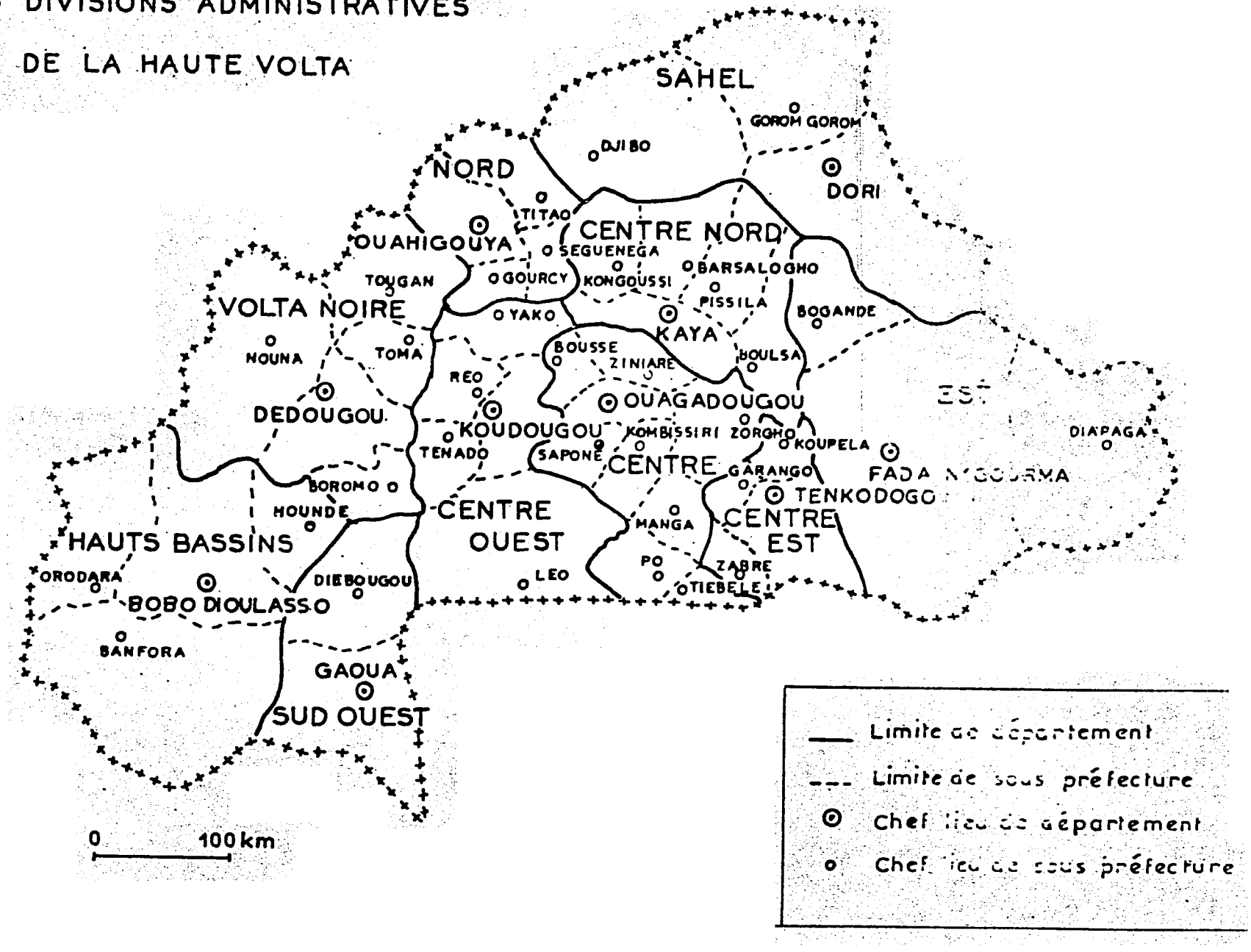
MAP 5

LES ETHNIES EN HAUTE VOLTA



MAP 6

LES DIVISIONS ADMINISTRATIVES DE LA HAUTE VOLTA



ANNEX I. PROCUREMENT PLAN AND DETAILED BREAKDOWN OF THE BUDGET

A. Procurement Plan

All commodities other than vehicles, mobylettes and a photocopying machine will be bought in the U.S. or as shelf-items in Ouagadougou.

1. Procurement method: The MOH will have to choose a Procurement Services Agent, approved by USAID, to procure the commodities on behalf of the MOH. Payment for the items and for the PSA's services will be through an AID/W issued Letter of Commitment initiated by a USAID/DPOR PIO/C. Shelf-items will be procured by the MOH in accordance with established AID procedures using advance and/or reimbursement methods.

PIO/Cs will be used in all cases under which procurement is effected, i.e., to establish an AID/W Direct Letter of Commitment to the PSA and to cover USAID/DPOR issued purchase orders, or reimbursements to the host-country. PIO/Cs will be drawn up by the USAID Project Manager, in consultation with the DPOR, prior to the submission to the Director of USAID for approval and the Director of the DPOR. Purchase orders for specific items covered under the PIO/Cs will be issued by USAID/DPOR. All copies of PSA issued purchase orders will be sent to the DPOR and to USAID.

2. Payment procedures: Reimbursement to the PSA will be effected by an AID/W issued Direct Letter of Commitment. Payment documents will be submitted to the AID certifying office in New York. Instances where payment is effected other than through a PSA, documentation will be submitted by the supplier to the USAID Controller, who will obtain the requisite administrative approvals, certify and forward to RAMC/Paris the request for the issuance of a check to the supplier. Procedures for local procurement by the DPOR will have to be approved in advance by USAID and developed in coordination with the USAID Controller. In the event the USAID Controller authorizes the issuance of advances to the DPOR, no bank will be selected by the MOH which will not provide statements to the USAID on an adequate and timely basis. Checks for payment of commodities and services procured in-country and in Code 935 countries will be ordered in the currency specified by the supplier, addressed to an account or address of his or her choice. Reimbursement to the PSA for expenditures incurred to procure commodities and services in the U.S. will be approved by the AID New York certifying office and paid by dollar check issued by AID/W FM/BFD against the AID/W Letter of Commitment.

3. Transportation and Insurance:

- Ocean transportation and insurance costs have been calculated at 60% of FAS cost for all commodities procured in the U.S. Ocean transportation and insurance will be arranged by the PSA or by the supplier. Items procured in the U.S. will be shipped CIF to the ports of Lome or Abidjan, in U.S. flag bottoms. U.S. flag bottoms call regularly at both ports.

- Air freight will be authorized by USAID on a case-by-case basis. Air shipment routes to Ouagadougou are best arranged via Paris. U.S. flag carriers can be used from the U.S. to Paris. Non-U.S. flag carriers have a reputation for efficient and rapid delivery of goods at the Ouagadougou airport warehouse. Consignment will be directly to the MOH/DPOR.

- All surface-shipped imported items, from whatever source, will be consigned to an MOH/DPOR-appointed transitaire (Lome or Abidjan) who will act on behalf of the MOH to effect clearance and road transport to Ouagadougou. Insurance will be obtained by the transitaire to cover the commodities during inland transportation. These instructions will appear in all PIO/Cs (AID Form 1194) and on all purchase orders issued by USAID. Final addressee will be shown as "Direction des Etudes et de la Planification/Ministère de la Santé de Haute-Volta, B.P. 7009, Ouagadougou". All PIO/Cs and purchase orders will indicate that distribution of original shipping documents will be forwarded immediately after shipment to:

  (a) The transitaire of port of delivery;

  (b) The Ministry of Health;

  (c) REDSO/WA in the event the port of delivery is Abidjan or to OAR/Lomé if port of delivery is Lomé;

  (d) USAID/Upper Volta

- The customs clearance and reception will be the responsibility of the MOH, which will include the application for and receipt of all exonerations for the exemption of all duties and taxes in conformance with the existing bilateral agreement between the USG and the GOUV.

4. Records and Accounting: The MOH/DPOR will maintain arrival records, inspection and receiving reports, and any related accounting records, and will make them available to the USAID Project Manager. Monitoring of commodity procurement will be done by the USAID Project Manager.

B. Detailed breakdown of the budget

(a) USAID inputs:

1. Technical assistance: The amount of $120,000 per person per year has been set aside for as many years as the technical assistance will be contributing to the Project. This rate is what is practiced on the international market. For the short-term assistance, a substantially higher rate was allocated as the cost of travel will not be spread over a long period of time ($3,000/week).

2. Training: The cost-estimate for training depends largely on where the school is located. For schools in West Africa, estimated costs are based on $ 600 per month. For schools in the U.S., the rate of $ 3,500 per month was used. The two rates include all estimated expenses as long as a minimum of six months is applied, thus spreading the trip cost.

3. Construction: The price range per square meter for construction of a building varies from CFAF 50,000 to CFAF 250,000 per meter in Ouagadougou. The price applied to the AID-financed building is CFAF 130,000/m^2. According to the architects of the Ministry of Public Works, this is the cost for average construction of this sort. The project may save the money put aside for the architect if it is decided

to have the plan designed by the Ministry of Public Works. It is recommended that this be done because it will save 7% of building cost and the project will gain time automatically on the delays necessary in having the plans appraised by the Ministry of Public Works. In addition, the architect will be available by the end of September to design the plans and draw up the bidding documents.

One possibility which was explored was to use stabilized earth for the construction. It seems to be a good solution for lowering construction and recurrent costs tied to the building.

4. Operating costs: In addition to the cost of utilities at $ 30,000, the MOH will take on the operating costs of $ 42,200 per year on a progressive basis, as outlined in the main body of the Project Paper. The operating costs are estimated to drop to $ 38,000 per year once the technical assistance departs. Per diem is calculated on the basis of $ 15 per day for health personnel who go from Ouagadougou to the field and $ 20 per day for field health personnel who come to Ouagadougou for the annual planning conference.

It will be the responsibility of the technical assistance team to advise the DPOR on how to reduce operating costs by using resources wisely, particularly energy.

5. Workshops and/or scientific conferences: Funding covers trip fare and per diem calculated at the rate of $ 2,000 per person whether Voltaic or expatriate technical assistance.

6. Evaluation consultants: Funding covers air fare and per diem at $ 3,000 per week. Additional in-country transportation, office facilities, etc., will be assumed under operating costs.

(b) GOUV inputs:

1. Salaries of personnel: Salaries are based upon the 1982 official handbook of the Ministry of Public Works.

2. Utilities: The Ministry of Finance is responsible for paying the bills for utilities of other Ministries. Bills are paid through "payment orders". Consequently, the MOH does not have much of an appreciation for the real recurrent costs as they never see the bills for electricity, water and telephone.

As soon as the project gets started, VOLTELEC will have to be notified that a building is going to be constructed near the hospital. The telephone company will also have to be alerted. If a regulator or transformer is necessary, the Project can fund it out of installation costs built into the construction line-item.

BUDGET FOR LONG-TERM TECHNICAL ASSISTANCE
(Planned Expenditures)
($ 000)

	June 1983	1984	1985	1986	1987	1988	# Years
Health Manager	$ 120	$ 120	$ 120	$ 120	$ 120	$ 120	5.0
Health Planner	60	120	120	60		360	3.0
Economist	60	120	60			240	2.0
Epidemiologist/ Evaluator		120	120			240	2.0
Documentalist		120	60			180	1.5
Total	$ 240	$ 600	$ 480	$ 180	$ 120	$1,620	13.5 years
Locally-hired Administrative Secretary	18	18	18	18	18		5.0 years

BUDGET FOR SHORT-TERM TECHNICAL ASSISTANCE
(Planned Expenditures)
($ 000)

	June 1983	1984	1985	1986	1987	1988	Total $
Systems Analyst (8 weeks)		$ 12		$ 12			$ 24
Financial Analyst (16 weeks)	$ 24		$ 24				48
Records System Developer (6 weeks)	9		9				18
Epidemiologist (16 weeks)		24		24			48
Discretionary (11 weeks)	6	9	9	9			33
57 weeks	$ 39	$ 45	$ 42	$ 45			$ 171
Evaluation:							
Health Manager (7 weeks)			$ 9			$ 12	$ 21
Health Planner (7 weeks)			9			12	21
Biostatistician (7 weeks)			9			12	21
Public Health Nurse (4 weeks)						12	12
Social Analyst (4 weeks)						12	12
29 weeks			$ 27			$ 60	$ 87

BUDGET FOR TRAINING
(Planned Expenditures)
($ 000)

	Year 1*/	Year 2	Year 3	Year 4	Year 5	Total
Economist		7.2				7.2
Biostatistician			7.2			7.2
Documentalist	7.2	7.2				14.4
Director			21.0			21.0
Health Planner	21.0					21.0
Evaluator	3.6					3.6
Totals	31.8	14.4	28.2	-	-	74.4

*/ Year 1 runs from October 1, 1982 through September 30, 1984.

COMMODITIES

Type of Office	Furniture and Equipment		Total
	Quantity	Unit Price	
Technical	14	$ 821.77	$ 12,000
Secretariat	1	5,666.62	6,000
Typist	4	799.70	3,500
Reproduction	1	14,833.00	15,000
Documentation	1	5,162.22	5,500
Conference Room	1	2,452.80	2,500
Other:			
Calculators and Computer			12,000
Camping Equipment	5	389.51	2,000
Miscellaneous			12,300
Generator	1	3,500.00	3,700
Air-Conditioners	12	500.00	6,500
Vehicles and Mobylettes			52,000
Total			$ 133,000
Documentation and Infland Freight (5%)			7,000
Procurement Service Agent (7%)			10,000
Marine and Inland Freight (60%)			80,000
Sub-total			$ 230,000
Unforeseen purchase of commodities			29,000
COMMODITIES TOTAL			$ 259,000

OFFICE EQUIPMENT

Item	Reference*/ No.	Price per Unit	Quantity	Amount
1. Technical Office				
Furniture:				
Desk, Double Pedestal 160" x 30"	WIL-A96-002 (Top: Teak Color: Lt. Sand)	$ 197.00	1	$ 197.00
Chair, Executive Swivel	WIL-B13-003 (Sand)	70.55	1	70.55
Cabinet, Filing, 4-drawer, Legal	WIL-A59-904	127.00	1	127.00
Cabinet, Storage, with doors, back 36x21x72	MMC 4587T16 (Tan)	265.75	1	265.75
Equipment:				
Frame, Drawer, Legal	MMC 5144T24	4.93	4	19.72
Frame, Drawer	WIL-A96-019	9.25	1	9.25
Folders, File Legal	MMC-5144T14	0.41	150	61.50
Folders, File, Letter	MMC-5144T12	0.36	25	9.00
Desk Lamp		50.00	1	50.00
Waste basket		12.00	1	12.00
Sub-total				$ 821.77
2. Secretariat Office				
Furniture:				
Desk, Secretarial 30x60	WIL-A96-006 ("L" Left) Top: teak Color: Lt. Sand)	$ 283.00	1	$ 283.00
Chair, Secretarial	WIL:B13-004 (Sand)	61.90	1	61.90
Cabinet, Filing, 4-drawer, Legal	WIL A59-904	127.00	2	254.00
Cabinet, Storage with doors and lock 36x21x72	MMC 4587 T16 Tan	265.75	1	265.75

*/ See key on p. 10.

OFFICE EQUIPMENT (Continued)

Item	Reference*/ No.	Price per unit	Quantity	Amount
Typewriter, IBM Selectric Sp. It. No. 47-123 11" Paper Cap. Single Pitch. Fab Rib 721 - French Keyboard 1 English element 1 French element Preferred type - suitable for stencils	GSA	$ 652.50	1	$ 652.50
Equipment:				
Typewriter, Manual, Std., Upright, 15" carriage French keyboard (preferred type suitable for stencils)	GSA	500.00	1	500.00
Frame, Drawer, Legal	MMC 4587 T16 Tan	4.93	4	19.72
Frame, Drawer	WIL A96-019	9.25	1	9.25
Folders, File, Legal	MMC 5144 T12	0.41	150	61.50
Folders, File, Letter	MMC 5144 T12	0.36	25	9.00
Photocopy Machine		3,500.00	1	3,500.00
Lamp, Desk		50.00	1	50.00
Sub-total				$ 5,666.62
3. Typists' Office				
Furniture:				
Desk, Work 30x48	WIL-A96-010 Lt. Sand, Teak top	$ 160.00	1	$ 160.00
Chair, Secretarial	WIL-B13-004 (Sand)	61.90	1	61.90
Equipment:				
Typewriter, Manual, Std. Upright French Keyboard 15" carriage. Preferred type suitable for stencils	No reference No.	500.00	1	500.00
Copy Stand, Typist (legal-size holder preferred)	HSH-A17-545	15.80	1	15.80
Waste basket		12.00	1	12.00
Desk Lamp		50.00	1	50.00
Sub-total				799.70

OFFICE EQUIPMENT (Continued)

Item	Reference*/ No.	Price per unit	Quantity	Amount
4. Reproduction Office				
Furniture:				
Desk, Work 30x48	WIL-A96-010 (Lt. Sand, Teak Top)	$ 160.00	1	$ 160.00
Chair, Secretarial	WIL-B13-004 (Sand)	61.90	1	61.90
Table, High Work 36x72	WIL-A96-013	144.00	1	144.00
Locker Unit, 8-Hanging K.D.	WIL 07-605-003	455.00	1	455.00
Master Lock and Key	WIL 07-605-008	15.70	1	15.70
Cabinet, Combination Storage Supply 72x36x18 K.D.	WIL 357-013	143.00	1	143.00
Tables (for Roneo-machine)		150.00	2	300.00
Equipment:				
Trays, Stakette 8 1/2x15 Tan	WIL 18-016-040	4.10	100	410.00
Garbage Can		46.95	2	93.90
Roneotype Machines		1,500.00	2	3,000.00
Photocopy Machine		10,000.00	1	10,000.00
Lamp, desk		50.00	1	50.00
Sub-total				$14,833.50
5. Documentation Office				
Furniture:				
Book shelves		$ 58.91	20	$ 1,178.20
Display racks	HSH A61472	96.40	2	192.80
Archive Storage Box		4.89	1	97.50
Desk double pedestal		197.00	1	197.00
Executive swivel		70.50	1	70.50
Reading table 36x72	W A96031	144.00	1	144.00

