

PDBBS578

AGENCY FOR INTERNATIONAL DEVELOPMENT  
PROJECT IDENTIFICATION DOCUMENT  
FACESHEET (PID)

1. TRANSACTION CODE  
 A = Add  
 C = Change  
 D = Delete  
 Revision No. \_\_\_\_\_  
 DOCUMENT CODE 1

2. COUNTRY/ENTITY  
BURKINA FASO

3. PROJECT NUMBER  
[REDACTED]

4. BUREAU/OFFICE  
AFRICA  
 A. Symbol AFR  
 B. Code [ ]

5. PROJECT TITLE (maximum 40 characters)  
Family Health & Health Financing

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION  
 A. Initial FY 1990  
 B. Final FY 1994  
 C. PACD 1996

7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =)

FUNDING SOURCE		LIFE OF PROJECT
A. AID		10,000
B. Other U.S.	1	
	2	
C. Host Country		2,500
D. Other Donor(s)		
TOTAL		12,500

8. PROPOSED BUDGET AID FUNDS (\$000)

A. APPRO- PRATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	500	10,000		1,500		10,000	
(2)							
(3)							
(4)							
TOTALS				1,500		10,000	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)  
 310 410 440 510 520 530

10. SECONDARY PURPOSE CODE

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)  
 A. Code BRW DEL PVOU TNG  
 B. Amount

12. PROJECT PURPOSE (maximum 430 characters)

- 1) To improve the functioning of the PHC by instituting community-based cost recovery mechanisms.
- 2) To maximize maternal and child health by instituting improved programs of family planning, diarrheal disease control, and nutrition.
- 3) To complete the process of institutionalizing health planning functions within the MOHSA.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: (1) USAID/Burkina-HPN Officer: (30 days); REDSO-POP & PD Officer: (30 days each).  
 (2) IQC-Social Scientist (15 days); Health Economist (30 days); Financial Analyst (21 days) - PD & S \$45,000.  
 (3) Special Studies: Pharm. Dist. and Procurement Spec.; Health Cost Recovery Specialist (15 days each).  
 Funds (4) Centrally Funded Specialists - selected cooperative agencies including PAC IIB, JHU/PCS, JHPIEGO, AIDSTECH, OR, DHS, PRITECH, Nutrition Surveillance, NCP - (7 days each).

14. ORIGINATING OFFICE CLEARANCE  
 Signature: Herbert N. Miller  
 Title: Mission Director  
 Date Signed: MM DD YY 06/06/91

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

16. PROJECT DOCUMENT ACTION TAKEN  
 S = Suspended  
 A = Approved  
 D = Disapproved  
 CA = Conditionally Approved  
 DD = Decision Deferred

17. COMMENTS

ACTION APPROVED BY  
 Signature: \_\_\_\_\_  
 Title: \_\_\_\_\_

19. ACTION REFERENCE

20. ACTION DATE  
 MM DD YY

FAMILY HEALTH AND HEALTH FINANCING PROJECT  
PROJECT NUMBER 686-0275  
PROJECT IDENTIFICATION DOCUMENT

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USAID FAMILY PLANNING PROVINCES \*



BEST AVAILABLE DOCUMENT

A

## ACRONYMS AND ABBREVIATIONS

### A.I.D. TERMINOLOGY

1. FPS PROJECT      Family Planning Support Project
2. SHPC PROJECT    Strengthening Health Planning Capacity Project

### HEALTH SECTOR TERMINOLOGY

1. DDC              Diarrheal Disease Control
2. FP                Family Planning
3. IEC              Information, Education, Communication
4. KAP Survey      Knowledge, Attitudes and Practices Survey
5. MCH              Maternal and Child Health
6. ORS              Oral Rehydration Salts
7. ORT              Oral Rehydration Therapy
8. PHC              Primary Health Care
9. STD              Sexually Transmitted Diseases
10. VSC             Voluntary Surgical Contraception

### BURKINABE ORGANIZATIONS

1. DAAF             Directorate of Administrative Affairs and Finance  
(DAAF             Direction des Affaires Administratives et Financieres)
2. DFH              Directorate of Family Health  
(DSF              Direction de Sante de la Famille)
3. DFP              Directorate of Family Promotion  
(DPF              Direction de la Promotion de la Famille)
4. DHE              Directorate of Health Education and Sanitation  
(DESA             Direction de l'Education pour la Sante et Assainissement)
5. DPT              Directorate of Professional Training  
(DFP              Direction de la Formation Professionnelle)
6. DESV             Directorate of Epidemiological Surveillance and Vaccinations  
(DSEV             Direction de la Surveill. Epidemiolog. et des Vaccinations)
7. DPS              Directorate of Pharmaceutical Supplies  
(DSPH             Direction des Services Pharmaceutiques)
8. DSP              Directorate of Studies and Planning  
(DEP              Direction des Etudes et de la Planification)
9. GOB              Government of Burkina
10. MC               Medical Center (PHC facility)  
(CM               Centre Medical)
11. M/D              Maternity/Dispensary (PHC facility)  
(CSPS             Centre de Sante et de Promotion Sociale)
12. MOHSA          Ministry of Health and Social Action
13. NFPTT          National Family Planning Training Team
14. PHD              Provincial Health Directorate  
(DPS.AS          Direction Provinciale de la Sante et de l'Action Sociale)
15. SONAPHARM    National Pharmaceutical Supply Company

### Executive Summary

The Health Financing and Family Health Project is a 7-year, \$10 million effort to: expand the availability of maternal and child health, and family planning services; introduce health cost recovery mechanisms into the primary health care system in order to improve the quality of health services; strengthen the planning capacity of the Ministry of Health and Social Action (MOHSA).

The Project is structured as an umbrella project with three discreet sub-projects, to permit greater programming flexibility and simplify design requirements. Linkages among the sub-projects will be established. The three sub-projects are:

#### Sub-project 1 - Health Care Financing

Purpose - To improve the functioning of primary health care by instituting community-based cost recovery mechanisms.

Sub-project 1 will use a U.S. PVO to assist provincial health directorates and community health committees in 5 provinces to set up and manage revolving-fund drug stores; install other cost recovery mechanisms such as fees for laboratory tests; improve health care services using the revenues generated; and upgrade the skills of the health workers. The project will provide technical assistance, training and start-up supplies of essential drugs.

#### Sub-project 2 - Maternal Child Health/Family Planning

Purpose - To maximize maternal and child health by instituting improved programs of family planning, diarrheal disease control and nutrition.