OFFICE EQUIPMENT (Continued)

Item	Reference*/ No.	Price per unit	Quantity	Amount
Equipment:				
Desk lamp		50.00	2	100.00
Overhead projector		426.80	1	426.80
Slide projector		568.32	1	568.32
16-mm projector		1,081.94	1	1,081.94
Camera, 35 mm and case		250.00	1	250.00
Instant picture camera		75.00	1	75.00
Cabinet stand for projector	EA OP AA74-513	151.12	1	151.12
		93.69	1	93.69
		88.30	1	88.30
Fire extinguisher		45.00	1	45.00
Projection screen		150.00	1	150.00
Waste basket		12.00	1	12.00
Easel-marker board set with stand		120.00	2	240.00
Sub-total				$5,162.17
Computer and Calculators				
Computer, Statistical, Programmable		10,000.00	1	10,000.00
Calculators, Programmable Printing		450.00	2	900.00
Calculators, Desk		150.00	2	300.00
Calculators, Hand		40.00	15	600.00
Sub-total				$11,800.00
Camping Equipment Unit: X 5				
Folding cot	MMC 9105T14 Pg.533	162.91	1	162.91
Mosquito nettings			2	
Lantern, kerosene with spare wicks	MMC 5810T1 Pg. 576	17.38	1	17.38
Pillow		15.00	1	15.00
Pillowcases		15.00	2	30.00
Sheets			3	100.00
Blankets 6690	MMC 6562T1 Pg. 602	22.11	2	44.22
Set of 2 Plastic Dishes, Cutlery, 2 Goblets		20.00	1	20.00
Sub-total				$ 389.51

OFFICE EQUIPMENT (Continued)

Item	Reference*/ No.	Price per unit	Quantity	Amount
Jerricans, metal for gasoline, 20 liter	MMC 4303T5 Pg. 170	$ 20.40	10	$ 204.00
Spouts, flexible for jerricans	MMC 4303T3 Pg. 170			
Refrigerator		350.00	1	350.00
Jerricans, plastic for water, 20 liters	MMC t224T3	13.50	6	31.50
Folding tables with plastic sheeting	MMC 91	53.52	2	107.04
Tarpulin, large duck water-resistant 12x16 double filled 12.41 wt.	MMC 7882T	57.60	1	57.60
Folding chairs		20.00	5	100.00
Stacking chairs (black)	MMC 5176T16 Pg. 89	46.82	40	1,872.80
Generator 4 KVA (ONAN + 25% spare parts)		1,500.00	1	3,500.00
Air-conditioners, 1½ kwa		500.00	12	6,000.00
Sub-total				12,2[illegible]8.96
<u>Vehicles and Mobylettes</u>				
Four-wheel drive vehicle		$12,000.00	2	$24,000.00
Four-door sedan vehicle		8,000.00	2	16,000.00
Mobylettes		800.00	2	1,600.00
Spare parts (25% of cost)				10,400.00
Sub-total				$52,000.00
Unforeseen purchase of commodities				29,000.00
COMMODITIES TOTAL				$259,000.00

*/ Key: WIL - Wilcox International 1982.
MMC - McMaster Carr-87.
GSA - FSC Class 7430 (Contract GS-00S-23063 Dec.15, 1980-Sept.31, 1981).
HSH - Highsmith Office and Audio-visual Products Catalogue 24A 1982.

OPERATING COSTS
($ 000)

Maintenance		
Building	CFAF 130,000/m + 1% of total cost	$ 1,473
Office equipment	$ 39,000 = 7% of total cost	2,789
Vehicles + POL	7,800 liters of gas + 10% of total cost	11,328
Mobylettes + POL	CFAF 7,500/month x 12 months/year	600
Generator	20/h x 240 h + 10% of total cost	670
Other		
Office supplies	CFAF 250,000/month, 12 months	10,000
Custodial supplies	CFAF 20,000/month, 12 months	800
Per diem, DPOR personnel to field	$15/day x 15x30	6,750
Per diem, MOH personnel to Ouagadougou	$20/day x 44x7	6,160
Transportation		1,650
		42,220

ESTIMATED GOUV CONTRIBUTION*/

Personnel	Salary per year	Indemnities	Total
Director	$ 5,951	$ 3,400	$ 9,351
Public Health Doctor	5,951	3,400	9,351
Logistical Supervisor	5,951	595	6,546
Economist	5,951	595	6,546
Statistician	3,500	350	3,850
Statistician	3,500	350	3,850
Public Health Nurse	3,500	350	3,850
Public Health Nurse	3,500	350	3,850
Documentalist	3,500	350	3,850
Office Clerk	1,359	300	1,659
Chauffeur	1,113	300	1,413
Chauffeur	1,113	300	1,413
Messenger	828	300	1,128
Janitor	791	300	1,091
Watchman	997	300	1,297
Typist	828	300	1,128
Typist	828	300	1,128
Typist	828	300	1,128
TOTAL MANPOWER COST PER YEAR			$65,000
Utilities			
Electricity	12 A/C 1½ kwa	1,400/month	$16,800
	Other use	200/month	2,400
Water		150/month	1,800
Telephone	$60/unit	720/month	8,640
TOTAL UTILITIES			30,000

*/ Salaries and benefits in US$ per year (US$ 1 = CFAF 300).

ESTIMATED GOUV CONTRIBUTION (Continued)

Maintenance			
Building	CFAF 13,000/m	1% of total cost	$ 1,473
Office equipment	$ 39,000	7% of total cost	2,789
Vehicles + POL	7,800 liters/gas	10% of total cost	11,328
Mobylettes + POL	CFAF 7,500/month		600
Generator	21/h x 240 h	10% of total cost	670
Other			
Office supplies	CFAF 200,000/month	12 months	8,000
Custodial supplies	CFAF 20,000/month	12 months	800
Per diem, DPOR	$ 15/day	10 x 30	4,500
Per diem MOH personnel	$ 20/day	44 x 7	6,160
Transportation			1,650
Total Maintenance			37,970
Total Utilities			29,640
Total Salaries			65,000
Recurrent costs to be taken over by MOH budget			$ 132,610

ROLE OF PROJECT FINANCED TECHNICAL ASSISTANCE AND SCOPES OF WORK

1. Role of Project - financed technical assistance :

During the life of the project, the five long-term members of the technical assistance team will concentrate on two types of activities :

a. Providing on-the-job training to five Voltaic counterparts : the Director of the DPOR, in health management; the Chief of Planning and Programming Service, in health planning; a Public Health Nurse in epidemiology/evaluation; an economist in health economics; and the librarian as documentalist; and

b. Jointly developing with Voltaic counterparts methods, procedures, and norms necessary for the operation of a functional DPOR including administrative/logistical personnel training and supervisory aspects at the central and departmental levels of the MOH.

It is expected that the field of Statistics will be covered by the WHO Statistician who will be integrated in the work of the DPOR and who will be responsible for the technical organization of the health information system and the training of a Voltaic counterpart.

Counterpart training will consist not only in on-the-job training, but also in formal training in francophone African or U.S. institutions.

Formal training will provide basic background information in the fields of health management, health planning, epidemiology, health economics, statistical analysis and documentation. Another important aspect of the training is related to the simplification, testing of the learned principles and its adaptation to the local realities of the country. This will be a major contribution of the in-country management training programs. The U.S. technical assistance team and the counterparts will be working together in revising the health information system and the data collection of basic information, analyzing health statistics, service and population statistics, setting norms and recommending policies in ministerial policy areas.

Managerial methods should include role-playing, case analysis, programmed instruction, simulation management games, and field work in collaboration with health service units. The whole technical assistance team should work around the "core" area of management. The approach of management training should be local problem-solving capacity rather than transplanted health management models. Funds have been budgeted for operational research studies aimed at the improvement of field activities and to demonstrate and show in a practical way what well-planned services are and what are the key practical elements that should be present in a technically conceived health-service unit. In this way, it would be possible to show the advantages of sound planning and programming and eventually replicate the essential elements in

other regions of the country.

Another important source of assistance will be the advice of short-term consultants in the areas of epidemiology, financial analysis, systems analysis, record systems development, development of human resources and other relevant areas which will be identified as the project is implemented. Eleven weeks of discretionary short-term technical assistance have been included in the project budget for operational research purposes.

2. Scopes of Work and Rationale for Technical Assistance :

A. Long-term technical assistance team

The long-term technical assistance team consists of five persons : a health manager, a health planner, an economist with a specialization in health, an epidemiologist/evaluator, and a documentalist. All members of the Technical Assistance team must be fluent in French, with a minimum of three years of previous working experience in LDCs, preferably a francophone African country.

1. The health manager, who is to be the Chief-of-Party of the technical assistance team will be with the Project in Upper Volta for five years. He or she will serve as the counterpart to the Director of the DPOR. As Chief-of-Party, the health manager will give direction, ensuring that the technical assistance is coordinated in a meaningful way at three levels.

a. Policy decision level - assisting the Director in the definition of long, medium and short-term objectives of the DPOR,

b. Administrative level - establishing the methods of carrying out the policy decisions approved by the Higher Council of Public Health; and

c. Operational level - translating the methods into practical actions by utilizing task and functional analysis procedures.

The health manager will also be responsible for ensuring the adequate accountability of A.I.D. funds, including maintaining of the checkbook for the loacl currency bank account and the responsibilities set forth in Annex P, the Accounting System.

In order to accomplish this Scope of Work (SOW) the health manager should be experienced as a health manager, fluent in French with three to five years of practical work in health management activities in LDCs, preferably in a francophone country. A hospital administrator or a business administrator with previous work in health related areas could be considered as suitable candidates provided that their record shows good performance outputs while working with counterparts. It is essential that the selected candidate be able to demonstrate satisfactorily that he or she has successfully worked with host country personnel, and has left trained host country personnel able to perform.

The qualities of a compassionate leader, respect for his/her peers, agreeable personality and eagerness to accomplish a

challenging type of work will be positive considerations in the selection process. The health manager must have a combination of political, personal, informational and decision-making roles to play. What he or she plans must be done in a practical context, not by means of an abstract theoretical process.

2. The health planner, who will be with the Project in Upper Volta for three years, will be the counterpart to the MD/MPH Chief of the Planning and Programming Service. The health planner should be a scientist formally trained in health planning with a D.P.H. in health planning or its equivalent.

The health planner should be able to design realistic plans (related to the available resources) and formulate them within a reasonable time period (plans cannot take so long to implement that their initial objective is no longer relevant). Additionally, he or she must be a coordinator, ensuring that the plans and their components are compatible, not only with health needs but with national, regional or local priorities and as far as possible with community expectations.

Planning is now more concerned with people and their needs and functions and has been defined as "the process of deciding in what respect the future should be better than the present, what changes are necessary to bring about improvement and how these changes can be implemented". *

The Director of the DPOR will travel to Washington to interview the top two or three candidates for the health manager and health planner positions.

3. The economist with a health specialization, who will be with the Project in Upper Volta for two years, will be the counterpart to the Chief of the Projects and Operational Research Office. He or she will be responsible for the development of increasing instruments which can be incorporated into such planning techniques as cost-effectiveness or cost-benefit analysis. The economist should be able to advise on the general economic approach to decision making - the need to know what it costs to provide a given service according to one alternative and establish with some measure what this service is able to achieve and what would be the result of using other alternatives.

Good health plans require that, in economic terms, we can describe what the resources are currently being used for and in what quantities, and what is being achieved.

Economists are still comparatively newcomers to the field of health care evaluation and their perspective is often misunderstood. The distinctiveness of their approach lies not so much in a concern with the cost of different health activities, but in attempting to establish relationships between cost and outcome. The economist will be involved in financial analysis, program budgeting and the application of basic economic ideas to the financial information system.

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* (Bispham, Holland and Stringer, 1971)

4. The epidemiologist/evaluator who will be with the project in Upper Volta for two years, will be the counterpart to the public health nurse who is Chief of the Office of Monitoring and Evaluation.

The epidemiologist/evaluator should have experience in community medicine, evaluation techniques and expertise in determining the appropriate need to justify an intervention, the options for allocating health resources and evaluating each option. It is desirable that the candidate has lived for at least two years in poor rural areas of an LDC, closely involved in studying the distribution and occurrence of a given disease of public health importance and the factors that influenced such distribution.

The collaboration of the epidemiologist in the Technical Assistance team is very important to program evaluation and to balancing the pragmatic approach of the manager or the economist. There is the potential for the managerial and economic viewpoints to lose sight of the ultimate goal of any health service, namely the improvement of health. And the improvement of the health of the populations, by defining health problems, finding and demonstrating ways of solving them, and applying the solutions, is the aim of the epidemiologist.

The health planner will find the ways to translate these apparently divergent views into comprehensive health plans. Managers tend strongly to be guided by an economic or productivity model of human activity : how to produce, and often to "sell" the most with the least expenditure. Epidemiology is the discipline concerned with problems of health and disease in human populations. It is to be distinguished from the practice of clinical medicine which is concerned with the health problems of individuals. Epidemiology is the scientific base for community medicine, for the study and control of disease, and the advancement of health in human populations. Epidemiology and community medicine are eclectic in that they must take into account the knowledge of many fields including biology, the physical sciences, statistics and psychology.

5. The documentalist, who will be with the Project for one and a half years, will be the counterpart to the Chief of the Office of Documentation and Archives. The documentalist should be a specialist in library science or documentation, familiar with soliciting documents, their reception, cataloging, storing, retrieving and advertising. Experience for one to two years in this type of documentation activity in francophone countries is important. It is suggested that the African Bibliographic Center, which has considerable experience in the Sahel, might be able to furnish the documentalist.

The accumulation of knowledge as well as the development of techniques relevant to the administrative functioning of health services and the adaptation of health care to the felt needs of the population, are known as health service research.

Without access to reliable and valid information, planning becomes an uninformed struggle for power; the administration of public health services generates roomfuls of data that must be assembled into information appropriate to the planning requirements. A planning unit requires the backstop of a documentation center to function. The documentalist is the person who is responsible for classifying and retrieving the information produced and providing the information published by the scientific community in related areas. The projected publication of a semestrial epidemiological bulletin and the Annual Statistical Bulletin require the organization of the documentation center. No scientific group can function properly without the support of such a center.

Another important activity of the documentation center is the data dissemination, once the quality of the statistical data produced by the DPOR will be improved.

6. Local - hire Administrative Secretary (60 PM) should be a highly skilled French-speaking administrative secretary functioning as Office Manager. He or she will be in charge of training the local secretary and three typists and organizing the secretarial office. The candidate should have a secretarial certificate, with practical experience in running and organizing a secretarial office with supervisory functions over auxiliary office personnel.

B. Short-term technical assistance

The short-term technical assistance consultants have been selected taking into consideration that the main objective of the DPOR is health planning.

Planning is one of the activities of a system and must be looked at it in terms of its measure of performance and of its advantages and disadvantages. Planning is concerned with decision making. Hence it must study a decision maker who chooses among alternative courses of action in order to reach certain first-stage goals which lead to other objectives.

The three major sub-systems of planning are social interaction, measurement and testing. If we were to follow the systems approach carefully, we should have to describe each sub-system in detail and attempt to assign measures of performance to them. To complicate things still further, the three sub-systems are all interacting through information and resources flows.

The complexities of health planning are such that in order to understand its interactions we need to utilize the systems approach. With this idea in mind, it is recommended that the project engage a financial analyst, a systems analyst and a record systems developer for short periods of time.

1. Financial Analyst (16 weeks) - the project will require a specialist in economic evaluation whose task is to relate the costs of health care to some measure of its outcome. Health planning needs a measure of (a) the resources used and (b) the outcome likely to be obtained. Without both sets of information, decisions are inevitably made on the basis of one or the other. The financial analyst will be working in close collaboration with the economist and the record systems developer. The financial analyst will be required for eight weeks in the second year of the project and eight weeks in the third year.

For the MOH of Upper Volta its limited resources make it more important to measure cost of the services provided and assessing the quality of them. To do so it is necessary to identify the incidence and volume of costs and to measure the impact of care. The existing health information system is inadequate for economic appraisal in terms of both the cost and quality information presently collected. The inadequate cost information can be attributed in large part to the input method of accounting which is still employed in much of the public sector.

The majority of Upper Volta's population lives in rural areas, where the health system is not yet developed. Current demographic dynamics show that the majority of the steadily increasing stream of new entrants to the labor force have to find their livelihood in the rural areas rather than in the small urban-wage-labor sector. This creates a problem for rural development as well as for the establishment of worthwhile primary health care programs. Systems analysis provides a conceptual structure to study the situation. Such approach not only provides an insight into the dynamics of the system but it also enables an appraisal of alternative planning and control policies.

2. Systems analyst (8 weeks) - to help to analyse the health delivery system (HDS) by developing "measures of performance" which are to be maximized, including the environment, the resources, the components and the management of the HDS. The DPOR has the mandate to establish a data base for ministerial decision-making, to provide for more effective MOH contributions to national planning efforts and to develop better managed and coordinated health programs and strategies, particularly for the ministry's priority concern of PHC services to the rural areas. To do so, it is necessary to use the systems analysis techniques.

Tentatively, the contribution of the systems analyst has been projected for the 2nd and 4th years when there will be enough relevant information gathered for this type of activity.

3. Record Systems Developer (6 weeks)- a specialist in designing statistical records to facilitate data registration and data processing. One of the activities of the DPOR is the simplification of the current Health Information System (HIS) in order to make it more functional and able to serve the needs of decision-makers of the MOH. This contribution has been programmed for the 2nd and 3rd years.

4. Epidemiologist (16 weeks) - The need to establish an epidemiological surveillance of diseases of public health importance in Upper Volta, induced the design team to recommend a short-term consultancy of an epidemiologist expert in this type of activity. His/her contribution is being programmed during the 2nd and 4th years.

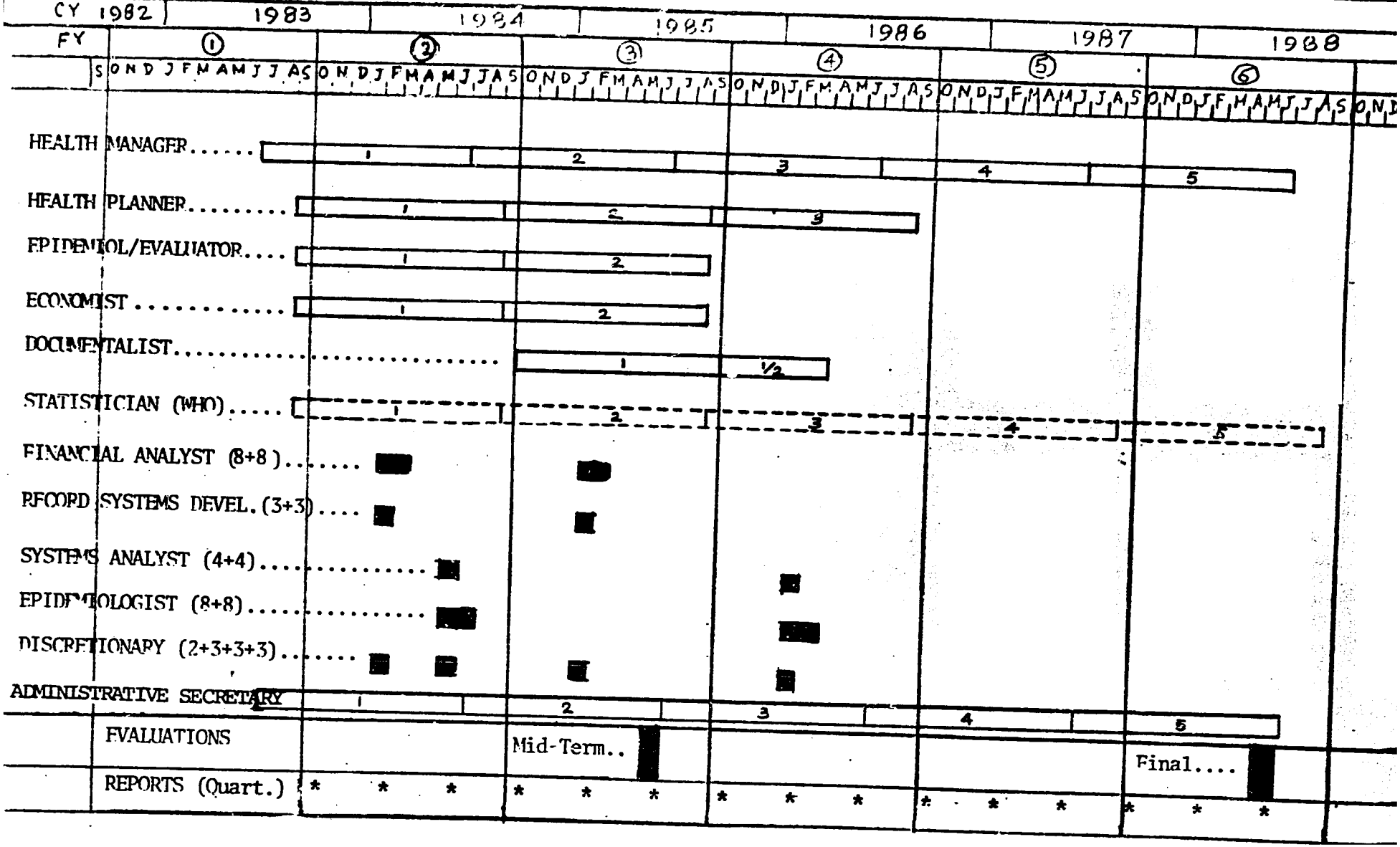
5. Short-term consultants (11 weeks) - listed as "discretionary" were budgeted to respond to currently unforeseen needs of the project. The scopes of work of these consultants will be prepared according to the needs. Their collaboration is anticipated during the second, third and fourth years of the project.

Figure 4 shows the distribution of the Technical Assistance during the 6 years of the Project.

Fig. 4 TECHNICAL ASSISTANCE

Long Term = 13.5 years (162 person/months): Short Term = 14.2 months (57 person/weeks).

COUNTRY:	PROJECT N°:	PROJECT TITLE:	DATE:	✓ ORIGINAL / REVISION	APPROVED
Upper Volta	686-0251	STRENGTHENING HEALTH PLANNING CAPACITY	08/17/82		



DETAILED DESCRIPTION OF ACTIVITIES AND TASKS OF THE DPOR STAFF

A. Description of the Activities of the DPOR staff Members and their Office

COUNTRY	PROJECT NO.	PROJECT TITLE	SUBJECT	DATE
Upper Volta	686-0251	Strengthening Health Planning Capacity	Implementation Plan	August, 1982

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
A. HEALTH MANAGEMENT	Directorate of Planning and Operational Research (DPOR).	Director of the DPOR with the technical assistance of a Health Manager	Health Program Development (HPD).	1) coordinate DPOR overall activities 2) work with policy-makers, other MOH technical and administrative structures, other Ministries and foreign donors, to : a. formulate operational research projects; b. serve as a clearing-house for approval of health projects proposed by national or foreign individuals, groups or organizations; c. prepare short, medium and long term programs (grouped by priority, objective and time horizon), for presentation to MOH policy-makers and the national planning staff. Use of the WHO "pragmatic approach"; and d. carry out the functional analysis of the health delivery system and propose strategies to substantially increase rural health services.	Health Program Development Report (HPDR) produced in April and October of each year (during the life of the project), with the Reports of the two services (Statistics and Planning/Programming) as Appendices.

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
B. HEALTH PLANNING	Planning and Programming Service of the DPOR.	Director of the Planning and Programming Service (Voltaic MD/MPH), with the T.A. of a Health Planner Expert.	Health Sector Analysis (HSA)	1) coordinate the activities of the three (3) offices of the service; 2) order health objectives by priority within the context of sectoral policies and resource constraints; 3) articulate present and future health service strategies, by : a. elaborating upon annual Plans of Action (1984 to 1988); b. determine the type of health programs that will help to articulate health policies with health needs; and 4) collaborate with service-oriented MOH structures, in the planning and programming of approved health programs or operational research studies.	Health Sector Analysis Report (HSAR) produced in May and September of each year (during the life of the project), with the Reports of the three (3) offices of the Service, as Appendices.
C. HEALTH STATISTICS	Statistical Service of the DPOR	Director of the Statistical Service (Voltaic statistician), with the T.A. of a Statistician Expert from WHO	Health Data Analysis (HDA).	1) coordinate the activities of the two (2) offices of the Service : Statistics and Documentations & Archives; 2) improve the health information system (from October 1983 to November 1984), including at the end a 3-month testing period in the field (3 Departments), to substantially raise the quality of the available information dealing with : a. target population (size, characteristics, distribution, growth, density,	Health Data Analysis Report (HDAR) produced in May and September of each year (during the life of the project) with the Reports of the two (2) offices of the Service as Appendices.

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
C. HEALTH STATISTICS (cont.)				by geographical areas; b. vital statistics (mortality and fertility patterns); c. health statistics (morbidity, mortality patterns); and d. health services, including personnel supervision and health resources utilization. 3) simplify and distribute sets of standard data collection formats for monthly use around the country by January 1985 by : a. hospitals/physicians; b. registered nurses and midwives; c. village health worker (VHW) and traditional midwife (TMW) or birth attendant. 4) in collaboration with the Office of Statistics, the eleven (11) statistical officers at the department level and the two (2) from national hospitals, process, analyze and illustrate health data results with tables and graphs as appropriate; and 5) beginning in 1985, prepare quarterly and annual health reports that include pertinent indicators of health status and health services at departmental and national levels.	

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
D. FINANCES/ LOGISTICS	Projects and Operational Research of the DPOR.	Chief of the Projects and Operational Research Office (Voltaic Economist) with T.A. of an economist expert	Financial and Administrative Analysis (FAA).	1) coordinate the financial and logistics activities of the DPOR; 2) analyze MOH budget over the past five (5) years to determine trends and make realistic projections for the next five (5) years; 3) study the actual costs of present and proposed health programs in terms of immediate and future recurrent expenses and resource requirements; 4) in collaboration with DPOR Director, DPOR Logistical Supervisor and other appropriate health personnel, prepare strategies to improve problem areas in organizational communication, delivery of commodities, transportation, program administration, etc. 5) analyze financial implications of these strategies (p.c.costs)	Financial and Administrative Analysis Report (FAAR) produced in May and September of each year (during the life of the project), with supporting information and materials as Appendices.
E. MONITORING AND EVALUATION	Office of Monitoring and Evaluation of the DPOR.	Chief of the Monitoring and Evaluation Office of the DPOR (Voltaic CESSI-Public Health Nurse) with the T.A. of an Epidemiologist/Evaluator Expert.	Standards/ Operational Research (S/OR)	1) in collaboration with appropriate MOH structures, elaborate a national Pharmacopoeia that uses generic drugs and avoids excessive numbers of pharmaceutical products; 2) develop standard norms and guide-lines for buying, storing, distributing and inventoring drugs, vaccines, equipment, furniture and supplies;	Standards and Operational Research Report (S/ORR) produced in May and September of each year (during the life of the project), with supporting information and materials as Appendices.

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
E. MONITORING AND EVALUATION (cont.)				3) based on local information, estimate annual needs/ requirements of the different health units of : drugs vaccines, equipment, furniture and supplies; 4) define norms and guidelines for epidemiological surveillance of diseases of public health importance in Upper Volta; and 5) design and coordinate operational research activities with other DPOR staff members, other MOH Directorates and, when necessary, using short-term T.A. Recommended subjects for O/R studies appear in the body of this document.	
F. DOCUMENTATION	Office of Documentation and Archives of the DPOR.	Chief of the Office of Documentation and Archives (Voltaic Documentalist) with the T.A. of a Documentalist Expert.	Planning and Programming Documentation (PPD).	1) keep files of ongoing private, public and donor-funded health programs in Upper Volta; 2) collect and file scientific publications dealing with health planning/programming; 3) keep updated data bank for information purposes; 4) develop appropriate filing codes and retrieval systems to facilitate the use of the information; 5) distribute and disseminate reports and information as required.	Planning and Programming Documentation Report (PPDR) produced in May and September of each year (during the life of the project), with supporting informatin.

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
G. HUMAN RESOURCES DEVELOPMENT	Office of Human Resources Development of the DPOR.	Chief of the Office of Human Resources Development of the DPOR (Voltaic Public Health Nurse, specialist in Professional Health Personnel Training.	Human Resources Development (HRD).	1) for each level and category of health personnel, develop norms and guidelines to standardize : a. recruitment; b. selection; c. training; d. supervision; e. evaluation f. continuous education; g. incentives; and h. job description/task analysis. 2) establish the needs of each category of health personnel according to population targets and determine the deficits by department and for the entire country; 3) estimate the annual training capabilities for each type of personnel and calculate the time periods necessary to fill the gaps; 4) study possibilities of polyvalent training and on-the-job training potential in each Department; 5) prepare a schema of training of trainers and calculate the feasibility of such an approach for a given Department; 6) review current career-ladder opportunities of each type of auxiliary and paramedical personnel and discuss with appropriate officials possibilities of steps necessary to accomplish transfers, common basic studies, part-	Human Resources Development Report (HRDR) produced in May and September of each year (during the life of the project), with supporting information and materials as Appendices.

DISCIPLINE	MOH STRUCTURE	RESPONSIBLE OFFICER	OUTCOME ACTIVITY	DESCRIPTION	REPORT PRODUCED
G. HUMAN RESOURCES DEVELOPMENT (cont)				time training, etc.; and 7) calculate training and supervision costs for urban and rural health personnel.	

B. Description of Specific Monitoring Responsibilities and Assignments

1. USAID :

Project monitoring will utilize the Pilot Monitoring System developed recently by the US Bureau of Census for AID. This system will be used on an experimental basis for a period of one year; if the results are satisfactory, this will be adopted as the monitoring system utilized by USAID during the life of the Project. The Pilot Monitoring System was developed in order to improve the ability of both AID/W and the USAIDs to monitor Project activities. The System has the following three components :

a. AID/W Project Information File, containing a complete history of the project, from start to finish. The technical backstop officer will update the file as additional information is provided throughout the project planning and implementation phases. (see Forms 1302 A-D in Attachment A at the end of this section).

b. Mission Quarterly Project Report, covering Project inputs and ouputs. This Report will initially be filled out by the backstop officer at AFR/DR/HN, when the PROAG will be signed. The technical backstop officer will use the logical framework matrix (Annex A), and the implementation plan in this Project Paper, to complete the scheduled information (see Form 1303 A-C, Attachment B). The technical backstop officer will forward the report form to the USAID to be cleared by the USAID Project Manager.

The form will be used by the project manager to discuss project status with the counterparts and the project contractors. The completed forms will provide the basis for management analysis of the project outputs and further actions required of key implementing agents.

On a scheduled basis, the form will be submitted to the AID/W technical backstop officer. The information will be reviewed and actions taken as requested. The report will then be filed in the AID/W Project Information File for the health project; and

c. Summary Card File, serving as quick reference for responding to inquiries. It is completed by the technical backstop officer when the project is proposed and will be updated throughout the life of the project. The technical backstop officer will forward a copy of the card to the project manager once the PROAG is signed and at the beginning of each fiscal year until the project is completed (see Form 1301, attachment C).

Although the proposed AID Monitoring System is still in an experimental phase, it seems that its advantages outweigh its inconveniences. As the summary of the monitoring document states, the proposed system will assist the management at both AID/W and in the USAIDs, to monitor projects throughout their development and implementation. It will facilitate a unified management approach to overall program development by using the communication of information between the USAIDs and AID/W.

2. GOUV

It is proposed that the GOUV should maintain a continuous monitoring of all activities carried out by the DPOR. The PP clearly defines project inputs, outputs and outcomes and the implementation plan was brought to the task/activity level. It is therefore possible to obtain at a glance the "raison d'être" of offices, services and central Direction and establish their relationships. It is anticipated that given the way it has been arranged, the information will easily flow from the bottom to the top and conversely from the top to the bottom.

Attachment "A"

AFR/DR/HN
PROJECT DESCRIPTION
AND HISTORY

USAID Projec
1.
2.
3.
. Host Countr
1. Primary:
2. Other:
3. Other:
. Name of Ir
1.
2.
. Long-Term
1.
2.
3.
4.
5.
6.
7.
8.
9.
0.
. AFR/DR/
1.
2.
3.
4.
5.
6.
K. Evalu
1.
2.
3.

C. Country

D. Project Purpo

E. Date PID Receipt AID/W

F. Other PID Studies
1 ☐ Yes 2 ☐ No
See Form BC-1302D

G. PID Design Team (Name(s))

	Affiliation
1. (Team Leader)	
2.	
3.	
4.	
5.	

H. PID Reviews — Date
1. Approved
2. Not Approved
3. Revision Requested
4. Other Action

I. PID Cable Response:

Number	Date
1.	
2.	
3.	

J. PID Comments

K. Project Paper Reviews — Date
1. Approved: ☐ AID/W ☐ USAID
2. Not Approved
3. Revision Requested
4. Other Action

L. Project Paper Design Team (Names(s))

	Affiliation
1. (Team Leader)	
2.	
3.	
4.	
5.	
6.	

M. Executive Committee Project Review (ECPR) — Date
1. Approved
2. Not Approved
3. Revision Requested
4. Other Action

N. Other Project Donors (Name(s))

	Affiliation
1.	
2.	
3.	

O. Authorized PP LOP:

Date	Amount
	$

P. PP Comments

Q. Date of Project Agreement

R. Obligations:

Date	Amount
1.	$
2.	$
3.	$
4.	$

AFR/DR/HN
PROJECT DESCRIPTION
AND HISTORY

Attachment "A"

C. Country

D. USAID Project Manager	Date Assigned	E. AID/W Project Officer	Date Assigned	F. AID/W Technical Officer	Date Assigned
1.					
2.					
3.					

G. Host Country Implementing Agency

1. Primary:
2. Other:
3. Other:

H. Name of Implementing Contractors	Address
1.	
2.	

I. Long-Term Assistance Team: Name (1)	Position (2)	Contractor Number (From B) (3)	Date Arrival (4)	Date Departure (5)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

J. AFR/DR/HN Field Trips/Project Visits: Name (1)	Position (2)	Date Arrival (3)	Date Departure (4)
1.			
2.			
3.			
4.			
5.			
6.			

K. Evaluations: Type	Date	Evaluations--*continued* Type	Date
1.		4.	
2.		5.	
3.		6.	

AFR/DR/HN
PROJECT DESCRIPTION
AND HISTORY

Attachment "A"

C. Country

D. Project Implementation Letters Subject (1)	Date (2)
1.	
2.	
3.	
4.	
5.	
6.	

E. Short-Term Consultants Name (1)	Discipline (2)	Purpose (3)	Date Arrival (4)	Date Departure (5)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

FORM BC-2332D

AFR/DR/HN
PROJECT DESCRIPTION
AND HISTORY

A. Project Title

Attachment "A"

C. Country

D. References (Special Studies, Evaluations, Waivers, etc.) Type of Document	Submitted by	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Form BC-1303A

MISSION QUARTERLY PROJECT REPORT

Quarter 1 2 3 4 Project FY _____

Reported by _____ (name) _____ (title)

Date Prepared _____ Obligations to Date $_____

Date of Latest Budget: _____

Project Title: _____ No. _____

_____

Country: _____

Project Inputs	AID LOP Funding	Expenditures Accrued This Quarter	Cumulative Expenditures Accrued to Date			Recommended Plan Changes/Comments
			Planned	Actual	Difference	
Technical Assistance						
Long-term						
Short-term						
Training						
Out-of-country						
In-country						
Commodities						
Construction						
Other: _____						
_____						

NOTES:

Attachment "B"

Form BC-1303B

MISSION QUARTERLY PROJECT REPORT

Quarter 1 2 3 4 Project FY ____

Reported By _____ (name) _____ (title)

Date Prepared _____

Date of Latest Implementation Plan _____

Project Title: _____ No. _____

Country: _____

No.	Project Outputs		Implementation-Scheduled versus Actual x= Started or ongoing c= completed this qtr. FY ___ Quarter 1 2 3 4 / FY ___ Quarter 1 2 3 4 / FY ___ Quarter 1 2 3 4 / FY ___ Quarter 1 2 3 4 / FY ___ Quarter 1 2 3 4	Comments, Explanations, Details
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		
		Sched.		
		Actual		

Attachment "B"

Form BC-1301C

MISSION QUARTERLY PROJECT REPORT

Quarter 1 2 3 4 Project FY_____

Reported By _____ (name) _____ (title)

Date Prepared _____

Date of Latest Implementation Plan

Project Title: _____ No._____

_____

Country: _____

Other Activities (not part of original log-frame or work-plan, new activities added later)	Implementation-Scheduled versus Actual x= Started or ongoing c= completed this qtr.																								Comments, Explanations, Details
		FY___ Quarter				FY___ Quarter				FY___ Quarter				FY___ Quarter				FY___ Quarter							
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4				
	Sched.																								
	Actual																								
	Sched.																								
	Actual																								
	Sched.																								
	Actual																								
	Sched.																								
	Actual																								
	Sched.																								
	Actual																								

Problems and/or Requests for Assistance

Problems/Requests	Action Required	Action Office	Date Due
1.			
2.			
3.			