Sub-project 2 will provide technical assistance and training through centrally-funded projects to expand on-going family planning activities in 15 provinces; and diarrheal disease control and nutrition activities in 10 of these provinces. Major activities include training, service delivery, information, education and communication (IEC), and operations and quantitative research.

#### Sub-project 3 - Health Planning

Purpose - To complete the process of institutionalizing health planning functions within the MOHSA.

Sub-project 3 will continue financial assistance to the Directorate of Planning and Studies (DPS) to enable it to produce important planning documents and annual reports; coordinate health activities in the country; and support the health information system.

By the end of the project, the MOHSA will have improved service delivery, management, supervisory and information systems; better trained personnel; and the population will have greater access to PHC services of improved quality.

#### Project Cost Estimate

Sub-project 1 Health Care Financing	\$2,925,000
Sub-project 2 Maternal and Child Health/Family Planning	6,525,000
Sub-project 3 Health Planning	550,000
Total	----- \$10,000,000

## I. Program Factors

### A. Conformity with Recipient Country Strategy/Program

The Government of Burkina (GOB) first committed itself to a nationwide primary health care (PHC) program in the "Document de Programme Sanitaire" in 1978. This document called for universal access to preventive/curative services, essential drugs, and immunizations. This commitment was manifested in mass public health campaigns in 1984 and 1985 which increased immunization levels and put in place a system of primary health care posts. The country's first five-year health development plan (1986-90) called for the mass construction and renovation of health centers to improve access to health care by rural residents.

However, both the mass public health campaigns and the rapid infrastructure development begun under the 1986-1990 development plan raised serious questions concerning the supervision and supplies required to make health services effective, and the recurrent financial resources needed to sustain them. In an effort to deal with these issues, the Ministry of Health and Social Action (MOHSA) experimented with a series of limited cost recovery measures. These experiments led to the design (with USAID and World Bank assistance) of the Boulgou Health Financing Study in 1987 to test health financing strategies in rural health clinics as a means of improving the quality of services and of increasing utilization of health facilities. As a result of the Boulgou Study and increased interest in health care financing, the GOB, in 1988, formally embraced the UNICEF/WHO-sponsored Bamako Initiative and its goal of financing a revitalized primary health care system through cost recovery mechanisms.

The GOB formally embraced maternal and child health (MCH) as a major component of its national PHC system in the 1978 "Document de Programmation Sanitaire". National initiatives to implement high priority MCH interventions such as family planning (FP), diarrheal disease control (DDC), and nutrition promotion were begun in 1985 with the creation of a national directorate responsible for maternal and child health. In 1985, the GOB drafted a Family Planning Action Plan which called for the integration of family planning services into all public health facilities. Since 1985, the MOHSA, with the assistance of USAID and UNFPA, has integrated family planning information and services into over 60 health facilities in all 30 provinces.

In 1985, the MOHSA drafted a long-term national Diarrheal Disease Control Program to be managed by the Directorate of Epidemiologic Surveillance and Vaccination (DESV). Although no operational workplan has been developed from this comprehensive national plan, UNICEF and recently USAID have funded a series of training, logistic, supervision, and awareness-raising activities throughout the country. In 1988, the MOHSA formally requested USAID to provide assistance in DDC control in 16 of Burkina's 30 provinces.

Faced with periodic bad harvests and chronic food deficit areas, the GOB has placed a high priority on nutrition promotion and the prevention of nutritional deficiencies. In 1985, the MOHSA included nutrition as one of the responsibilities of its newly established maternal and child health directorate. Pilot projects are presently underway in growth monitoring, prevention of vitamin A deficiency, and nutrition communication. The MOHSA has made a commitment to nutrition promotion without food supplements.

## B. Relationship to A.I.D. Strategies and Policies

### 1. Relationship of Project to Country Programming Strategy

USAID/Burkina does not have an approved CDSS or SPSS at this time. The most recent comprehensive statements of program strategy are the USAID/Burkina 1987 Program Rationale Statement and State 286755 which reports the results of AID/W's 1988 review of the Mission's FY 1990 ABS. These documents clearly identify the health/family planning sector as one of the two sectors in which the A.I.D. program will be concentrated and endorse the design of a new health/family planning program for FY 1990. (Program Rationale Statement page 8; 88 State 286755 Paragraph 6.5)

The project outlined in this PID has been designed around the Mission's assistance criteria as set forth in the Program Rationale Statement (page 6). The various components will seek to use A.I.D. inputs to leverage the resources of the GOB and other donors by creating replicable models. The selected components are all in areas in which A.I.D. has a comparative advantage by virtue of experience and the availability of mechanisms such as centrally-funded projects. The elements of the proposed project build on prior A.I.D. investments. They are either successors to successful projects nearing completion or are based on A.I.D.-financed studies and pilot activities. The choice of project structure (see Section II) and the choice of implementation methods are designed to provide program flexibility.

### 2. Relationship of Project to A.I.D. and Africa Bureau Regional Strategies

The Health Care Financing Sub-project is consistent with A.I.D.'s position vis-a-vis the Bamako Initiative. The "Draft A.I.D. Position Paper on the Bamako Initiative," written in 1988, states that A.I.D. consistently tries to work with countries to build health care systems that can be sustained with locally available resources. In addition, the Bureau for Africa's 1987 Child Survival Action Plan (CSAP) encourages health financing initiatives to improve low quality medical care which results from free medical services. Its 1988 Population and Family Planning Strategy (PFPS) calls for the initiation of full and partial cost recovery mechanisms to ensure program sustainability.

MCH and family planning are cornerstones of the A.I.D. health and population development assistance strategy. Specifically, the proposed interventions of family planning information, training, and service delivery are consistent with the strategies outlined by the Africa Bureau in the PFPS. Similarly, nutrition, child spacing, and the control of diarrheal diseases are major components of the Africa's Bureau's CSAP.

The Health Planning Sub-project addresses itself to the several key concerns expressed by both the CSAP and the PFPS, particularly the importance of strengthening health management and the development of effective health information systems. Health planning has been the cornerstone of USAID/Burkina health development strategy since the design of the Strengthening Health Planning Capacity (SHPC) project in 1982.

The project conforms to the DFA Action Plan for FY 89-91. The program directions section of Target 1-3 for family planning and the child survival call for missions to: integrate family planning with child survival activities; stress the importance of going beyond ORT and immunization in child survival; and recognize the need for cost recovery mechanisms. The project will integrate, at the field level, family planning, DDC and nutrition interventions as well as initiate cost recovery mechanisms.