Project Implementation Letters Issued This Quarter

Subject	Date	Subject	Date
1.		3.	
2.		4.	

Attachment "C"

FORM BC-1301 (1-13-82)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AFR/DR/HN PROJECT SUMMARY CARD
HEALTH/NUTRITION

1. Country
2. Date prepared
3. Source
4. Update
5. Project title
Project number
6. Name of AFR/DR/HN officer
7. AID Funding LOP
Amount
Years
8. Appropriation(s)
9. Type of project – *Mark (X) one*
☐ PHS ☐ EDC ☐ Non-health *(Complete reverse side)*
☐ WSS ☐ HPM
10. Project components – *Mark (X) appropriate boxes*
☐ Health education
☐ Nutrition
☐ Water supply
☐ Sanitation
☐ MCH
☐ FP
☐ Immunizations
☐ EDC – *Specify disease* _____
☐ Curative
☐ ORT
☐ Other – *Specify* _____
11. Strategies – *Mark (X) appropriate boxes*
☐ Drug systems
☐ Pro-pharmacy
☐ Community participation
☐ Logistic system
☐ Plan/Management
☐ Research
☐ VHW training
☐ Other training
☐ Local financing
☐ Construction
☐ Referrals
12. Name of contractor
PVO ☐ Yes ☐ No
OPG ☐ Yes ☐ No
13. Operational status

	Dates		Dates
a. Pre-PID		d. Implementation	
b. PID (1) Submitted		e. Phase	
(2) Approved		f. Extended	
c. PP (1) Submitted		g. Completed	
(2) Approved			

14. Evaluation
15. Notes

16. Additional information on non-health projects
a. LOP funding of health component
b. Name of AID/W project officer
c. Name of technical office responsible (besides DR/HN)
d. Name of USAID project manager
e. Name of USAID manager if health component (if different from item d)
f. Host country implementing agency for health component
g. Description of health component (to be kept with DR/HN staff)
17. Remarks

FORM BC-1301 (1-13-82)

WORLD BANK, WORLD HEALTH ORGANIZATION AND OTHER DONOR ACTIVITIES IN HEALTH

1. World Bank Activities in Health as they Relate to this Project

The World Bank and AID are in full agreement that sound planning is the necessary preliminary step to the implementation of any health project in Upper Volta. Fortunately, the Voltaic Government shares the same perception and has therefore created the Directorate of Planning and Operational Research in order to provide the MOH with the institutional capacity of planning, monitoring and evaluating health projects and programs.

The close cooperation between AID and the World Bank with respect to the design of this project has many positive benefits. Until the USAID is able to field the long-term technical assistance team (by June, 1983), the World Bank is prepared to provide the MOH with a "Project Preparation Fund" (PPF) to render the DPOR operational as soon as possible, beginning in September, 1982. Once the DPOR is able to identify and design feasible and financially sound projects, the World Bank is interested in helping the MOH in financing some of these projects, especially as they relate to the national policy of primary health care implementation.

The PPF will also help finance technical assistance in the form of a health planner, whose primary task will be to prepare a project loan to be financed by the World Bank. It is hoped that this project will be negotiated before June, 1984. If the World Bank Board of Governors approves the project, funds can be made available a few weeks after negotiations end, at which time PPF expenses will cease.

2. World Health Organization Activities in Health as they Relate to this Project

Along with USAID and the World Bank, WHO considers planning to be the cornerstone of the Health Delivery System (HDS). For several years, WHO has been helping the MOH in its planning and programming activities. Recently, a WHO-financed Statistician was assigned to provide technical assistance to the DPOR under the WHO project, Health Services Development (UPV/SPH/601) for 60 person-months. He is in charge of :

- coordinating the centralization, analysis, updating and dissemination of health information (both epidemiological and managerial) which will help to guide the actions of the various health service levels;
- developing methodologies and mechanisms for gathering, registering, processing, analysing and reporting;
- assisting the peripheral levels of the HDS by helping in personnel training, designing educational materials, etc.;
- contributing to the preparation of weekly, monthly and annual reports of the MOH;
- gathering relevant health information useful for potential users of health information;

- helping to provide pertinent information required by international organizations and more particularly those related to the International Health Agreement (WHO, Regional Sanitary Organization, etc.); and
- contributing to related activities required by the GOUV within the above mentioned frame of reference.

The design of both the AID and World Bank projects anticipate the continued provision of statistical advisory services by WHO. The WHO statistician will be the counterpart of the Chief of the Statistical Service of the DPOR.

3. Other Donor Activities in Health

Information concerning other donor activities in health is hampered by the lack of centralized data. Table 1 gives a comparison of the various sectors to which donors provide assistance. Clearly, the Health Sector has received the least amount of donor assistance since 1977.

a. UNDP - Presently plans are being developed for a U.S. $ 6.2 million ($ 3.7 million from UNDP and $ 2.5 million from FENU - Fond d'Equipement des Nations Unies) for a five year Primary Health Care Project in the Kaya region. The plan foresees construction of thirty-five "Centres de Santé de Promotion Sociale" (Social Centers), eight Health Centers and the initial sensitization training equipment and supervision of 688 Village Health Center Teams (VHCT), consisting of one Health Agent and one Traditional Birth Attendant. Plans are supposed to be finalized by the end of the calendar year.

b. UNFPA - For the past two years there has been an office in Ouagadougou which is staffed by one Zairois gynecologist and a secretary. At this time there are no concrete projects.

c. UNICEF -The MOH receives about $ 500,000 annually from UNICEF; the Ministry of Social Affairs receives an additional $ 100,000 annually. These funds are used as follows :

(1) Primary Health Care - $ 67,000 for furniture, equipment, bicyles, mobylettes, etc. for 30 Social Centers;

(2) EPI - $ 150,000 for vaccines and transportation;

(3) National Public Health School - $ 35,000 for transportation and teaching materials.

The rest goes for housing and scholarships.

d. WHO - Staffed with seven people in the MOH (4 physicians, 1 statistician, 1 engineer, 1 epidemiologist), WHO has an annual budget of approximately $ 1.2 million. Most of the budget goes for technical assistance ($ 160,000 for each expatriate T.A.) and scholarships for Voltaics.

e. FED -(Fond Européen de Développement) - Annual approximate dollar funds spent on Health come to $ 3 million. Most of it goes for construction of small rural dispensaries and village huts in the Departement du Nord. There is practically no technical assistance.

f. FAC (Fond d'Assistance et de Coopération) - Most of their funds go towards French technical assistance (mainly doctors), who receive supplies (drugs and equipment) to work with. Most of it goes to the national hospital and the former Service des Grandes Endémies.

g. German Government - Their operating area is in Gounghin. The several physicians are working at a remodeled provincial hospital with supervisory links to the Health Centers and Dispensaries.

h. Private Voluntary Organization - Of the several PVOs operating in Upper Volta, the British affiliate of the Save the Children Fund is involved directly in the health sector. They have a health project in Gorom-Gorom, Préfecture du Sahel, where 3 nurse/health visitors, 1 administrator, and one German voluntee physician are operating out of an MCH Center. They train VHWs and have already trained some fifty volunteers. The Project has been functioning since 1973 with an annual operating budget (exclusive of expatriate expenses) of approximately $ 10,000.

TABLE 1

UPPER VOLTA

FOREIGN ASSISTANCE PER SECTOR : 1977 - 1980

(In FCAF Millions)

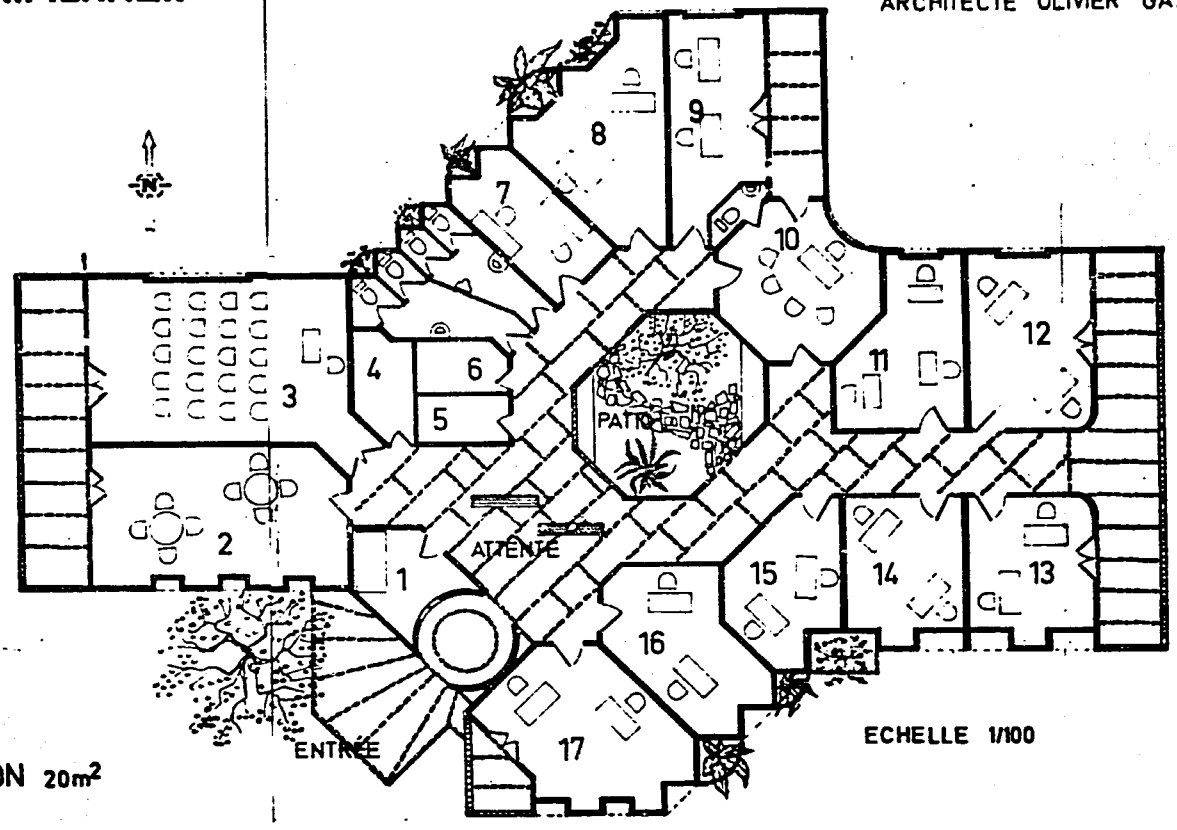
SECTORS	1977 Amount	1977 Percent	1978 Amount	1978 Percent	1979 Amount	1979 Percent	1980 Amount	1980 Percent	TOTAL: 7-80 Amount	TOTAL: 7-80 Percent
Rural Development	12,663	33.4	11,752	33.0	13,514	31.2	17,965	31.7	55,894	32.5
Transportation & Telecommunications	13,565	35.8	7,184	20.3	9,257	21.4	11,085	19.6	41,091	23.9
Industry, Mining & Energy	2,315	6.1	3,755	10.6	2,659	6.1	11,625	20.5	20,354	11.8
Education	2,703	7.1	3,673	10.3	8,412	19.4	4,313	7.6	19,101	11.1
Water Supply & Housing	2,285	6.0	1,914	5.3	3,419	7.9	1,542	2.7	9,160	5.3
Health	714	1.8	1,754	4.9	2,226	5.2	3,132	5.6	6,826	4.0
Miscellaneous	3,596	9.8	5,479	15.6	3,803	8.8	6,912	12.3	19,790	11.4
TOTALS	37,841	100.0	35,511	100.0	43,290	100.0	56,574	100.0	172,216	100.0

Source : Upper Volta, Health Sector Review
April 30, 1982, The World Bank.

ANNEX N - CONSTRUCTION PLAN

DIRECTION DE LA PLANIFICATION

SERVICE ARCHITECTURE AOUT 1982
ARCHITECTE OLIVIER GASCUEL



ECHELLE 1/100

1 _LOGE DU GARDIEN 7.5 m²
2 _DOCUMENTATION 32 m²
3 _SALLE DE REUNION 41 m²
4 _DEBARRAS 5 m²
5 _MAGASIN AUTOMOBILE 5 m²
6 _MAGASIN BUREAU 5 m²
7 _REPRODUCTION 12 m²
8 _SECRETARIAT 20 m²
9 _ADMINISTRATEUR 20 m²
10 _DIRECTEUR 20 m²
11 _DACTYLOS 17 m²
12 _PLANIFICATION et PROGRAMMATION 20 m²
13 _SUIVI EVALUATION 16 m²
14 _ETUDES PROJETS 16 m²
15 _RESSOURCES HUMAINES 16 m²
16 _STATISTIQUES 16 m²
17 _SERVICE DES STATISTIQUES 20 m²
18 _ TOILETTES 16 m²

TOTAL 304.5 m²

SURFACE AU SOL 650 m²

TRAINING PLAN

The five members of the U.S. technical assistance team will concentrate on two related objectives : the first is to train nine Voltaic counterparts for their future role as the Ministry's planning staff and the second is to develop the procedures necessary for the operation of a functional DPOR.

Counterpart training will consist of both on-the-job training and formal training in francophone African or U.S. institutions. The primary objective of the formal training component will be to provide sufficent academic background in such areas as health management, health planning, epidemiology/evaluation, economics, statistical analysis and documentation to allow the counterparts to best profit from their on-the-job training.

The T.A. team and their counterparts will be working together to revise the present health information system, to establish a verified baseline of data, to analyze program and population statistics, to plan projects in ministerial priority areas and to prepare plans for ministerial policy makers and the Ministry of Economy and Plan. As the project advances, the counterparts will be able to assume increasing responsibility in the activities of the DPOR.

A. Schedule

Figure 3 shows the training schedule. The details have been extensively discussed previously. Sending personnel for training will have, in general, beneficial effects for the DPOR. First, for the impact on the trainee, he/she will return with a different perspective of his/her own work; second, the DPOR will gain a better trained member who will try to implement some new ideas, and third, his/her example will interest other staff members in finding training opportunities to improve their own performance. These will be positive aspects and if the environment of the Directorate is interesting and challenging, the post-training phase will be a success. Otherwise, the motivation of the person will decrease and his/her behavior will suffer. For the MOH as a whole, the impact will not be so dramatic in quantitative terms as the number of students will be five. However, qualitatively, the impact will be rather extensive when considering the important role of the DPOR.

B. Participant Training (see Figure 3)

1. Long-Term :

   a. During the second year of the Project, the Economist, Chief of Projects and Operational Research, will study Health Economics and Financial Analysis for one year, preferably at an African school of economics in Dakar or Abidjan, or else at IREDU, the Université de Dijon, France.

b. During the third year of the Project, the Statistician, Chief of the Statistical Service, will study Statistical Analysis for one year at the Statistical Training Institute of Yaounde, Cameroun, or at the Statistical School of Abidjan, Ivory Coast.

c. During the first and second years of the Project, the Documentalist, Chief of the Office of Documentation and Archives will study Documentation for two years at the Training Center for Documentation Specialists in Dakar, Senegal.

2. Medium-Term

a. During the fourth year of the Project, the Director of the DPOR will study Health Management for six months at Michigan State University (USA).