## II. Project Goal, Structure and Background Information

### A. Introduction

The proposed project is an umbrella or sector project consisting of a grouping of discreet health programs with a common goal. We have organized the PID to present a clear picture of each sub-project. This section presents information relative to the project as a whole. The following sections provide the project descriptions and factors affecting sub-project selection and further development on a sub-project by sub-project basis.

### B. Project Goal

To improve the health status of the people of Burkina, especially women and children.

### C. Rationale for Project Structure and Selection of Project Components

#### 1. Criteria for Selection of Activities

Each activity included in the project has been selected for several of the following reasons:

- The activity is a high priority MCH or PHC intervention in the eyes of both the GOB and AID.
- The activity represents an extension and expansion of a successful activity previously financed by A.I.D.
- Sufficient information on the activity, resulting from studies and research, exists to provide a basis for proceeding with detailed project design.
- The activity requires the application of techniques, technology and/or expertise which A.I.D. is qualified to provide.
- The activity complements the activities of other donors.

#### 2. Managerial/Organization Rationale for Project Structure

From the managerial and organizational point of view, the project structure, an umbrella project with three sub-projects, has several advantages:

- Combining the programs into a single project reduces the project design burden. Design team members will contribute to more than one sub-project. A single PID, PP, Authorization and Project Agreement can be utilized.
- Grouping the interventions into three sub-projects provides cohesive project management units. Each of the three sub-projects involves a different group of people from within the implementing agency and requires different A.I.D.-financed inputs. The PP will clearly outline mechanisms of coordination between the sub-projects.

The proposed project structure provides programming flexibility. The PP will allocate the proposed LOP funding of \$10 million to the three sub-projects and the various activities under the sub-projects on the basis of the budget estimates developed during the project design process. However, the project structure will permit the shifting of funds from one activity to another and from one sub-project to another depending on progress in attaining the purpose.

### 3. Technical Rationale for Project Structure

The MCH components of this project (family planning, diarrheal disease control, nutrition) will be managed at the central level by the MOHSA as separate activities but will be implemented at the field level as fully integrated service delivery programs. Each intervention will have its own national coordinator, training modules, and for the most part national trainers. At the field level, these programs will be implemented by the same service providers in the same geographic areas and have integrated supervision, logistic, and information systems as well as refresher training programs. The base area will be the fifteen provinces in which the Family Planning Support Project is operating and in which family planning activities under this project will continue. Nutrition and DDC activities will be conducted in a smaller number of provinces selected from the fifteen.

The health financing component will be managed by the provincial health directors in five provinces where the MCH components will be fully implemented. This component will reinforce the project's MCH activities by improving the overall functioning and staffing of health centers and by making local funds available for MCH activities.

By concentrating project activities geographically, essential MCH and PHC activities will be implemented in a fully integrated fashion with maximum impact on the target beneficiary population of women and children.

### D. Background Information on the Health Sector

The MOHSA has seven central directorates which deal with health activities. The Directorates of Family Health (DFH), Epidemiological Surveillance and Vaccinations (DESV) and Pharmaceutical Supply (DPS) are responsible for managing vertical programs such as immunizations, nutrition, family planning, etc. The Directorates of Studies and Planning (DSP), Professional Training (DPT), Health Education and Sanitation (DHES), Administrative Affairs and Finance (DAAF), are cross-cutting departments which provide support to all MOHSA programs. There is neither a national PHC director nor a preventive health coordinator. All directorates report to the Secretary General. All health activities conducted in a particular province are under the jurisdiction of the provincial health directorate (PHD).

The MOHSA features a pyramidal health structure with two national hospitals, 7 regional hospitals (with surgical services) and approximately 50 medical centers (MC) staffed by a doctor or registered nurse. Each MC is the supervision and reference point of a health zone which includes 4 to 12 maternities/dispensaries (M/D) managed by a registered nurse or a certified nurse. Below the M/Ds in each zone are up to several hundred primary health care posts which are staffed by community health workers and trained birth attendants chosen and paid by the community. At the present time, there is approximately one M/D for every 22,000 persons.

In the mid-1980's, the MOHSA set up a system of 29 drug depots and 294 community drug stores to serve the pharmaceutical needs of the population. Unfortunately, many of these drug stores have been decapitalized and have closed down. Those that still function have ongoing financial and logistic problems. None of these pharmacies provide any financial support to PHC services.

A table of organization for the MOHSA and a graphic depiction of its geographic structure are presented in Attachment D.

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### E. Other Donor Participation in the Health Sector

**Family Planning:** The UNFPA assists the DSF to implement an integrated MCH/FP project in 9 provinces which include family planning service delivery, training, and contraceptive procurement. In addition, UNFPA supports a separate information, education and communications (IEC) project with the MOHSA's Direction de la Promotion de la Famille. The World Bank finances an integrated MCH/FP project in 6 provinces which was modeled to a large extent after the USAID Family Planning Support (FPS) Project. USAID provides support in family planning to the remaining 15 provinces.

**Diarrheal Diseases Control:** UNICEF supports diarrheal diseases control (DDC) activities in 14 provinces which include training, logistic, and communication activities. In 1986, UNICEF funded a large diarrheal disease survey in 10 of these provinces. In addition, the West German government is planning to fund DDC activities in the 5 provinces where it intervenes. Finally, a number of PVO's fund DDC training as part of integrated health promotion programs in various provinces.

**Nutrition:** UNICEF is funding a pilot vitamin A project in 14 provinces which is implemented by Helen Keller International. In addition, UNICEF finances scales and growth cards, production of weaning foods, design of educational materials, functioning of MOHSA nutrition rehabilitation centers, and other small nutrition activities. A number of PVO's fund nutrition promotion activities as part of integrated health programs. Finally, Catholic Relief Services (CRS) has a small program which provides food and financial support to MOHSA nutrition rehabilitation centers. A long running CRS program to support MCH centers with food supplements has recently been terminated.

**Health Financing:** As part of its \$34 million health loan to Burkina, the World Bank is co-financing (with USAID) the Boulgou Cost Recovery Study. The majority of the World Bank's loan is being used to renovate and equip M/Ds, PHDs, and regional hospitals. The World Bank has expressed an interest in continuing its support for health financing in its next health loan by renovating and equipping health facilities which will be involved in cost recovery activities. USAID has already approached the World Bank concerning possible collaboration in this area.

UNICEF is strongly committed to the financing of PHC through cost recovery mechanisms as outlined in the Bamako initiative. In 1991, UNICEF will implement a health cost recovery project in 5 provinces based on the Bamako Initiative.

The national immunization program is fully funded by UNICEF and other donors.

### III. Sub-project 1 - Health Financing

#### A. Project Description

##### 1. Perceived Problem

With a gross per capita domestic product of \$150 in 1986, Burkina is one of the poorest countries in the world. While the GOB allocates an average of 6.7 percent of its national budget to the public health care sector, the amount available is insufficient to finance the activities of the existing health system. About 85 percent of the average health budget (\$15 million) is spent on salaries; yet, there is hardly a health facility which is adequately staffed. The remaining 17 percent of the health budget, or 34 U.S. cents per capita, is insufficient to cover the normal functioning and maintenance costs of the health facilities. Virtually no central government funds are available for new investments in the health sector.

As a result of these budgetary constraints, many of the nation's health facilities are nonfunctional because of insufficient equipment, drugs, and personnel and the dilapidated state of many of the buildings. The poor state of the health facilities results in poor quality health care for the population. As a direct consequence, the rate of utilization of the national public health system by the population is low, particularly in rural areas. Most money spent out-of-pocket for health care is for purchasing uncontrolled drugs in the local market or consulting untrained traditional practitioners, as no private sector modern health care exists in rural areas.

GOB leaders recognize that mechanisms must be developed to finance community health care services so that needed improvements in the quality and access of community health care can be achieved. Faced with the recurrent cost problems of the new public health system, the Ministry of Health and Social Action (MOHSA) initiated a series of cost recovery mechanisms including user fees at all hospitals supervised by a physician, the sale of vaccination cards, and the sale of chloroquine during mass anti-malarial campaigns.

These cost recovery experiments were largely unsuccessful due to their limited application and the absence of any organizational structure permitting a rational utilization of the funds collected. As a result, the MOHSA in collaboration with USAID and the World Bank designed the Boulgou Health Financing Study in 1987. The objective of the study was to develop and test health financing strategies which would permit health care centers to recover all of their recurrent costs exclusive of salaries of permanent staff and to increase the quality and the utilization of these centers.

Boulgou Study results to date indicate that community-managed revolving-fund drug stores and fees for laboratory tests can generate sufficient income to cover all the recurrent costs of a well functioning D/M exclusive of permanent professional staff salaries. D/Ms in the study area have improved the quality of their health care by providing an uninterrupted stock of essential drugs, providing key laboratory tests, and having funds available for building maintenance, supplies, and supervisory activities. The drug stores have been selling drugs at a 32 percent mark-up with rates of only 2-6 percent for loss and wastage.

The GOB in 1988 formally embraced the UNICEF/WHO sponsored Bamako Initiative. The goal of this initiative is to finance a revitalized primary health care system through cost recovery mechanisms, particularly the sale of essential drugs. In January 1989 a national interministerial committee was established on the Bamako Initiative and in February 1988, at the annual health donors conference, the GOB asked for broad donor support for its health financing objectives.

## 2. Sub-project Purpose

The sub-project purpose is to improve the functioning of PHC by instituting community-based cost recovery mechanisms.

## 3. Expected Achievements and Accomplishments

By the end of the project, approximately ten health zones (serving about 1.2 million people) will have:

- community-operated pharmacies selling essential drugs which generate surplus income;
- regular supplies of essential drugs;
- health facilities with the capability to perform essential laboratory tests for which fees are charged;
- improved diagnostic and drug treatment schedules;
- effective logistics, financial, and supervision systems to assure effective management of the health cost recovery mechanisms;
- adequate funds available from the sale of drugs, fees for laboratory tests, and other cost recovery activities to finance the variable recurrent costs (other than salaries of permanent staff) of a full range of health center activities.

As a direct result of the project, approximately 75 health facilities in ten health zones will provide better quality health care to rural residents as measured by the following indicators:

- reduced numbers of medical evacuations;
- increased utilization of health facilities and services by a minimum of 50 percent; and
- decreased mortality rates due to dehydration.

## 4. Outline of the Project and How it Will Work

The health cost recovery component will be an application and further development of the ongoing Boulgou Cost Recovery Study. The primary implementing agents will be:

- a project-financed U.S. PVO (including a health economist)
- the MOHSA provincial health directorates in the 5 project provinces
- community health committees
- the DSP

Project activities are described below:

1. The DSP will assist the PVO and the provincial health directorates to develop profiles for fully functioning MCs and M/Ds which will be used as models for improving service delivery. Based on these models, the project will conduct studies to determine the recurrent costs of delivering health services at the two types of facilities. In addition, studies will be conducted to determine the optimal fee schedules for cost recovery mechanisms, and to update and/or extend to the project area other key economic studies already done under the Boulgou Study and the SHPC Project. During the life of the project other economic and non-economic studies, including the collection and analysis of baseline data such as health indicators, will be carried out by the PVO in conjunction with the PHDs, and the DSP.
2. A U.S. PVO will assist community health committees to establish revolving-fund drug stores which will provide essential drugs for the health centers in the project area. Based on the Boulgou model, drug depots will be established at the MC's which will obtain their drugs directly from the parastatal, SONAPHARM, which is responsible for the national pharmaceutical supply system. The drug stores will replenish their drug supplies directly from the drug depots at the MC level at no mark-up. Through the PVO, the project will finance the renovation of suitable locales, the purchase of furniture, and the purchase of start-up supplies of essential drugs for these ten depots as well as the approximately 65 drug stores attached to M/Ds in the health zones. Depots and drug stores will be managed by local health committees.
3. The PVO and PHDs will organize or strengthen community health committees in 75 communities. A formal agreement will be signed between the committees and the PHDs which will govern the operation of the drug store and/or depot and the use of surplus funds. The committees will hire the people who run the pharmacies, directly oversee the day-to-day operation of the pharmacies, decide how surplus revenues will be used and supervise the utilization of these funds. The PVO will provide the committee with advice, training, and supervision.
4. The PVO and PHDs will assess the status of existing primary health care facilities (the MCs and M/Ds) and, to the extent required, renovate and re-equip the facilities to a level which will permit them to deliver a minimum acceptable level of PHC services. The provinces to be selected for this component will be among those already assisted by the World Bank's health infrastructure project, minimizing the need for renovation of PHC facilities under the project.
5. The PVO and PHDs will design and install in the MCs and M/Ds an improved diagnostic and treatment manual which will standardize current diagnosis and treatment practices for common diseases and conditions. This new manual will be based on a revised, essential drug list which the MOHSA is now designing, and will emphasize the integration of curative and preventive services. Service providers will be trained in the utilization of this manual as well as receive other refresher training.