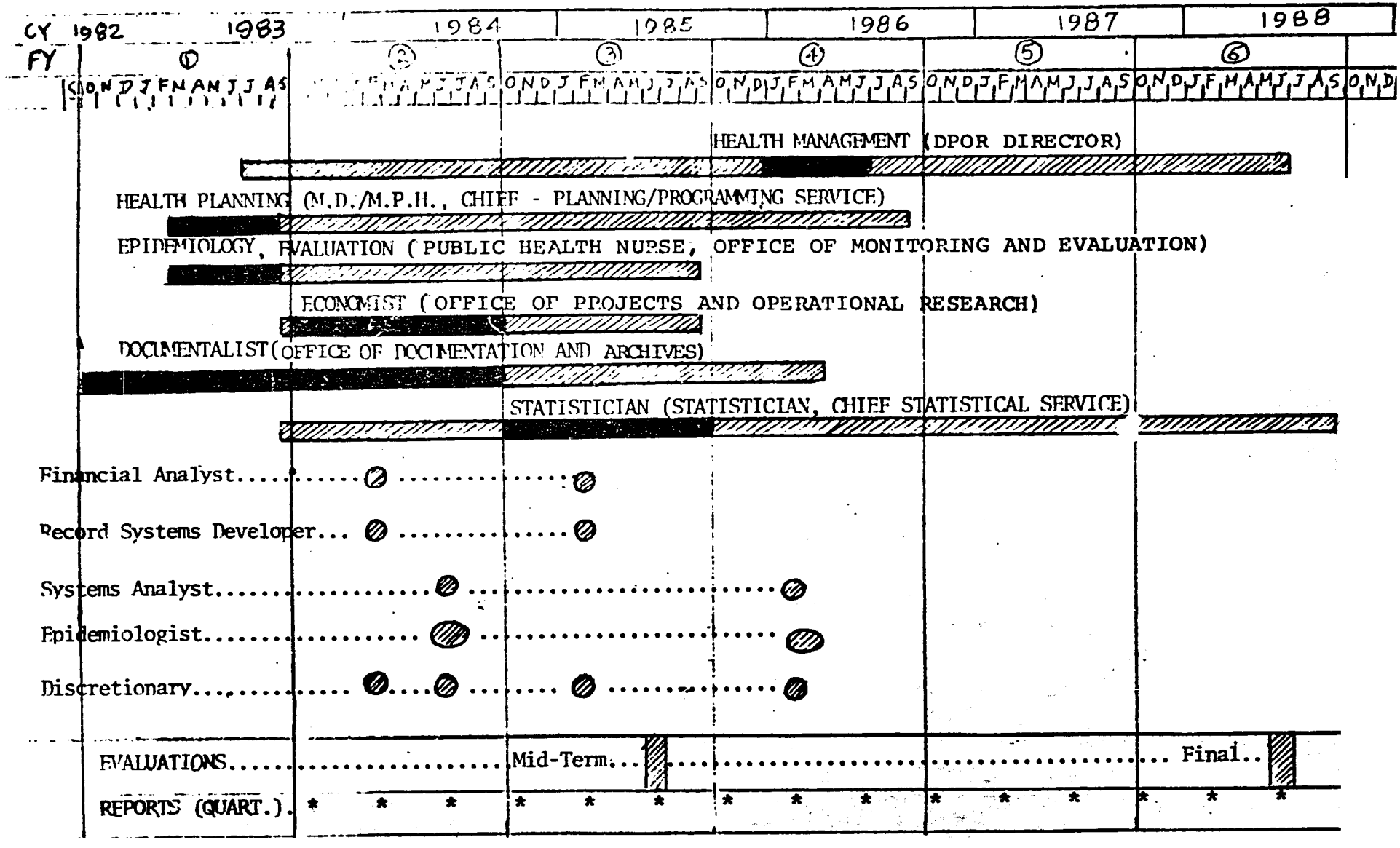
b. During the first year of the Project, the Health Planner, MD/MPH, Chief of the Planning and Programming Service will study Health Planning for six months at the University of California at Santa Cruz (USA).

c. During the first year of the Project, the Evaluator, Public Health Nurse/CESSI, Chief of the Office of Monitoring and Evaluation will study Public Health/Epidemiology for six months at the Regional Training Center of the World Health Organization in Lomé, Togo, or the Public Health Center of Cotonou, Benin.

Participant training has been divided in two groups : the first group is composed of four counterparts who will be trained at the beginning of the Project; the second group has two counterparts who will be trained after some period in on-the-job training carried out by the T.A. team.

Fig.3. PARTICIPANT TRAINING OF VOLTAIC COUNTERPARTS : in black, period of training abroad. (shadowed areas = Technical Assistance).

COUNTRY:	PROJECT N°:	PROJECT TITLE:	DATE:	ORIGINAL	APPROVED
Upper Volta	686-0251	STRENGTHENING HEALTH PLANNING CAPACITY	08/17/82	✓ REVISION	



ANNEX O

UNITED STATES GOVERNMENT

memorandum

DATE: September 20, 1982

REPLY TO ATTN OF: Patricia J. Lerner, Project Development Officer

SUBJECT: Request for Procurement Source/Origin Waiver for the Strengthening Health Planning Capacity Project (686-0251)

TO: The Director, USAID/Upper Volta

Procurement Source/Origin Waiver
No. 1

Problem : Your approval is requested for a Source/Origin Waiver from Geographic Code 000 (US only) to Geographic Code 935 (Special Free World) to permit the procurement of two motorized bicycles for the Strengthening Health Planning Capacity Project.

A.	Co-operating Country	: Upper Volta
B.	Authorizing Document	: Project Paper
C.	Project	: Strengthening Health Planning Capacity
D.	Project Number	: 686-0251
E.	Nature of funding	: Grant
F.	Description of goods	: Two (2) motorized bicycles
G.	Approximate Value	: $ 2,000
H.	Probable Origin	: France
I.	Probable Source	: Upper Volta, Ivory Coast
J.	Value, Mission-issued waivers to date for this project	: - 0 -

Discussion :

In accordance with Section 636 (i) of the Foreign Assistance Act of 1961, as amended, motor vehicles, to be eligible for AID-financing, must be manufactured in the U.S. (Code 000) unless "special circumstances" exist, in which case the requirement for manufacture in the U.S. may be waived. Under AID Handbook 1, Supplement B, Chapter 4C2d (1), inability of U.S. manufacturers to provide a particular type of needed vehicle constitutes such a "special circumstance" meriting a waiver. In addition, under AID Handbook 1, Supplement B, Chapter 5B4a, one of the criteria justifying a waiver of the authorized geographic codes is that "the commodity is not available from countries or areas included in the authorized geographic code". You must also certify that exclusion of procurement from Free World Sources (Code 935) "would seriously impede attainment of U.S. foreign policy

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

objectives and objectives of the foreign assistance program".

The two motorized bicyles in the subject project will be used to transport Project personnel on dirt paths and on roads in very poor condition. Break-downs can be expected to be frequent; therefore, local familiarity with the maintenance of such vehicles and the ready availability of spare parts requires that such vehicles be well known in Upper Volta. American-made motorized bicycles would pose undo logistical problems for the personnel who will be responsible for the maintenance of them. There is no source of American spare parts in Upper Volta and a breakdown would certainly put the motorized bicycles out of use while waiting for parts to arrive from the U.S. Another problem would arise in trying to mix American standard tools with metric tools. French-made mobylettes and Japanese-made motorized bicycles, on the other hand, do exist in the country in large numbers and are known to be very reliable and much less expensive to operate and maintain than motorcycles, for example.

Primary Justification :

U.S. manufactured motorized bicycles can not be readily maintained and repaired in Upper Volta.

Recommendation :

For the above reasons, you are requested to :

1) approve, by signing below, a source/origin waiver from AID Geographic Code 935 to permit the procurement of two motorized bicycles for the subject project,

2) certify that exclusion of procurement from Free World countries other than the co-operating country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program, and

3) find that special circumstances exist to waive the requirements of Section 636 (i) of the Act.

Approved : _____

Disapproved : _____

Date : 9-21-82

Drafted by : REDSO/WA RLA: ADNewton:gf
Clearances : REDSO/WA RLA: ADNewton (draft)
OPR/AADIR: M.A.Rugh _____
PDO : P.J.Lerner _____
OFM : J.Stanford _____

ANNEX O

UNITED STATES GOVERNMENT

memorandum

DATE: September 20, 1982

REPLY TO ATTN OF: Patricia J. Lerner, Project Development Officer

SUBJECT: Strengthening Health Planning Capacity - Project n°686-0251
Request for Procurement Source/Origin Waiver

TO: The Director, USAID/Upper Volta

Procurement Source/Origin Waiver
No. 2

Problem : Your approval is requested for a Source/Origin Waiver from Geographic Code 941 to Geographic Code 935 (Special Free World) to permit the procurement of a photocopying machine for the Strengthening Health Planning Capacity Project.

A. Cooperating Country	: Upper Volta
B. Authorizing Document	: Project Paper
C. Project	: Strengthening Health Planning Capacity
D. Project Number	: 686-0251
E. Nature of Funding	: Grant
F. Description of Goods	: One (1) photocopying machine, 220 volts/50 cycles
G. Approximate Value	: $ 13,000
H. Probable Origin	: The Netherlands
I. Probable Source	: The Ivory Coast
J. Value of Mission-issued waivers to date for this project	: $ 2,000

Discussion :

Under AID Handbook 1, Supplement B, Chapter 5A1d (2) (a), the authorized source for grants to RLDC's is AID Geographic Code 941. Under Chapter 5B4a, one of the criteria for waiving the authorized Geographic Code is that "the commodity is not available from countries or areas included in the authorized Geographic Code". You have been delegated the authority to make such a waiver determination under AID Delegation of Authority No.140, but you must certify that exclusion of procurement from Code 935 (Free World) countries would seriously impede attainment of U.S. foreign policy objectives and objectives

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

X183

of the foreign assistance program".

The photocopying machine to be procured under this project will be the only such copying machine for the Directorate of Planning and Operational Research, and is essential to the project. USAID/Upper Volta has been unable to locate/identify a photocopying machine of AID Geographic Code 941 origin that has the necessary production capacity and is maintainable and serviceable. European-manufactured machines do meet this test and are available in the Ivory Coast.

Primary Justification :

The type of photocopying machine needed by the subject project is not available from countries included in AID Geographic Code 941.

Recommendation :

For the above reasons, you are requested to approve by signing below, a source and origin waiver from AID Geographic Code 941 to AID Geographic Code 935 to permit the procurement of a photocopying machine for the subject project, and to certify that exclusion of procurement from free world countries other than the cooperating country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

Approved : _____

Disapproved : _____

Date : 9/21/82

Drafted by : REDSO/WA RLA: ADNewton:gf
Clerances : PDO:PJLerner _____
OPR/AADIR: MARugh _____
OFM: JCStanford _____

ANNEX P

STRENGTHENING HEALTH PLANNING CAPACITY (686-0251)

ACCOUNTING SYSTEM

I. Cash Receipts and Disbursements Journal

A. The project will maintain a cash receipts and disbursements journal (Exhibit C). This journal will record all cash receipts and disbursements and keep a running total of the cash book balance. The journal will be posted after each transaction. The columns are self-explanatory and will follow the budget categories in a Project Implementation Letter to be issued. The journal should be balanced and totaled at the end of each month and should be closed out and summarized at the end of each quarter.

B. The total disbursements at the end of any period should equal the total of the individual disbursement columns. The opening balance of the cash account plus receipts less disbursements should agree with the ending balance of the total column. The total disbursements must agree with the total disbursements on the bank reconciliation and with the Quarterly Disbursement Report for the period.

C. Petty Cash. The petty cash column is to be used only to create the petty cash fund. Thereafter, the individual budget disbursement catagories will be charged as the petty cash is reimbursed.

D. Posting of Totals. The total disbursements by budget category will be posted to the Quarterly Disbursement Report (Exhibit A) at the end of each quarter.

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE (686-0251)

SYSTEME COMPTABLE

I. Journal des Entrées et Sorties de Caisse

A. Le projet tiendra un journal des entrées et sorties de caisse (Document C). Ce journal enregistrera toutes les entrées et toutes les sorties et établira régulièrement le solde au journal de caisse. Ce journal sera mis à jour après chaque opération. Les colonnes s'expliquent par elles-mêmes et suivront les rubriques budgétaires dans la future Lettre d'Exécution du projet. Le solde du journal devra être tiré à la fin de chaque mois, arrêté et résumé à la fin de chaque trimestre.

B. Le total des sorties à la fin de chaque période devra être égal au total des colonnes individuelles de sorties. Le solde d'ouverture du compte de caisse, plus les entrées, moins les sorties, devra concorder avec le solde final de la colonne du total. Le total des sorties doit coincider avec les débours totaux inscrits sur l'état de rapprochement bancaire et au Rapport Trimestriel des Sorties pour la période concernée.

C. Petite Caisse. La colonne de la petite caisse ne doit servir qu'à la création du fonds de petite caisse. Par la suite, chaque catégorie de sortie budgétaire sera imputée au fur et à mesure que la petite caisse sera remboursée.

D. Mise à jour des totaux. Le total des sorties de chaque rubrique budgétaire fera l'objet d'une mise à jour dans le Rapport Financier Trimestriel (Document A) à la fin de chaque trimestre.

The total of disbursements for the reporting period on the report must agree with disbursements column on the journal for the quarter and the disbursements on the bank reconciliation (Exhibit B).

E. Interest. If funds are deposited in an interest-bearing account, interest received from the bank will be posted to the journal when the bank statement is received. The interest will be posted to the receipts column and the total cash increased accordingly. A check will then be written to the American Embassy/Ouagadougou for the interest. The amount of the check will be recorded in the receipts column as a negative amount and the total cash balance reduced. This is done so as not to affect cash disbursements. It should be noted that any refunds from vendors or cancelled checks should be recorded as negative disbursements and not as receipts. Interest and bank charges will normally be reconciling items on the bank reconciliation (Exhibit B).

F. Bank Charges. Bank charges will be recorded at the time the bank statement is received. Bank charges are often listed as reconciling items on the bank reconciliation. IMPORTANT : Bank charges can not be offset against interest income. They must be charged in the journal as a disbursement under one of the budget categories. The American Embassy/Ouagadougou must receive the full amount of the interests earned on the account.

G. No Bank transfers of any kind are to be allowed, all charges to the bank account are to be made by check except for bank charges.

Le total des sorties pour la période d'enregistrement sur le rapport doit coincider avec la colonne des sorties du journal pour le trimestre et à celle des sorties sur l'état de rapprochement bancaire (Document B.)

E. Intérêts. Si les fonds sont déposés dans un compte produisant des intérêts, les intérêts reçus de la banque seront enregistrés dans le journal dès réception du relevé bancaire. Ils seront portés respectivement à la colonne des entrées et à celle du total de caisse qui augmentera du montant correspondant. Un chèque sera ensuite établi à l'ordre de l'Ambassade des Etats-Unis/Ouagadougou pour les intérêts. Le montant du chèque sera inscrit en négatif dans la colonne des entrées et le solde de caisse total réduit. On procède de la sorte pour ne pas affecter les sorties de caisse. Il convient de noter que toutes les ristournes accordées par les fournisseurs ou tous les chèques annulés devront être enregistrés comme des sorties négatives et non comme des entrées. Les intérêts et les frais bancaires feront normalement partie des rubriques d'apurement sur l'état de rapprochement bancaire (Document B).

F. Frais Bancaires. Les frais bancaires seront enregistrés dès réception du relevé bancaire. Les frais bancaires sont souvent répertoriés comme rubrique d'apurement sur l'état de rapprochement bancaire. IMPORTANT : les frais bancaires ne peuvent être compensés par le revenu des intérêts. Ils doivent être imputés au journal comme sortie sous l'une des rubriques budgétaires. L'Ambassade des Etats-Unis/Ouagadougou doit percevoir le montant intégral des intérêts versés au compte.

G. Aucun transfert bancaire d'aucune sorte ne doit être autorisé; tous les frais afférant au compte bancaire doivent être effectués par chèque, à l'exception des frais bancaires à proprement parler.

H. The checkbook is to be maintained by the project Chief-of-Party of the technical assistance team and all checks should be prepared by him or her, and entered in the cash journal as they are prepared.

I. The bank account must require two signatures.

J. The Chief-of-Party of the technical assistance team must not be a check signer.

K. The Chief-of-Party of the technical assistance team will prepare vouchers for payment for the director to approve. The voucher should have an original invoice, purchase order or other authorizing document, and a receiving report if necessary.

L. For salaries, there must be a list of the employees to be paid and their gross pay, taxes and net pay. The check for salaries to be paid in cash should be for the net amount.

M. Social Security tax and income tax should be paid with separate checks.

N. Each quarter will end on the last day of September, December, March, June.

O. The project's fiscal year will be determined at a later date.

II. <u>Bank Reconciliation (Exhibit B)</u>

A. The bank account must be reconciled each month. However, the USAID only requires that a quarterly bank reconciliation be transmitted to it. A copy of the bank statements for the quarter must be attached to the bank reconciliation. This means all bank statements for the quarter, not just the last statement for the quarter.

H. Le Chef de l'Equipe d'assistance technique du projet devra garder le chéquier et préparer tous les chèques qui devront être inscrits au journal à ce moment.

I. Le compte bancaire doit exiger deux signatures conjointes.

J. Le Chef de l'Equipe d'assistance technique ne doit pas être l'un des signataires.

K. Le Chef de l'Equipe d'assistance technique préparera les pièces comptables pour l'approbation par le Directeur. Toute pièce devra être accompagnée d'une facture originale, d'un bon d'achat ou de tout autre document prouvant qu'elle a été autorisée, et même d'un bon de réception, si nécessaire.

L. Pour les salaires, une liste des employés à payer sera établie, comportant leur salaire brut, les taxes, et leur salaire net. Le chèque pour les salaires devra être établi pour le montant net.

M. La taxe de sécurité sociale et l'impôt sur le revenu devront être payés par chèques séparés.

N. L'échéance de chaque trimestre sera fixée au dernier jour des mois de septembre, décembre, mars et juin.

O. L'année fiscale du projet sera déterminée à une date ultérieure.

II. <u>Etat de Rapprochement Bancaire (Document B)</u>

A. Le compte bancaire devra faire l'objet d'un état de rapprochement mensuel. Toutefois, l'USAID exige seulement qu'un état de rapprochement bancaire trimestriel lui soit transmis. Une copie des relevés bancaires devra être jointe à cet état; c'est-à-dire tous les relevés bancaires du trimestre et non seulement le dernier.

The bank statements should be mailed to the project Chief-of-Party of the technical assistance team who will prepare all reports and maintain the journals. The bank account must be kept in a bank that prepares bank statements monthly and distributes them to its customers no later than the 10th day following the end of a month.

Les relevés bancaires devront être envoyés au Chef de l'Equipe d'assistance technique du projet qui préparera tous les rapports et tiendra le journal. Le compte bancaire sera ouvert auprès d'une banque assurant des relevés mensuels et les faisant parvenir à ses clients dans un délai ne dépassant pas plus de dix jours à la fin de chaque mois.

B. Bank Balance Section. The balance on the bank statement for the end of the quarter must be entered on the form. Any bank error should be noted and statement of what action has been taken should be attached. Deposits in transit should be added and outstanding checks deducted. Interest posted to the bank account but not recorded in the books should be deducted and bank charges deducted on the bank statement and not recorded in the books at the end of the period should be added to the bank balance. The bank charges and interest should be entered in the journal in the following quarter.

B. Section du solde bancaire. Le solde inscrit sur le relevé bancaire trimestriel doit être enregistré sur le formulaire. Toute erreur de la banque devra être spécifiée et un exposé de l'action entreprise devra être joint. Les dépôts en transit devront être ajoutés, et les chèques en souffrance déduits. Les intérêts apparaissant dans le compte bancaire, mais non inscrits dans les livres devront être déduits; les frais déduits du relevé bancaire, et non inscrits dans les livres à la fin de la période, devront être ajoutés au solde. Les frais bancaires et les intérêts devront être inscrits au journal du trimestre suivant.