6. The PVO and PHDs will introduce essential laboratory tests at the MCs and M/Ds. These will include standard blood and stool analyses for malaria, parasites, and anemia; and urine analyses for evidence of infection, albumin, and glucose. The fee schedules established for these tests will permit the auto-financing of this activity. The funds will be managed by the staff of each health facility using a simple financial management system installed by the PVO. Expenditure of funds will be controlled by the health center in collaboration with the community health committee. Reagents for lab testing will be obtained from SONAPHARM.
7. Using the models developed under the Boulgou Study, the PVO and PHDs will install logistics, financial, and supervision systems in the health zones of the project area. Community health committees will be trained in basic accounting to permit the management of community drug stores. Community pharmacists will be provided instruction in drug logistics, stock management, and essential drugs. Health center personnel will be trained to conduct laboratory tests and to manage the funds generated from these tests and other cost recovery mechanisms. Finally, a supervision system in the health zones will be introduced not only for the cost recovery mechanisms but also for PHC activities.
8. The PVO and PHDs, working with the community health committees will develop, test and implement other cost recovery mechanisms. These may include user fees for in-patient and maternity beds, and fees for consultations.
9. The PVO will assist the community health committees and the professional staffs of the MCs and M/Ds to develop programs for the use of funds generated by the drug depots, drug stores and other cost recovery mechanisms. Profits from drug sales will first be used to replenish drug supplies and pay local pharmacists. Remaining funds will be used to improve primary health care services at the MCs and M/Ds (e.g., maintenance of facilities, provision of consumable supplies, conducting of supervision activities). A portion of the income will be earmarked by agreement for health prevention activities such as purchasing gas for maintaining the vaccination cold chain. Funds may also be used to train and hire additional local personnel to staff the health centers including traditional midwives and health agents to supervise primary health care posts. Income from the cost recovery mechanisms introduced at health centers such as fees for laboratory tests will be used to cover the recurrent costs of normal PHC activities.

## B. Factors Affecting Sub-project Selection and Further Development

### 1. Social Considerations

The direct beneficiaries of the sub-project will be the estimated 1.2 million people living in the five provinces in which the project will be implemented. They will have access to improved PHC services as result of the sub-project. The five provinces will also be included in the project's MCH/FP component. This will ensure that mothers and children are particularly benefited. Health personnel will also benefit because they will have adequate tools with which to perform their jobs and receive refresher training. They will be better motivated as a result of the improved conditions and community participation.

Although a substantial portion of public health services are being provided free of charge in Burkina, patients still pay for drugs and visits to traditional healers. Studies have confirmed that the Burkinabe spend a substantial amount of their limited cash incomes on health services and drugs, often from uncontrolled sources. The Boulgou experience also confirms the necessity as well as the feasibility of basing the sub-project on community participation.

The sub-project is based on decentralization of management responsibilities and the involvement of the community. Community health committees will be formed and trained to run the revolving fund drug stores, to determine how funds raised will be used, and to participate in deciding on other cost recovery mechanisms. The community will be able to make decisions regarding its health services and will share responsibility for financing the services.

## 2. Economic Considerations

Under the Health Financing sub-project a quantifiable investment will be made with the expectation of generating income. A detailed economic analysis will be included in the PP.

Preliminary results from Boulgou clearly indicate that the sub-project has the potential to be economically feasible. Ten drug stores have been in operation for approximately 8 months, selling essential drugs at a mark-up of 32 percent. Waste and loss has been limited to 2-6 percent. After restocking and paying operating costs (including salary of the pharmacist), the drug stores have generated a surplus of 15 to 25 percent. Essential drugs are now provided to localities which before had no access to these drugs. Studies and progress reports indicate that in addition to covering the operating costs of the drug store, community-based drug stores together with laboratory fees can recover the variable recurrent costs of a well-functioning M/D excluding only the salaries of the permanent professional health staff provided by the MOHSA and amortization costs.

To date, the Boulgou Study has verified that people are willing to pay for essential drugs at the standard 32 percent mark-up applied in rural areas. It has also shown that members of the community are willing to take an active part in improving health care. Finally, Boulgou has shown that utilization of health facilities will increase with the availability of essential drugs.

One area in need of further study will be the capability of the 51 percent state-owned SONAPHARM to supply the drugs and lab supplies required by the project in a timely and efficient fashion. Other donors are presently working with SONAPHARM to improve its entire procurement system. UNICEF, as part of the Bamako Initiative to begin in 1991, will assist SONAPHARM to open up a special section to assure the steady supply of generic essential drugs. Provisions for a detailed analysis of SONAPHARM will be included in the design strategy. This project will have little effect on the few private drug stores in the country since almost all of them are located in the three largest cities which are outside the project zone.

### 3. Relevant Experience With Other Projects

The Boulgou Study will provide a tested method of organizing and implementing health cost recovery mechanisms. The designers and implementers of the Boulgou Study participated in study tours to cost recovery projects conducted in Benin and Mali.

### 4. Proposed Implementing Agency

This sub-project will be implemented by the provincial health directorates in the five project provinces. Technical advice will be provided by the DSP, which presently oversees the activities of the Boulgou Cost Recovery Study. A U.S. PVO will provide technical assistance and supervision on the provincial level. The PVO, in conjunction with the PHDs, will furnish the expatriate and local personnel necessary to assure the establishment and functioning of revolving fund drug stores and other cost recovery activities. In addition, the PVO will assist the PHDs to conduct all training and supervision activities. A long term health economist will also be required to support the PVO and PHDs with the economic and financial aspects of the activity.

### 5. Estimated Costs

The U.S. PVO will be responsible for: providing personnel; the renovation of the revolving fund pharmacies, drug depots and MCs including the procurement of services, materials and equipment; the procurement and distribution of the initial supply of drugs; and in-country and participant training. The GOR will provide, in addition to the time of its professional staff at the provincial and community levels, a suitable location for the drug stores and depots. These will generally be within existing PHC facilities. If possible the PVO will provide the health economist. Otherwise the Mission will enter into a PSC with a suitable candidate.