C. Book Balance Section. Beginning balance is the unadjusted book balance from the end of the previous quarter. The net deposits are added. That is AID advances and interest income net of checks written to the American Embassy/Ouagadougou for interest. Remember that voided checks and refunds from vendors are shown as negative disbursements. The ending book balance must agree with the adjusted bank balance and there can be no difference.

C. Section du solde du livre de compte. Le solde de départ est le solde non ajusté du livre à la fin du trimestre précédent. Les dépôts nets sont ajoutés. Il s'agit des avances de l'USAID et des intérêts nets du revenu des chèques libellés au nom de l'Ambassade des Etats-Unis/Ouagadougou pour les intérêts. Il faut rappeler que les chèques annulés et les ristournes consenties par les fournisseurs apparaissent dans les sorties en négatif. Le solde final du livre doit coincider avec le solde bancaire ajusté, et il ne peut y avoir aucune différence.

II. Quarterly Disbursement Report (Exhibit A).

A. Disbursement report must be filed with the USAID by the 15th day after the end of a quarter.

III. Rapport Trimestriel des Sorties (Document A)

A. L'USAID devra avoir reçu le rapport des sorties avant le 15ème jour suivant la fin du trimestre.

B. The items on the left-hand side are from the budget in the Project Implementation Letter. The project may keep more detailed records but the USAID requires only the general categories listed. All disbursements must be indicated on the report even if there are no budget categories for particular items. The report for the quarter must agree with the cash disbursement journal and the cash disbursements on the bank reconciliation. If an item does not have an amount budgeted, then enter the category of expense as a separate line item without any budget authorization and extend it to the balance remaining column as a negative total.

B. Les articles inscrits sur la gauche proviennent du budget, selon la Lettre d'Exécution. Le projet peut conserver des registres plus détaillés, mais l'USAID n'exige que les rubriques générales répertoriées. Toutes les sorties doivent être indiquées au rapport, même si certaines d'entre elles n'entrent pas dans les catégories inscrites au budget. Le rapport pour le trimestre doit coincider avec le journal des sorties de caisse et avec les sorties de caisse mentionnées dans l'état de rapprochement bancaire. Si une rubrique n'a pas été prévue au budget, il convient d'inscrire le montant de la dépense dans une rubrique séparée, sans autorisation budgétaire, et de le porter dans la colonne du solde restant, comme total négatif.

C. The cumulative prior period column is from the cumulative disbursements column of the prior quarter's disbursement report.

C. La colonne pour la période antérieure vient de la colonne cumulative du rapport financier du trimestre précédent.

D. The disbursements are from the current quarter's journal and must agree with the disbursements listed on the bank reconciliation.

D. Les sorties proviennent du journal du trimestre en cours et doivent coincider avec les sorties enregistrées sur l'état de rapprochement bancaire.

E. The cumulative column is the total cumulative disbursements of the prior period and the disbursements of the current reporting period.

E. La colonne cumulative correspond au total de la période précédente et aux colonnes de la période en cours d'enregistrement.

F. The unliquidated encumbrances figures are from the quarterly encumbrance report, (Exhibit F). It is important to understand that the disbursement report and the encumbrance report must be together. This is because each report needs information from the other.

F. Les montants des engagements non liquidés proviennent du rapport des engagements trimestriels (Document F). Il est important de comprendre que le rapport des sorties et le rapport des engagements doivent être dressés en même temps. Ceci parce que chacun d'entre eux a besoin des renseignements provenant de l'autre.

G. The column, total cumulative disbursements and unliquidated encumbrances, is a total of the total cumulative disbursements and unliquidated encumbrances at end of quarter columns.

G. La colonne des sorties cumulatives totales et des engagements non liquidés correspond au total des sorties cumulatives totales et des engagements non liquidés à la fin des colonnes du trimestre.

H. The budget remaining column is the difference between the budget column and the column total cumulative disbursements and unliquidated encumbrances.

I. All columns should be added down and totaled. The totals should then be cross footed and agreed to all other reports and journals having the same totals.

J. An AID Form 1034 voucher should be prepared at the end of each quarter to reduce the outstanding advance by giving credit for allowable disbursements made by the project. Be sure to only indicate allowable disbursements on the Form 1034. Items for which there is no budget are generally unallowable. Only items actually disbursed are allowable. If the total on the 1034 is different than the total of current reporting period's disbursements attach a memorandum explaining why.

K. There can be a budget variance of up to 15% in any one line item in the budget as long as the total budget is not exceeded.

L. Petty cash is shown without a budget amount so it can be reflected as a negative in the balance available column. The reason for this is that the funds have been disbursed and they are not available until they are actually returned to the bank account or accounted for as a disbursement. Theoretically, when the last petty cash transactions are received or the fund is reduced there will be a negative disbursement for the period in the petty cash line item offsetting positive transactions in each disbursement category to close out the petty cash fund or to reduce the petty cash fund.

H. La colonne du reliquat budgétaire correspond à la différence entre la colonne du budget et la colonne totalisant les sorties cumulatives et les engagements non liquidés.

I. Toutes les colonnes devront être additionnées et totalisées. Les totaux devront alors subir tous les modes de preuve et correspondre à tous les autres rapports et journaux portant sur les mêmes totaux.

J. Un formulaire comptable 1034 de l'USAID devra être préparé à la fin de chaque trimestre afin de réduire l'avance en souffrance en donnant un crédit pour les dépenses admissibles effectuées par le projet. Il faut s'assurer que seules les sorties admissibles soient mentionnées au formulaire 1034. Les rubriques pour lesquelles il n'existe aucun budget ne sont généralement pas admissibles. Seules les rubriques ayant fait l'objet d'une dépense effective sont admissibles. Si le total du formulaire 1034 est différent du total des sorties inscrites sur le rapport des sorties pour la période en cours, il faudra joindre un mémorandum expliquant la ou les raisons de cette différence.

K. Il peut exister une variation allant jusqu'à 15% pour chaque rubrique budgétaire tant que le budget total n'est pas dépassé.

L. La petite caisse ressort sans montant budgétaire de telle sorte qu'elle peut figurer en négatif dans la colonne du solde disponible. La raison en est que les fonds ont été versés et qu'ils ne sont plus disponibles avant d'être effectivement retournés au compte bancaire ou pris en compte en tant que sortie. Théoriquement, lorsqu'on reçoit les dernières opérations de la petite caisse, on aura une sortie inscrite en négatif pour la période, dans la rubrique de la petite caisse, et qui compensera les opérations positives dans chaque catégorie de sortie pour clôturer ou réduire le fonds de petite caisse.

Petty cash funds are shown at their imprest amounts in the advance reconciliation report.

Les fonds de petite caisse sont inscrits selon leur montant en tant qu'avances de fonds dans le rapport préliminaire sur l'état de rapprochement.

IV. Donor Receivable Account and Advance Reconciliation Report

A. The Donor Receivable Account and Advance Reconciliation Report (Exhibit D) is to be prepared at the end of each quarter. This report will enable the project's management and the USAID to reconcile all advances to the project bank account and to keep track of the dollars remaining in the PIL budget which have not been advanced by the USAID.

B. Section I is prepared by the Chief-of-Party of the technical assistance team taking the dollar amount of the PIL and subtracting all advances, reimbursements, and purchase orders issued by the USAID out of local currency operating funds, translated into dollars. To do this properly the project's Chief-of-Party of the technical assistance team will need a copy of 1034 voucher or other USAID document used to make an advance, reimbursement or purchase. The USAID documents will indicate the amount in dollars for the transaction. Please be aware that the USAID official records are kept in dollars not F CFA and that the Project Implementation Letters are limited to their dollar amounts not F CFA amounts.

C. Section II is prepared by recording the total AID advances received for the life of the project in F CFA and subtracting the cumulative disbursements from the quarterly disbursement report. The balance should equal the book balance of the cash account. This should also agree with the bank reconciliation.

IV. Compte à Recevoir du Donateur et Rapport Préliminaire sur l'Etat de Rapprochement

A. Le compte à recevoir du donateur et rapport préliminaire sur l'état de rapprochement (Document D) doit être préparé à la fin de chaque trimestre. Ce rapport permettra à la Direction du Projet à l'USAID d'apurer toutes les avances au compte bancaire du projet et de garder la trace des fonds en dollars restant au budget et n'ayant pas fait l'objet d'une avance de la part de l'USAID.

B. La section 1 est préparée par le Chef de l'Equipe d'assistance technique en prenant le montant en dollars de la Lettre d'Exécution du Projet et en soustrayant toutes les avances, remboursements et bons de commande passés par l'USAID sur les fonds d'exploitation locaux, convertis en dollars. Pour mener à bien cette entreprise, le Chef de l'Equipe a besoin d'une copie du formulaire 1034 ou de tout autre document de l'USAID utilisé pour effectuer un remboursement, un achat ou une avance. Les documents de l'USAID indiqueront le montant en dollars de la transaction. Il faut noter que les documents financiers officiels de l'USAID sont établis en dollars et non en F CFA et que les Lettres d'Exécution du Projet se limitent à leur montant en dollars et non en F CFA.

C. La section II est préparée en enregistrant le total des avances de l'USAID reçues pour la durée du projet en F CFA et en soustrayant les sorties cumulatives du rapport financier trimestriel. Le solde devra être équivalent au solde du livre du Compte de Caisse. Ceci devra également coincider avec l'état de rapprochement bancaire.

D. Section III reconciles the total AID advance in F CFA and the vouchers submitted to AID. The purpose is to highlight any problem with disallowances or non-submission of vouchers to AID. This section allows the USAID to reconcile its project advance control sheets to the project's financial records. Again, the balancing figure is the project's book cash balance.

E. The USAID will submit a copy of all processed 1034's to the project officer for distribution to the project accountant. All disallowed items should be resolved as soon as possible.

F. Section IV is to be used by the USAID/OFM to reconcile the Project Advance Control Sheet to the advance reconciliation report.

V. Advance Request Form (Exhibit E).

The advance request form should be presented to the USAID during the last month of a quarter for the advance necessary to operate the project during the next quarter.

The request summarizes the cash on hand at the beginning of the current quarter and then reflects disbursements and advances received through the date that the request is prepared. Then the expenditures for the remainder of the current quarter are estimated and the estimated cash balance at the end of the current quarter determined. Then the estimate of expenditures for the next quarter supported by a budget (Exhibit F) are subtracted from the estimated cash balance and the advance requested added. The result of this arithmetic operation is the estimated cash balance at the end of the next quarter.

D. La section III rapproche le total des avances de l'AID en F CFA et les factures soumises à l'AID. Le but recherché est de mettre en lumière tout problème de rejet de paiement ou de non présentation de factures à l'AID. Cette section permet à l'USAID de comparer ses feuilles de contrôle des avances avec les registres financiers du projet. Là encore le solde correspondra au solde des liquidités inscrit au livre du compte de caisse du projet.

E. L'USAID soumettra une copie de tous les formulaires 1034 à remplir au responsable du projet pour qu'il les distribue au comptable du projet. Tous les rejets de paiement devront faire l'objet d'une solution le plus rapidement possible.

F. La section IV servira au bureau financier de l'USAID/OFM de comparaison entre la feuille de contrôle des avances et le rapport d'apurement des avances.

V. Formulaire de Demande d'Avance (Document E).

Le formulaire de demande d'avance devra être présenté à l'USAID au cours du dernier mois d'un trimestre pour l'avance nécessaire au fonctionnement du projet au trimestre suivant.

La demande fait le point des liquidités existantes au début du trimestre en cours, puis répertorie les sorties et les avances perçues jusqu'à la date à laquelle la demande est établie. Puis, on évalue les dépenses pour le reste du trimestre en cours et on détermine le solde de caisse approximatif à la fin du même trimestre. Enfin, on soustrait du solde de caisse évalué approximativement l'estimation des dépenses pour le prochain trimestre sur la base d'un budget (Document F), et l'on ajoute l'avance demandée.Le résultat de cette opération arithmétique correspond à l'estimation du solde de caisse pour la fin du trimestre suivant.

Please remember that US Treasury and AID regulations require that cash not be advanced beyond a 30 day need. This means that advances will be granted on a quarterly basis but ordered to be delivered on monthly basis as appropriate unless the USAID Mission Director requests only one advance check per quarter.

Il faut noter que le Trésor des Etats-Unis et les réglements de l'USAID exigent qu'aucune avance de liquidités ne soit consentie pour couvrir plus de 30 jours de besoin. Ceci signifie que les avances seront accordées sur une base trimestrielle mais seront distribuées sur une base mensuelle, comme prévu, à moins que le Directeur de la Mission USAID ne demande qu'un seul chèque d'avance par trimestre.

VI. Encumbrance Journal (Exhibit G)

A. The purpose of the Encumbrance Journal is to establish an on-going record of all financial commitments against the project. Examples of commitments are :

1. Purchase orders (including gasoline bons)
2. Travel authorizations
3. Contracts for services
4. Contracts for commodities
5. Leases for buildings or land
6. Leases for equipment
7. Disbursements or unpaid invoices for items or services not ordered using any of the above methods.
8. Payroll for the following month should be recorded as an encumbrance at the end of each month. The above commitments are to be entered in the journal as they are incurred; that is as a contract is signed or a purchase order issued or a payment made. By subtracting the encumbrance from the budget, the accountant can determine how much money is left to be encumbered.
9. Sometimes goods or services may be received without items 1-7. In these circumstances, an encumbrance must be made.

VI. Journal des Engagements (Document G)

A. Le but du Journal des Engagements est de mettre en place un système d'enregistrement permanent de tous les engagements financiers à la charge du projet. On peut citer, à titre d'exemple :

1. les bons de commande (y compris les bons d'essence)
2. les autorisations de voyage
3. les contrats de service
4. les contrats de biens
5. les locations de bâtiments ou de terrains
6. les locations de matériels
7. les sorties ou les factures impayées pour des biens ou des services n'ayant pas été commandés conformément aux méthodes décrites ci-dessus.
8. les salaires pour le mois suivant devront être enregistrés comme un engagement à la fin de chaque mois. Les engagements susmentionnés doivent être inscrits au journal au fur et à mesure qu'ils surviennent; c'est-à-dire dès qu'un contrat est signé, ou un bon de commande émis, ou un paiement effectué. En déduisant l'engagement du budget, le comptable peut déterminer le montant qui peut encore être engagé.
9. parfois des biens ou des services peuvent être reçus sans articles 1-7. En ce cas, un engagement doit être fait.

B. If it is later determined that an encumbrance was overstated or understated an adjustment must be made. These adjustments will be accomplished using a Journal Voucher (Exhibit H). The voucher must clearly explain why an adjustment is necessary and which original encumbrance is being adjusted. These vouchers should be numbered sequentially by month and calendar year. For example, the 3rd voucher of March 1982 would be March 82-3. The vouchers must be kept on file in the accounting department, with any supporting documentation attached. Changes requiring an upward revision of the original encumbrance must be approved by the Project Director.

B. Si l'on s'aperçoit à posteriori qu'un engagement a été surestimé ou sous-estimé, un ajustement doit être fait. Ces ajustements seront effectués en utilisant un journal de caisse (Document H). Celui-ci devra expliquer la (les) raison(s) pour laquelle (lesquelles) un ajustement est nécessaire, et spécifier quel engagement original fait l'objet dudit ajustement. Ils devraient être numérotés par ordre chronologique, par mois et par année civile. Par exemple, le 3ème de Mars 1982 serait Mars 82-3. Ils doivent être gardés dans un dossier du département comptable, accompagnés de tous les documents justificatifs. Les modifications impliquant comme révision une augmentation de l'engagement original doivent être approuvées par le Directeur du Projet.

C. At the end of each quarter add down the amount columns and see that they then add across to the total amount column. Then take the total of the amount column and subtract the sum from the total balance remaining at the end of the last quarter. This result should be the remaining balance at the end of the quarter as long as the budget figures were not changed. In addition add down all the balance column and see that they agree with the total balance column. When funds are added or deleted to a budget the transaction should only affect the balance column and not the amount column. The amount columns are to be used only for encumbrances. If the only transaction for a quarter was to disencumber something, then there could be a negative encumbrance for a particular quarter.

C. A la fin de chaque trimestre, faites le total des colonnes du montant et voyez si elles correspondent alors à la colonne du montant total. Puis prenez la colonne du montant et déduisez de celui-ci la somme du solde total restant à la fin du dernier trimestre. Le résultat obtenu devrait correspondre au solde restant à la fin du trimestre tant que les chiffres du budget demeurent inchangés. Enfin, faites le total de toute la colonne du solde et vérifiez que les chiffres correspondent effectivement au total de la colonne du solde. Lorsque des sommes sont ajoutées ou rayées du budget, la transaction ne devrait affecter que la colonne du solde et non la colonne du montant. Les colonnes du montant ne doivent être utilisées que pour des engagements. Au cas où l'unique transaction pour un trimestre aurait pour objet le retrait d'un engagement, il pourrait alors y avoir un engagement négatif pour un trimestre particulier.

D. The account should record encumbrances as soon as they are incurred. The Project Director must approve all encumbrances. Before approving an encumbrance the Project Director should have the Chief-of-Party of the technical assistance team determine that there are funds available.

D. Le compte devra enregistrer les engagements dès qu'ils surviennent. Le Directeur du Projet doit approuver tous les engagements. Auparavant, il devra demander au Chef de l'Equipe d'Assistance Technique de déterminer s'il existe des fonds disponibles.

E. As encumbrances are liquidated a check mark should be placed next to the reference column to indicate that the encumbrance has been liquidated. At the end of each quarter all unliquidated encumbrances must be investigated to determine whether they need to be adjusted.

VII. Quarterly Encumbrance Report (Exhibit F)

A. The purpose of the quarterly encumbrance report is to show management how much budget authority has been encumbered and how much is remaining. The report also shows how much the unliquidated encumbrances are.

B. The report is relatively simple to prepare andis similar to the quarterly disbursement report. The budget categories are the same and some of the same information is used.

C. The budget items refer to the same items listed on the quarterly disbursement reports, which come from the PIL.

D. The figures for the cumulative prior period encumbrance column come from the previous quarter's report. In the case shown it would be 9-30-81.

E. The figures for the encumbrances for the current period come from the encumbrance journal amount columns.

F. The total cumulative encumbrances column is the sum of the prior period's cumulative encumbrances plus the current period's encumbrances.

E. Au fur et à mesure que les engagements sont liquidés, il conviendra d'effectuer un pointage à côté de la colonne concernée pour indiquer cette liquidation. A la fin de chaque trimestre, tous les engagements non liquidés doivent être examinés pour déterminer s'ils ont ou non besoin d'un ajustement.

VII. Rapport des Engagements Trimestriel (Document F)

A. L'objet du Rapport Trimestriel des Engagements est de montrer à la Direction la part du budget qui a été engagée et la part restante. Il montre également à combien se montent les engagements non liquidés.

B. Le rapport est relativement simple à préparer et ressemble au rapport des sorties trimestriel. Les catégories budgétaires sont les mêmes, et une partie des mêmes renseignements est utilisée.

C. Les rubriques budgétaires font référence à celles répertoriées sur le rapport des sorties trimestriel, qui proviennent de la Lettre d'Exécution du Projet.

D. Les chiffres de la colonne cumulative des engagements pour la période antérieure proviennent du rapport trimestriel précédent. Dans le cas concerné, il s'agirait du 30/9/81.

E. Les chiffres des engagements pour la période en cours proviennent des colonnes de montant du journal des engagements.

F. La colonne totale des engagements cumulatifs correspond à la somme des engagements cumulatifs de la période précédente additionnée des engagements de la période en cours.

G. The cumulative disbursements are taken from the quarterly disbursement report for the current quarter.

H. The unliquidated encumbrances are the difference between the total cumulative encumbrances at the end of the current quarter less the cumulative disbursements at the end of the current quarter. These figures must also agree with the balance column totals on the encumbrance journal. If they do not agree, there is a mistake and your report must be rechecked.

VIII. Quarterly Vehicle Utilization Report (Exhibit I)

A. Gasoline purchases will be accompanied by a vehicle log for each vehicle showing the date of purchase, mileage, liters of gasoline purchased, gasoline bon numbers, location or any repair or scheduled maintenance such as change of air filter or oil filter.

B. Invoices for repair of vehicles will bear a notation identifying which vehicle was repaired.

IX. Miscellaneous Provisions

A. Purchase Orders

The project should purchase pre-numbered purchase order books with 3 sheets for each order. The original and a copy will be submitted to the vendor and the 3rd copy will remain in the book. The original is then returned by the vendor with the invoice.

G. Les sorties cumulatives sont extraites du rapport des sorties trimestriel pour le trimestre en cours.

H. Les engagements non liquidés représentent la différence entre les engagements cumulatatifs totaux à la fin du trimestre en cours, dont sont déduits les sorties cumulatives à la fin du trimestre en cours. Ces chiffres doivent également coincider avec les totaux de la colonne du solde sur le journal des engagements. S'ils ne coïncident pas avec eux, une erreur a été commise, et il faudra à nouveau vérifier le livre.

VIII. Rapport Trimestriel d'Utilisation des Véhicules (Document I)

A. Les achats d'essence seront accompagnés d'une inscription sur un registre pour chaque véhicule, indiquant la date de l'achat, le kilométrage, le nombre de litres achetés, les numéros des bons d'essence, le lieu et la date de toute réparation effectuée ou prévue telle qu'un changement de filtre à air ou de filtre à huile.

B. Les factures de réparation des véhicules porteront une notation permettant d'identifier le véhicule ayant fait l'objet de la réparation.

IX. Dispositions diverses

A. Bons d'Achat

Le projet devra acheter des livres d'achat pré-numérotés comprenant 3 feuillets pour chaque commande. L'original et une copie seront présentés au fournisseur, et la 3ème copie restera dans le livre. L'original est ensuite retourné par le fournisseur avec la facture.

Before issuing a purchase order the director should request the Chief-of-Party of the technical assistance team to certify that funds are available. The Chief-of-Party of the technical assistance team should record the purchase order in the encumbrance journal as soon as it is issued. When the original purchase order is returned with the invoice, it should be compared to the invoice and receiving report. If all is in order the papers should be clipped together and the invoice checked for mathematical accuracy. The Chief-of-Party of the technical assistance team should indicate that the invoice is in order by initialing it and dating it. The documents should then be filed in an open account payable file.

If the amount of the invoice agrees with the original entry in the encumbrance journal there is no need for an adjustment. However, if the amount is more or less than the encumbrance journal, a journal voucher is required to make the adjustment. If the adjustment is upward the director must sign the voucher. Purchases over 30,000 F CFA should be made by purchase order. After an invoice is received against a purchase order an indication should be made on the copy of the purchase order in the purchase order book.

If the invoice closes out the order indicate this on the copy and mark it closed.

If it is a partial billing this should be indicated.

The copy in the book should always be referenced to be sure that the item has been processed before.

All approved changes to the original purchase order should be indicated on the copy in the book.

Avent d'émettre un bon de commande, le directeur devra demander au Chef d'Equipe de certifier que des fonds sont disponibles Le Chef d'Equipe devra enregistrer le bon de commande dans le journal des engagements, dès son émission. Lorsque le bon de commande original est retourné avec la facture, il faudra le comparer à la facture et au bon de réception. Si tout est en ordre, les documents devront être attachés ensemble et la facture soumise à un mode de preuve mathématique. Le Chef d'Equipe devra indiquer que la facture est en ordre en y apposant son paraphe et en la datant. Les documents devront alors être consignés dans un dossier ouvert de compte payable.

Si le montant de la facture coincide avec l'entrée originale inscrite dans le journal des engagements, aucun ajustement n'est nécessaire. Toutefois, si le montant marque une légère différence, en plus ou en moins, par rapport au journal des engagements, une pièce comptable du journal est exigée pour procéder à l'ajustement. Si l'ajustement va dans le sens de la hausse, le directeur doit signer le document comptable. Tout achat dépassant 30.000 F CFA devra être effectué par bon de commande, mention devra en être faite sur la copie du bon de commande dans le livre des commandes.

1. Si la facture couvre le montant total de la commande, l'indiquer sur la copie et mentionner qu'elle est couverte.

2. S'il s'agit d'une facturation partielle, ceci devra être indiqué.

3. La copie du livre devra toujours porter une référence afin de s'assurer que l'article n'a pas déjà été traité auparavant.

4. Toutes les modifications approuvées apportées sur le bon de commande original devront être indiquées sur la copie dans le livre.

5. Cancelled purchase orders should be marked cancelled in the purchase order book and an adjustment made in the encumbrance journal.

The director will approve payment by initialing the invoice after having reviewed the complete voucher, i.e. invoice, purchase order and receiving report. The Chief-of-Party of the technical assistance team will then draw a check for the director's signature and the signature of the other check signer. The Chief-of-Party of the technical assistance team will immediately record the check in the cash receipts and disbursements journal and indicate that the purchase order has been paid in the encumbrance journal. The check number and the date of the check will be written on the invoice and the invoice should be stamped "paid".

The documents should then be filed away in check-number sequence to support the 1034 voucher submission to USAID.

B. Invoices which have no Purchase Order

If an invoice or request for payment is received for which there is no purchase order or memorandum from the director, travel authorization, contract, loan, etc. the Chief-of-Party of the technical assistance team must present the item to the director for his immediate approval. If the invoice is for goods the Chief-of-Party of the technical assistance team should determine whether or not there is a receiving report. If not, the Chief-of-Party of the technical assistance team must determine that the goods were received and have the person who received the goods sign and date the invoice. Immediately thereafter, the Chief-of-Party of the technical assistance team should record the invoice in the encumbrance journal using either a journal voucher or a proforma purchase order. The invoice should then be filed in the open payable file.

5. Les bons de commande annulés devront porter la mention "annulé" dans le livre des commandes, et un ajustement devra être effectué dans le journal des engagements.

Le directeur approuvera un paiement en apposant son paraphe sur la facture après avoir passé en revue tous les documents comptables, c'est-à-dire : la facture, le bon de commande et le bon de réception. Le Chef d'Equipe de l'assistance technique établira alors un chèque pour présentation à la signature du directeur et à celle du signataire conjoint. Le Chef d'Equipe enregistrera immédiatement le chèque au journal des entrées et des sorties de caisse et indiquera au journal des engagements qu'un bon de commande a été réglé. Le numéro du chèque et sa date d'émission seront inscrits sur la facture, et celle-ci devra porter la mention "réglée".

Les documents devront alors être classés au dossier par ordre chronologique du chèque à titre de pièce justificative du formulaire 1034 à présenter à l'USAID.

B. Factures sans Bon de Commande

Si une facture ou une demande de paiement arrive, pour laquelle il n'existe aucun bon de commande, ni mémo du Directeur, ni une autorisation de voyage, un contrat, un prêt, etc. le Chef d'Equipe de l'assistance technique doit la présenter au directeur pour approbation immédiate. Si la facture concerne des biens, le chef d'équipe de l'assistance technique devra déterminer s'il existe un bon de réception. Dans la négative, le Chef d'Equipe de l'assistance technique doit indiquer que les biens ont été reçus et faire signer et dater la facture par la personne qui a réceptionné les biens. Immédiatement après, le Chef d'Equipe de l'assistance technique devra enregistrer la facture dans le journal des engagements en utilisant soit un document du journal, soit une facture proforma. La facture devra alors être classée au dossier des paiements à effectuer.

C. Receiving Reports

The project should buy a standard receiving report book at a stationary store and it should be used to record the receipt of all goods and services. One copy should be sent to the Chief-of-Party of the technical assistance team and the other copy kept by the person receiving the goods.

D. Travel Advances

Advances of Per Diem should be made only on the authorization of the director and a formal travel authorization should be entered in the encumbrance journal. The amount of the advance should be entered on the copy of the travel autorisation kept by the Chief-of-Party of the technical assistance team as well as the copy kept by the traveller. If a check is used, the advance should be charged to travel advance. If petty cash is used a petty cash receipt will be signed by the traveller and the travel authorization number entered on the petty cash slip. When the petty cash fund is reimbursed the advance will be charged to travel advance.

The travel authorizations should be filed in numerical sequence.

E. Check Requests using Purchase Orders

Sometimes a check is needed immediately to pay for personal services or a miscellaneous purchase. Sometimes, a store will want immediate payment in cash in excess of the petty cash fund. These are discussed below.

C. Les Bons de Réception

Le projet devra acheter un livre standard pour les bons de réception, dans une papeterie, qui devra servir à enregistrer toute réception, tant pour les biens que pour les services. Une copie devra être envoyée au Chef d'Equipe de l'assistance technique et une autre conservée par le réceptionnaire.

D. Avances de Voyage

Des avances de voyage ne devront être consenties que sur autorisation du directeur, et une autorisation formelle de voyage devra être utilisée. Le montant de l'autorisation de voyage devra être inscrit au journal des engagements. Le montant de l'avance devra être inscrit sur la copie de l'autorisation de voyage que garde le Chef d'Equipe de l'assistance technique, de même que sur celle que garde le voyageur. Si un chèque est utilisé, l'avance devra être imputée aux avances de voyage. Si la petite caisse est utilisée, un reçu de petite cais se sera signé par le voyageur et le numéro de l'autorisation de voyage inscrit sur le bordereau de la petite caisse. Lorsque le fonds de la petite caisse sera remboursé, l'avance sera imputée aux avances de voyage

Les autorisations de voyage devront être classées par ordre chronologique.

E. Demande de chèques utilisant des bons de commande

Parfois, un chèque est nécessaire immédiatement pour payer les services d'une personne ou d'un achat quelconque. Parfois, un fournisseur voudra un paiement immédiat en liquide qui dépasse les fonds de la petite caisse. Ces points sont discutés ci-après :

1. Miscellaneous Payments for Goods and Services

In this situation a purchase order should be filled out by the Chief-of-Party of the technical assistance team and approved by the Director as substantiation for the check being written. The Chief-of-Party of the technical assistance team will write out the check and charge the proper disbursement and at the same time record the transaction as an encumbrance in the encumbrance journal. The Chief-of-Party of the technical assistance team will file the copy of the purchase order in his PAID bill file with the check number and date paid written on it. When the receipt is received from the store it should be filed with the copy of the purchase order and the person receiving the item must sign for it on the invoice unless there is a receiving report.

- Check made out to cash or to a person to obtain cash for payroll or the purchase of items in excess of the petty cash fund

Here again, a purchase order should be used as the authorizing document for the Chief-of-Party of the technical assistance team to issue the check. The name of the person who is to be the payee and the reason for the check should be stated. If for payroll the schedule of people to be paid should be attached. If for a mass per diem payment for a conference or training session, all the names of the people attending and the amount to be paid to each should be noted. All persons receiving cash must sign for it. All items must be recorded in the encumbrance journal.

1. Paiements divers pour biens et services

En pareil cas, un bon de commande devra être rempli par le Chef d'Equipe de l'assistance technique, approuvé par le directeur pour justifier l'émission du chèque. Le Chef d'Equipe de l'assistance technique libellera le chèque et l'imputera à la rubrique de la sortie correspondante, et il consignera en même temps la transaction comme engagement dans le journal des engagements. Le Chef d'Equipe de l'assistance technique classera la copie du bon de commande dans son dossier "Factures payées", en mentionnant le numéro du chèque et la date du paiement. Lorsque le reçu du fournisseur est arrivé, il devra être classé avec la copie du bon de commande, et le réceptionnaire devra apposer sa signature sur la facture, sauf s'il existe un bon de réception.

2. Chèque pour des liquidités ou pour qu'une personne obtienne des liquidités pour des bulletins de salaire ou pour des achats d'articles au-delà des fonds de la petite caisse.

Ici encore, un bon de commande devra être utilisé en tant qu'autorisation écrite pour que le Chef d'Equipe de l'assistance technique puisse émettre le chèque. Le nom de la personne bénéficiaire et la raison du chèque devront être précisés. S'il s'agit de salaires, la liste des gens à payer devra être jointe. S'il s'agit d'un paiement pour tout un ensemble de per diem pour une conférence ou un stage de formation, le nom de toutes les personnes participantes et le montant à payer à chacune d'elles devront être notés. Toutes les personnes qui reçoivent des liquidités doivent signer pour le montant reçu. Tous les articles de dépenses doivent être enregistrés au journal des engagements.

F. Special note about the Encumbrance Journal

1. Remember that all transactions in the cash disbursement journal must find their way into the encumbrance journal except for the receipt and payment of interest to the USAID.

2. For example the following items must all result in a separate entry or adjustment in the encumbrance journal or at least an indication of payment for the original encumbrance.

   a. Payment of invoice without purchase order
   b. Receipt of invoice without purchase order
   c. Payment for casual labor
   d. Direct payment for miscellaneous purchases
   e. Payroll
   f. Per diem payments
   g. Check to cash or bearer for purchasing goods or services
   h. Tax payments.

G. Service Taxes

Never pay or accept an invoice with TPS listed separately. The USAID must automatically disallow TPS.

The project must maintain a schedule of all equipment purchased with local funds. The schedule must include the description of the item, its location, date of purchase, check number, quantity and unit and total cost. Items costing 60,000 F CFA or more need to be recorded.

F. Note Spéciale Concernant le Journal des Engagements

1. Souvenez-vous que toutes les transactions du journal des sorties de caisse doivent trouver leur place au journal des engagements, sauf en ce qui concerne la réception et le versement de l'intérêt à l'USAID.

2. Par exemple, les rubriques suivantes doivent toutes faire l'objet d'une entrée ou d'un ajustement séparé dans le journal des engagements, ou au moins d'une indication de paiement pour l'engagement original :

   a. paiement de facture sans bon de commande
   b. réception de facture sans bon de commande
   c. paiement pour travaux occasionnels
   d. paiement direct pour achats divers
   e. salaires
   f. paiement de per-diem
   g. chèque pour liquidités ou au porteur pour l'achat de biens ou de services
   h. paiement de taxes.

G. Taxes Pour Services

Ne payez ni n'acceptez jamais une facture avec TPS à part. L'USAID doit rejeter automatiquement la TPS.

Le projet doit garder une liste de tous les équipements achetés à l'aide des fonds locaux. Cette liste doit inclure la désignation de l'article, sa destination, la date d'achat, le numéro du chèque, la quantité et le prix unitaire et total. Tout achat dépassant 60.000 FCFA doit faire l'objet d'une inscription au livre de compte.

EXHIBIT A

STRENGTHENING HEALTH PLANNING CAPACITY

OPERATING ACCOUNT

PROJECT (636-0251)

QUARTERLY DISBURSEMENT REPORT

REPORT FOR THE PERIOD (date) THROUGH (date)

BUDGET ITEMS	CFA BUDGET	DISBURSEMENTS			UNLIQUIDATED ENCUMBRANCES AT END OF QUARTER	TOTAL CUMULATIVE DISBURSEMENTS AND UNLIQUIDATED ENCUMBRANCES	BUDGET REMAINING AT END OF QUARTER
		CUMULATIVE PRIOR PERIODS	CURRENT REPORTING PERIOD	TOTAL CUMULATIVE DISBURSEMENTS			
Salaries & GPSS							
POL							
Per Diem							
Transportation							
Office Supplies							
Maintenance							
Vehicles							
Generator							
Office Equipment							
Building							
Equipment							
Travel Advances							
Petty Cash Fund							

Note : Construction expenditures will be made directly by the USAID to the contractor based upon requests for payment from the project director and approved by the appropriate USAID official.