#### Sub-project Estimated Costs

#### Estimated Costs for PVO

1. Studies	
2. Short Term Consultants	\$50,000
3. Personnel	50,000
	1,070,000
Public Health Spec./Proj.Mgr (75,000 x 5 yrs)	375,000
Health Economist (150,000 x 3 yrs)	450,000
Local Project Manager (9,000 x 5 yrs)	45,000
Local Project Supervisors (5 x 6,000 x 5 yrs)	150,000
Local Accountant (2 x 5,000 x 5 yrs)	50,000
4. Renovation/Equipping of Pharmacies	125,000
5. Initial Supply of Drugs for Pharmacies	300,000
6. PVO and PHD Supervision	100,000
7. In-country Training	75,000
8. Participant Training	45,000
9. Renovation of Medical Centers and A/Ds	125,000
10. Clinical and Laboratory Equipment	90,000
Sub-Total	----- 2,030,000
PVO Administrative Overhead	----- 855,000
Total for PVO	----- 2,855,000

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Other Costs

Audits  
Evaluations

15,000  
25,000

Sub-project Total

-----  
\$2,925,000

6. Project Design Issues

This section discusses project design issues which have been identified in the context of the Boulgou Study and PID preparation.

a. Will the increased availability of drugs provide incentives for overuse of pharmaceuticals?

The MOHSA is in the process of revising and streamlining the essential drug list for the country. In addition, an improved diagnostic and drug treatment manual, linked to the essential drug list, will help assure rational use of drugs and will help to keep any tendency to overuse in check. Drug sales will be closely monitored to identify prescription and consumption trends. This aspect will receive specific attention in developing the sub-project supervision system.

b. How will the sub-project impact on existing private sector vendors of pharmaceutical products?

There are few existing private sector drug sellers in the rural areas where the sub-project will operate. In fact, the sub-project will be targetting underserved areas which are not attractive to private sector marketers.

c. Will fee schedules and other cost recovery mechanisms make PHC services less accessible or act as a disincentive to the rural population?

The results of the Boulgou Study indicate that people are willing to pay for essential laboratory tests. In fact, the project will result in an increased utilization of community health services due to the improved availability of essential drugs and laboratory tests. It appears people are willing to pay if they perceive that they are getting better service. Should the need arise, community health committees can develop policies for handling families too poor to be able to pay.

d. Will the GOB allow health facilities to retain the revenues generated by cost recovery mechanisms?

In principle, all funds generated at government health facilities must be sent to the treasury after which 75 percent is returned to the facilities which generated them. In practice, the health facilities under the Boulgou Study have succeeded in retaining fees for laboratory tests without objections from the Ministry of Finance. With the acceptance by the GOB of the Bamako Initiative, UNICEF, WHO and USAID have been assured that the statutory constraint will be eliminated. If there is any indication that this may cause a problem, an appropriate condition precedent will be negotiated with the GOB.

e. Does the proposed procurement of pharmaceuticals comply with A.I.D. policy?

A waiver will be sought to permit procurement of non-U.S. pharmaceuticals. During the P2 design stage, a complete list of essential drugs that are likely to be procured will be obtained from SONAPHARM and reviewed to assure that all comply with U.S. standards. Also, SONAPHARM procurement procedures will be reviewed to assure that competitive procurement procedures are used.

#### IV. Sub-project 2 - Maternal and Child Health/Family Planning

##### A. Project Description

##### 1. Perceived Problem

a. Family Planning: With a total fertility rate of 7.2 children per woman and a natural growth rate of 3.27 percent (2.68 net), Burkina's population will double in about 25 years, putting enormous pressure on its meager national resources (see Attachment E). The high fertility rate is detrimental to maternal health and contributes to the high maternal and infant mortality and morbidity rates. The GOB has made laudable progress in its national family planning program since its inception in 1985. Burkina is now seen as a success story in family planning in the region, with contraceptive prevalence increasing at an estimated 35 percent a year.

Despite these achievements, contraceptive use does not exceed 2 percent, access to family planning services is limited to 60 centers, and family planning information is not reaching most rural residents. Nonprescription contraceptives need to be made readily available at the community level and new approaches to IEC need to be developed.

b. Diarrheal Disease Control: According to 1986 data, diarrheal diseases are the second leading cause of death in the under-five population. In that year, diarrheal diseases accounted for 29 percent of deaths reported in the two national hospitals and 11 percent of deaths among children under five reported by other health facilities. The National Diarrheal Disease Program, designed in 1985, is still not operational except in pilot zones due to a lack of financing. While oral rehydration salts (ORS) are available in most health facilities, little oral rehydration therapy (ORT) is being administered due to lack of trained personnel, educational materials, and outreach efforts.

c. Nutrition: Burkinabe women and children are particularly vulnerable to the effects of malnutrition. Traditional feeding practices, food taboos and lack of knowledge are the major factors contributing to malnutrition, while seasonal food shortages often occur in the northern part of the country. Surveys have indicated malnutrition rates of from 3 to 20 percent based on the norms for weight for height. In addition to protein-calorie malnutrition, anemia, Vitamin A and iodine deficiencies are widespread, particularly in northern Burkina. While scales and growth charts are available in many health clinics, nutrition surveillance and education activities are hampered by the lack of trained health personnel, appropriate educational materials, and outreach activities.

##### 2. Sub-project Purpose

The sub-project purpose is to maximize maternal and child health by instituting improved programs of family planning, diarrheal disease control, and nutrition.

##### 3. Expected Achievements and Accomplishments

a. Family Planning: By the end of the project, family planning information and services will be expanded in the 15 provinces included in the FHS Project. Residents in the project area will have ready access to family planning information and services, and contraceptives. Local PVO's and private sector companies with health facilities will have new or improved family planning

information and service programs. The impact of these achievements will be measured by increased contraceptive prevalence in the country. After seven years of project implementation, it is expected that approximately 120,000 or eight percent of Burkina's couples of childbearing age will be using modern contraception.

b. Diarrheal Disease Control: The DDC program will be strengthened at the central level and in 10 of the provinces covered by the FPS project. Training, supervision, and logistics will be reinforced. Educational messages, materials, and approaches to promote ORT and dietary management of diarrhea will be designed, tested, and implemented. ORT units will be established in major health facilities. The impact of the program will be measured by the following indicators among children under five: reduced diarrheal disease case fatality rates at bedded health facilities; increased percentage of diarrheal cases treated with ORT; and increased usage of ORS as a therapy method. By the end of the project, it is expected that distribution and use of ORS will double in the project area.

c. Nutrition: Growth monitoring and promotion activities will be strengthened in the same 10 provinces. Growth monitoring of children under five will be instituted in the health centers. Nutrition education messages, materials and approaches will be designed, tested, and implemented. The management capacity of the MOHSA's Nutrition Service will be strengthened. Program success will be measured by increased numbers of children undergoing growth monitoring and promotion in the project area by the end of the project.

#### 4. Sub-project Outline and How It Will Work

The project will improve the maternal and child health care services by reinforcing selected priority interventions. Major project activities are described below by component although they are interrelated and form an integral part of the MOHSA's maternal and child health program.

##### a. Family Planning

The FP component will expand on the successful FPS Project. Specific accomplishments under the FPS Project included the establishment of the National Family Planning Training Team (NFPTT), pre-service and in-service training curricula and programs for nurse/midwives and social educators, the capacity to produce IEC materials and conduct IEC campaigns, and the establishment of two reference centers for the treatment of sexually transmitted diseases (STDs).

The project will provide technical assistance and financial support through appropriate ST/POP projects in each of the following areas. The different activities and their implementing MOHSA and Cooperating Agencies are summarized in Section B.4.

1) Training: This project will provide funding and technical assistance to the DFH to conduct in-country training for MOHSA personnel in FP services and IEC. The project will continue the same 'training of trainers' approach as was used in the FPS project. The training skills of the NFPTT will be upgraded through refresher training. The NFPTT will conduct in-service training for new service providers from existing service delivery sites and from new sites. Provincial training teams will conduct bi-annual refresher

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training which will cover FP and other MCH topics for health and social workers previously trained under the FPS project. Tutors at the national public health schools will be given refresher training to strengthen their capability to implement the pre-service training curriculum developed under the FPS project.

Personnel from the two national hospitals and selected regional hospitals will receive special training in voluntary surgical contraception (VSC) and infertility management. Directorate and provincial level managers will be given training in management and supervision.

2) Service Delivery: FP service delivery will be strengthened in both the public and private sectors through the provision of training, logistical support, clinical equipment and supplies, and contraceptives. VSC and infertility diagnostic equipment will be provided to designated centers. A small number of service sites will be renovated. Private sector entities that will receive support from the project include the Burkinabe Association for Family Welfare (ABBEF), the Burkina Midwives Association (BMA) and large employee health facilities.

The project will establish an STD reference center in the northern part of the country and provide additional technical support to the two existing STD centers. In addition, STD educational materials will be developed for use by service providers and MOHSA social educators.

The project will provide technical assistance and funds for the National AIDS Control Committee to establish a condom social marketing program. The Directorate of Health Education and Sanitation (DHES) will conduct marketing research and promote a brand name condom which will be distributed through the national drug distribution system to pharmacies and depots, including those in the project's cost recovery zone. The pharmacies and depots will, in turn, supply individual retailers. A modest profit margin will be allowed as incentive, and the remaining sale revenues will be ploughed back into the program to cover operational costs and resupply. Social marketing training will be provided for DESA personnel, pharmacists and other distributors. This program will utilize the experience gained from the successful condom distribution program in Ouagadougou, implemented with the assistance of AIDSTECH.

3) Information, Education and Communication: The IEC efforts carried out by the MOHSA under the FPS project will be accelerated. MOHSA personnel will conduct awareness-raising campaigns in the provinces for target groups which will include opinion leaders. The project will provide IEC print materials (reprinted and new) and essential IEC equipment and supplies to trained social educators. Radio and television programs on FP and MCH will be produced and broadcast on a regular basis. A theater play will be produced and staged in each of the project provinces.

4) Data Collection and Research: The project will fund a demographic and health survey that will provide base-line data on contraceptive prevalence and health and demographic indicators. In addition, the project will fund several operations research studies in the area of integrated MCH/FP service delivery. The DFH will coordinate the implementation of these activities.

## b. Diarrheal Disease Control

The project will support the objectives of the National Diarrheal Disease Control Program, providing the financial resources and technical assistance required to render it operational. The DDC activities begun by the MOHSA in collaboration with ST/Health's PRITECH project will be expanded. At the present time, the PRITECH Project is assisting the DSEV to conduct training and establish ORT units at health facilities in four provinces, and develop IEC materials.

The new project will continue PRITECH technical assistance and financial support for these DDC training, demonstration and IEC activities. A national IEC strategy and program for DDC will be developed and implemented in collaboration with UNICEF. Knowledge, attitudes and practices (KAP) surveys will be conducted to evaluate the success of educational efforts. Provincial training teams will provide DDC training to health center personnel and primary health workers in 10 project provinces and set up ORT units or corners in major health facilities. Assistance will be provided to the PHDs to improve the distribution of ORS packets in the country.

## c. Nutrition

- 1) **Strengthening of the MOHSA's Nutrition Service:** The project will provide short-term technical assistance and short-term training to the DFH Nutrition Service to strengthen its capacity to plan, manage and coordinate nutrition programs. In addition, the ST/M Nutrition Communication Project will provide technical assistance and funding to the Nutrition Service to conduct operations research studies that will identify effective approaches for implementing integrated nutrition interventions at the community level. Finally, the project will support an interministerial nutrition committee to encourage inter-sectoral cooperation and coordination.
- 2) **Growth Monitoring and Promotion:** The project will provide technical and financial support through the Nutrition Communication Project to the Nutrition Service to improve growth monitoring and promotion activities. The Nutrition Service will assist 10 provincial health directorates to conduct competency-based training for health workers in growth monitoring and nutrition, counselling, and to provide follow-up supervision. The Nutrition Service will produce a revised child growth card. This component will be an expansion of the growth monitoring activities currently being implemented on a pilot basis under the A.I.D.-funded Nutrition Surveillance Project (implemented by UNDP).
- 3) **Nutrition IEC:** The Nutrition Communication Project (NCP) will assist the DHES and the Nutrition Service to research, design and produce nutrition educational materials aimed at improving the diets of pregnant/lactating women and young children. In addition, the NCP will provide training to health workers from the 10 provinces in the use of these materials. Alternate communication approaches such as theater and radio will be explored and utilized to promote better nutrition. These activities will be an expansion of the ongoing NCP assisted project which is conducting similar pilot activities in three provinces.

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## B. Factors Affecting Project Selection and Further Development

### 1. Social Considerations

The direct beneficiaries of the project will be the Burkinabe women of reproductive age and children under five years of age residing in the project area. These are the most disadvantaged groups in Burkinabe society due to their low status in the traditional social strata. The other group of indirect beneficiaries of the project will be the MOHSA personnel who will receive training and logistics support that will allow them to perform their jobs better.