DOCUMENT A

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE

COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

RAPPORT DES SORTIES TRIMESTRIEL

(date)

Rubriques Budgétaires	Budget CFA	Périodes Antérieures Cumulatives	Période actuelle d'enregistrement	Sorties Cumulatives Totales	Engagements non-liquidés à la fin du trimestre	Sorties Cumulatives Totales et Engagements non Liquidés	Budget restant à la fin du trimestre
Salaires & CNSS							
Essence, huile							
Lubrifiants							
Per diem							
Transport							
Fourniture bureau							
Entretien							
Véhicules							
Générateur							
Equipement bureau							
Immeuble							
Avances de voyage							
Petite Caisse							

Remarque : Les dépenses de construction seront payées directement par l'USAID à l'Entrepreneur, sur la base d'une demande de paiement émise par le Directeur du projet et approuvée par les responsables de l'USAID concernés

EXHIBIT B

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT

BANK RECONCILIATION

PROJECT (686-0251)
AS OF (date)

	F.CFA
BANK :	
Balance per Bank	
Bank errors: None	
Corrected Bank Balance	
Add: Outstanding deposits	
Less: Outstanding checks	
Bank Interest	
Bank Charges	
Adjusted Bank Balance	
BOOKS :	
Beginning Balance	
Add: Deposits	
Less: Disbursements	
Ending Book Balance	
RECONCILIATION:	
Adjusted Bank Balance	
Ending Book Balance	
Difference	0

STRENTGHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT
PROJECT (686-0251)

EXHIBIT C

CASH RECEIPTS AND DISBURSEMENTS JOURNAL FOR THE QUARTER ENDED (Date)

						DISBURSEMENTS							
DATE	DESCRIPTION	CHECK N° OR OTHER REFERENCE	RECEIPTS	DISBURSEMENT	TOTAL	POL	PER DIEM	EQUIPMENT	LOCAL SAL. & CNSS	TRAVEL ADVANCES	VEHICLE MAINTENANCE	GENERAL	
												Descript.	Amt

EXHIBIT D

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT

PROJECT (686-0251)

DONOR RECEIVABLE ACCOUNT AND ADVANCE RECONCILIATION REPORT

I. Project Implementation Letter funding
Advances, Reimbursements or Purchases

Total of purchase orders to be paid or paid by USAID	$
Previous Advances cumulative:	$
Previous Reimbursements cumulative:	$
Advances received this quarter:	$
Reimbursements received this quarter:	$
Total Receipts against PIL Funding (date)	$
Balance of PIL remaining to be received in dol	$

II. AID total advances received:

	F CFA
Less cumulative disbursements:	
Cash balance per books (date)	

III. AID total advance:

	F CFA
Vouchers submitted and accepted through (date)	( )
Disallowed items, TPS, etc.	( )
Vouchers in process quarter ended (date)	( )
Petty Cash or Travel Advances outstanding	( )
Cash balance per books (date)	

IV. (For Use by USAID/OFM Only

	F CFA
Net Advance Balance at (date)	
Deduct : Advances not received by project	( )
Disallowances	( )
Petty Cash Funds and Travel advances	( )
Vouchers in Process	( )
Unaccounted Funds	( )
Balance agreed to Section II and III	0

OCUMENT D

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTI
COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

COMPTE A RECEVOIR DU DONATEUR

ET RAPPORT D'AJUSTEMENT DE L'AVANCE AU (date)

I. Financement de la Lettre d'Exécution du Projet
Avances, Remboursements ou Achats

Total des bons de commande à payer ou payés par l'USAID	$
Cumul des avances antérieures	$
Cumul des remboursements antérieurs	$
Avances reçues ce trimestre	$
Remboursements reçus ce trimestre	$
Total des recettes selon le financement de la Lettre d'Exécution du Projet (date)	$
Solde du reste de la Lettre d'Exécution du Projet, à recevoir en dollars	$

II. Avances AID totales reçues — F CFA

Moins les débours cumulatifs	
Solde de caisse sion les livres au (date)	

III. Avances AID totale — F CFA

Pièces justificatives présentées et approuvées au (date	( )
Articles rejetés, TPS, etc.	( )
Pièces justificatives en cours d'établissement pour le trimestre arrivant à échéance le (date)	( )
Petite caisse ou avances de voyage en souffrance	( )
Solde de caisse selon les livres au (date)	

V. (Ne doit être utilisé que par OFM/USAID) — F CFA

Solde d'avance net au (date)	
Moins : les avances non reçues par le projet	( )
les rejets de paiement	( )
les fonds de petite caisse et les avances de voyage	( )
les pièces en cours d'établissement	( )
les fonds non comptabilisés	(----0----)
Solde correspondant aux Sections II et III	

EXHIBIT E

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT

PROJECT (686-0251)

ADVANCE REQUEST FORM
FOR THE QUARTER ENDED (DATE)

F CFA

Cash on hand at start of current quarter (date) :

Advances received to date for quarter ended (date) :

Less : Cash disbursed quarter ended (date) through (date) :
Estimated disbursements for remainder of quarter :

Estimated cash balance at end of quarter (date) :

Estimated disbursements quarter ended (date) :

Requested advance for quarter ended (date) :

Estimated ending cash balance at (date) :

Checks to be ordered as follows

F CFA

(Amount) (Date)

(Amount) (Date)

(Amount) (Date)

Total requested Advance

DOCUMENT E

REHFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE
COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

DEMANDE D'AVANCE POUR LE TRIMESTRE ECHU AU (date)

	F CFA
Liquidités existantes au début du trimestre débutant (date)	
Avances reçues à ce jour pour le trimestre parvenant à échéance (date) :	
Moins : les liquidités déboursées au cours du trimestre du (date) au (date) :	
Sorties prévues pour le reste du trimestre :	
Solde bancaire estimé à la fin du trimestre (date) :	
Sorties estimées pour la fin du trimestre échu le (date)	
Avance demandée pour le trimestre échu le (date) :	
Solde des liquidités de clôture estimé au (date) :	

Chèques à enregistrer comme suit :	F CFA
(Montant) (Date)	
(Montant) (Date)	
(Montant) (Date)	
Avance totale demandée	

EXHIBIT F

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT

PROJECT (686-0251)

QUARTERLY ENCUMBRANCE REPORT FOR THE QUARTER ENDED (date)

BUDGET ITEMS	ENCUMBRANCES			LESS CUMULATIVE DISBURSEMENTS AS OF (date)	UNLIQUIDATED ENCUMBRANCES AT (date)
	CUMULATIVE PRIOR PERIODS'	CURRENT REPORTING PERIOD	TOTAL CUMULATIVE ENCUMBRANCES		
Salaries & CNSS					
POL					
Per Diem					
Transportation					
Office Supplies					
Maintenance					
Vehicles					
Generator					
Office Equipment					
Building					
Equipment					
Travel Advances					
Petty Cash Fund					

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE
COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)
RAPPORT DES ENGAGEMENTS TRIMESTRIELS POUR LE TRIMESTRE ECHU AU (date)

Rubriques Budgétaires	Engagements			Moins les Sorties Cumulatives au (date)	Engagements Non Liquidés au (date)
	Périodes Antérieures Cumulatives	Périodes d'Enregistrement en cours	Engagements Totaux Cumulatifs		
Salaires & CNSS					
Essence, huile lubrifiants					
Per Diem					
Transport					
Matériel bureau					
Entretien					
Véhicules					
Générateur					
Equipement bureau					
Immeuble					
Equipement					
Avances de voyage					
Petite Caisse					

EXHIBIT G

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT
PROJECT (686-0251)

ENCUMBRANCE JOURNAL

DATE	TRANSACTION	VENDOR	REF N°	SALARIES & CNSS		POL		PER DIEM		TRANSPOR-TATION		OFFICE SUPPLIES		MAINTENANCE VEHICLES		EQUIPM	
				Amt	Bal	Amt	Bal	Amt	Bal	Amt	Bal	Amt	Bal	Amt	Bal	Amt	B

DOCUMENT C

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE

COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

JOURNAL DES ENTREES ET DES SORTIES POUR LE TRIMESTRE ARRIVANT A ECHEANCE LE (date)

						S O R T I E S							
DATE	DESCRIPTION	N° du CHEQUE OU AUTRE REFERENCE	ENTREES	SORTIES	TOTAL	ESSENCE HUILE LUBRIFIANTS	PER DIEM	EQUIPMENT	SALAIRES LOCAUX & CNSS	AVANCE DE VOYAGE	ENTRETIEN DES VEHICULES	GENERAL	
												Descript.	Montant

DOCUMENT G

REMFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE
COMPTE D'EXPLOITATION DE L'USAID
PROJET (686-0251)

JOURNAL DES ENGAGEMENTS

DATE	TRANSACTION	VENDEUR	REF N°	SALAIRES & CNSS		ESSENCE, HUILE LUBRIFIANTS		PER DIEM		TRANSPORT		MATERIEL DE BUREAU		ENTRETIEN DES VEHICULES	
				Montant	Solde	Montant	Solde	Montant	Solde	Montant	Solde	Montant	Solde	Montant	Solde

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE

COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

ETAT DE RAPPROCHEMENT BANCAI
(date)

	F CFA
BANQUE	
Solde selon la banque	
Erreurs bancaires : aucune	--
Solde bancaire corrigé	
Plus : les dépôts en souffrance	
Moins : les chèques en souffrance	
Intérêt bancaire	
Frais bancaires	
Solde bancaire ajusté	
LIVRES	
Solde d'ouverture	
Plus : les dépôts	
Moins : les sorties	
Solde bancaire de clôture	
AJUSTEMENT	
Solde bancaire ajusté	
Solde bancaire de clôture	
Différence :	----0-----

X 716

EXHIBIT H

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT

PROJECT (686-0251)

ENCUMBRANCE JOURNAL VOUCHER

J.V. No

Date

ACCOUNT		INCREASE ENCUMBRANCE	DECREASE ENCUMBRANCE
NO.	TITLE		
	TOTAL		

DESCRIPTION

Prepared by	Date	Approved by	Date	Posted by	Date

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DOCUMENT H

RENFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE
COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

JOURNAL DES ENGAGEMENTS

Pièce Comptable No

Date

	COMPTE		
No	INTITULE	ENGAGEMENT AUGMENTE	ENGAGEMENT REDUIT
	TOTAL		

Description

Préparé par	Date	Approuvé par	Date	Passé par	Date

EXHIBIT I

STRENGTHENING HEALTH PLANNING CAPACITY
OPERATING ACCOUNT

PROJECT (686-0251)

QUARTERLY VEHICLE UTILIZATION REPORT

A. Quarterly Milage

	(A) Beginning of quarter	(B) End of quarter	Total
a. Vehicle Nr 1			
b. Vehicle Nr 2			
c.			
.			
.			
.			
Totals			

• Quarterly Gasoline Utilization

a. Bon balance beginning quarter (1)		.....
b. Add: bons received from dealer (1)		.....
c. Less: bons used during quarter (1)		
a. vehicle Nr 1	.....	
b. vehicle Nr 2	.....	
c.	.....	
.	.....	
.	.....	
Total		
- - n balance at end of quarter		.....
		.....

(1) Quantity of 20 L. Bons.

DOCUMENT I

REHFORCEMENT DE LA CAPACITE DE PLANIFICATION DE LA SANTE

COMPTE D'EXPLOITATION DE L'USAID

PROJET (686-0251)

RAPPORT TRIMESTRIEL D'UTILISATION DES VEHICULES

A. Kilométrage pour le trimestre :	(A) Début du Trimestre	(B) Fin du Trimestre	(B-C) Total
a. Véhicule No 1			
b. Véhicule No 2			
c.			
Totaux			

B. Utilisation d'essence pour le trimestre :

a. Solde des bons au début du trimestre (1)		.....
b. Plus : les bons reçus du détaillant (1)		.....
c. Moins : les bons utilisés en cours du trimestre (1)		
a. Véhicule No 1	.....	
b. Véhicule No 2	.....	
c.	.....	
.	.....	
.	.....	
Total		
d. Solde des bons à la fin du trimestre		

(1) Bons de 20 litres

ANNEX Ω

AGENCY FOR INTERNATIONAL DEVELOPMENT

ADVICE OF PROGRAM CHANGE

COUNTRY	:	Upper Volta
PROJECT TITLE	:	Strengthening Health Planning Capacity
PROJECT NUMBER	:	686-0251
FY 1982 CP REFERENCE	:	Annex I, Africa Program, Page 129
APPROPRIATION CATEGORY	:	Sahel Development Program
LIFE-OF-PROJECT FUNDING	:	$4,000,000
INTENDED FY 1982 OBLIGATION	:	$4,000,000

This is to advise that A.I.D. intends to obligate $4,000,000 for the Strengthening Health Planning Capacity Project. Since the FY 1982 CP was prepared, changes in the structure of the Government of Upper Volta Ministry of Health and recent involvement of other donors in the health sector have led to a focusing of the project along lines slightly different from what was presented in the original Congressional Presentation.

This project will strengthen the planning capacity of the newly organized Directorate of Planning and Operational Research (DPOR) unit of the Ministry of Health. The technical assistance team will provide on-the-job training to Voltatic counterparts and, together, will develop methods, procedures and forms for the operation of a functional directorate, including administrative, logistical and training aspects at the central and departmental levels. The major portion of the funding will be used for technical assistance and training. The IBRD is supporting A.I.D.'s efforts by providing the DPOR with a health planner and some technical assistance prior to the arrival of the A.I.D. financial technical assistance team. WHO will provide a statistician for four person years.

At the end of this six-year project there will be a functioning DPOR within the Ministry of Health, staffed by at least five Voltaics trained in health planning and programming areas. Ultimately, the entire country will benefit directly from having the health needs of its people met more efficiently and comprehensively through better application of both internal and external resources.

In accordance with Section 121(d) of the Foreign Assistance Act (FAA), the Assistant Administrator for Africa determined on 9/1/82 that the Government of Upper Volta will maintain a system of accounts with respect to Sahel Development Funds which meets the requirements of Section 121(d) of the FAA.

Attachment: Activity Data Sheet

AGENCY FOR INTERNATIONAL DEVELOPMENT
ACTIVITY DATA SHEET

PROGRAM: UPPER VOLTA

CP 91-06 (8 79)

TITLE	FUNDING SOURCE	PROPOSED OBLIGATION (In thousands of dollars)	
Strengthening Health Planning Capacity	Sahel Development Program	FY 82 $4,000	LIFE OF PROJECT (Auth.) 4,000
NUMBER 686-0251 NEW ☒ GRANT ☒ LOAN ☐ CONTINUING ☐	PRIOR REFERENCE FY 82 Annex I, Africa Program p. 129	INITIAL OBLIGATION FY 82 / ESTIMATED FINAL OBLIGATION FY 82	ESTIMATED COMPLETION DATE OF PROJECT FY 88

Purpose: To strengthen the planning capacity of the Directorate of Planning and Operational Research (DPOR) of Upper Volta Ministry of Health (MOH), for the systematic analysis of health needs and resources, the development of health strategies and programs, and to provide a more effective MOH contribution to national planning efforts.

Project Description: Strengthening the planning capacity of the MOH is essential to effective delivery of rural primary health care services. The DPOR has a mandate to establish an improved data base for ministerial decision-making, to provide for more effective MOH contributions to national planning efforts, and to develop better managed and coordinated health programs and strategies, particularly for the Ministry's priority concern of primary health care services to the rural areas.

The project will fund a technical assistance team of five persons during the six-year life of the project: a Health Manager, a Health Planner, an Economist with Health Specialization, an Epidemiologist/Evaluator and a Documentalist. The Technical Assistance team will provide on-the-job training to Voltaic counterparts and, together, they will develop methods, procedures and norms necessary for the operation of a functional directorate, including administrative, logistical and training aspects at the central and departmental levels. Medium-term and long-term training in the fields of health management, health planning, health evaluation, statistics and economics will be made available to MOH personnel in the DPOR. At the end of this six-year project there will be a functioning DPOR within the MOH, staffed by at least five Voltaics trained in health planning/programming areas.

Relationship of Project to A.I.D. Country Strategy: Health related problems take a major toll on the agricultural workforce, threatening the attainment of Upper Volta's food self-sufficiency goals. Thus, the project complements A.I.D.'s number one priority of increased food production. Furthermore, a high rate of population growth threatens attainment of other goals, such as satisfaction of basic human needs. This project will address family planning/demographic issues as part of the comprehensive planning to be carried out in the DPOR. The Government, A.I.D., and other donors see this project as a necessary first step to provide a strong planning and support structure for the envisaged basic rural health care system. Related to this project is a centrally-funded contract to train trainers of village midwives.

Beneficiaries: Initial direct beneficiaries are the employees of the DPOR in the MOH and other GOUV personnel who interface with the DPOR, employees of the MOH who work in towns and villages outside the capital city, and rural residents participating in workshops funded by the project. Longer term benefits will accrue to rural residents who receive drugs and other medicines in a more efficient and consistent manner as a result of improved distribution logistics, and rural residents who participate in the pilot or test activities through which the DPOR will gather data during the project. Ultimately, the entire country will benefit directly from having the health needs of its people met more efficiently and comprehensively through better application of both internal and external resources.

Host Country and Other Donors: This project has been closely coordinated with the MOH and the IBRD. The IBRD is supporting A.I.D.'s efforts by providing the DPOR with a health planner and some technical assistance prior to the arrival of the A.I.D.-financed technical assistance team. WHO will provide a statistician for 4 PY. The GOUV will provide personnel and their salaries, utilities, logistical support to the director of the DPOR and rent and maintenance costs for a building until the A.I.D.-financed building is constructed. Beginning in the second year, a percentage of local operating costs, which by year 6 will reach 100 percent, and recurrent costs of the A.I.D.-financed building will also be paid by the GOUV.

Major Outputs:	All Years
MOH Staff Trained	13
Information System and Data Bank Organized and Functioning	1
Yearly Health Plan of Action Produced	5
Operational Research Projects Coordinated	3
Policy Proposals Prepared and Submitted to MOH	3
DPOR Office/Supporting Services Building	1

A.I.D. Financed Inputs:		($Thousands) Life of Project
Personnel:	5 long-term (162 PM)	2,316
	4 short-term (14.2 PM)	244
	1 local-hire secretary (60 PM)	128
Training:	3 long-term (48 PM)	40
	3 medium-term (18 PM)	64
Construction:	DPOR Office Building	312
Commodities:	Office Equipment & Vehicles	372
Other Costs:	Local Operating Costs, Evaluations, Special Studies, Workshops	524
	Total	4,000

U.S. FINANCING (In thousands of dollars)	Obligations	Expenditures	Unliquidated
Through September 30, 1980	-	-	-
Estimated Fiscal Year 1981	-	-	
Estimated through September 30, 1981	-	-	-
		Future Year Obligations	Estimated Total Cost
Proposed Fiscal Year 1982	4,000	-	4,000

PRINCIPAL CONTRACTORS OR AGENCIES

To be selected