In varying degrees, all levels of the government, the private sector and the population will be involved in the design, development and implementation of this sub-project. KAP and ethnographic surveys will be conducted to provide information for activity design and evaluation to ensure that the interventions will be accepted by the population. The population's participation will be essential for achieving acceptance of preventive health actions, which will eventually be sustained by the community.

IEC efforts have led to increasing acceptance of family planning at the policy and at the individual level. Economic pressures have also contributed to the change in attitudes that favor large families. The project's IEC efforts will ensure that the people are sufficiently informed to enable them to make the appropriate choices regarding family planning. There are still many traditional feeding and hygiene practices that are harmful to the health and nutrition of mothers and children. Changing these practices is a slow process, and will require research and a trial and error process to identify approaches that will work which are included in the project.

### 2. Economic Considerations

The economic impacts of these sub-project activities are difficult to quantify even in the long term. However, there will be immediate savings to the family and to the government in curative service costs due to the reduction of births, diseases and deaths. Savings to the public sector and the cost effectiveness of various approaches will be examined at the PP stage.

The project will not finance recurrent costs such as personnel salaries, and major capital investment. The project will bear the costs of logistics support and commodities for the family planning, ORT and nutrition components. This will make only marginal additions to the already existing recurrent costs of the health centers. These costs will be estimated during PP preparation.

### 3. Experience with Similar Projects

The new project builds on several on-going USAID-financed child survival efforts. Under the FPS Project, the MOHSA has begun in-country clinical training and services in 15 provinces; developed an IEC program; and established management and logistic systems. According to the recent interim evaluation, the FPS project succeeded "in a brief time in developing skilled manpower, strong management, appropriate training resources and service delivery." The project success is reflected in a tripling of contraceptive use. The new project will be developed using the solid institutional base established under the FPS Project.

With the assistance of the centrally funded AIDSTECH Project, USAID supports a condom distribution program in Ouagadougou. This program has sold over 50,000 condoms at bars, hotels, gas stations, restaurants and other similar locations where individuals at risk for AIDS would be able to buy them.

USAID is supporting the National Diarrheal Disease Control Program through the PRITECH project. The activity which began in 1988 has successfully developed the following: a DDC training module; an ORT flip-chart; a training program for provincial training teams, provincial health agents and primary health care workers in 4 provinces; and ORT units in major health facilities in these provinces.

Two nutrition projects are now underway. The Nutrition Surveillance Project managed by UNDP, will reinforce a nutrition surveillance system and promote nutrition interventions in 3 provinces. The project will also strengthen the management capability of the Nutrition Service and set up a system for multi-sectoral coordination at the central and provincial levels. The project is behind schedule due to administrative and procurement delays.

The Nutrition Communications Project, scheduled to begin in April 1989, will assist the DFH and DHES to conduct pilot IEC activities which develop effective approaches for increasing the nutrition awareness of parents and improving the nutritional status of mothers and young children. These activities will include research and development of messages, production and evaluation of educational materials and mass media programs, and training of health workers in nutrition IEC in 3 provinces.

#### 4. Implementing Agencies

The Cooperating Agencies (CA's) for centrally-funded projects which will assist the MOHSA Directorates in implementing the different activities are summarized as follows:

<u>Activity</u>	<u>MOHSA Agency</u>	<u>ST Projects</u>
<u>Family Planning</u>		<u>ST/POP</u>
Clinical Training	Dir. Family Health	Training Paramedical, Auxiliary & Community Personnel (PAC) IIB
Management Trg	Provincial Health Dir.	Service Expansion And Technical Support (SEATS)
Service Delivery	Dir. Family Health	SEATS
Public Sector	ABBEF, BMA, Office of Employee Health	SEATS
Private Sector	National & selected Regional Hospital	Training in Reproductive Health
VSC	Dir. Epidemiological Surveillance & Vacc.	Training in Reproductive Health
STD	Dir. Family Health	Population Communication Services (PCS)
IEC		AIDSTECH (ST/Health)
Social Marketing	National AIDS Control Committee & Dir. Health Education	Demographic & Health Survey (DHS)
Base-line Survey	Dir. Family Health	Strategies for Improving Service Delivery (OR)
Operations Research	Dir. Family Health	

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DDC

Dir. Epidemiological  
Surveillance & Vacc.

ST/Health  
PRITECH

Nutrition  
Surveillance  
IEC

DFH/Nutrition Service  
DFH & Dir. Health  
Education

ST/Nutrition  
Nutrition Surveillance (ST/N)  
Nutrition Communication (ST/N)

5. Estimated Cost and Methods of Financing

USAID will finance technical assistance, in-country training, and local operational costs through buy-ins to centrally funded projects. It is expected the CA's will use their central funds to provide supplementary financing for technical assistance costs. USAID will carry out directly the procurement of commodities, services for evaluations and audits, and U.S. and third country training. (The PP design team will consider assigning the project PVO with the procurement of all project commodities other than contraceptives.) Renovation of service sites will be done by local contractors under host country contracts with the MOHSA.

Sub-project Estimated Cost

Illustrative List of Buy-ins

a. Family Planning	
JHPIEGO	200,000
SEATS (incl. PAC IIB, PCS, OR)	1,650,000
AIDSTECH	1,250,000
DHS	200,000
b. DDC	
PRITECH	750,000
c. Nutrition	
Nutrition Surveillance	350,000
NCP	400,000
Sub-Total	-----
	\$4,800,000

Other Sub-project Costs

Participant training	200,000
Contraceptives	500,000
Clinical equipment & supplies	100,000
Renovation of service sites	100,000
PSC for sub-project management	725,000
Audits	20,000
Evaluations	80,000
Sub-total	-----
	\$1,725,000
Sub-project Total	-----
	\$6,525,000

6. Project Design Issues

a. The family planning information system will need to be strengthened to provide timely data for program managers.

b. The logistic system for ORS may need to be reinforced to meet the expected increased demand for this treatment.

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## V. Sub-project 3 - Health Planning

### A. Project Description

#### 1. Perceived Problem

With the assistance of AID's Strengthening Health Planning Capacity (SHPC) Project, the MOHSA has developed a strong capacity to plan in the health sector. The interim evaluation of the SHPC Project in 1987 found that "progress in developing policies, procedures, plans, training of key personnel, and coordination has been extremely rapid."

The SHPC Project Paper (1982) and the Project Paper Supplement (1986), carefully estimated the recurrent cost implications of the project and constructed a project budget under which the GOB would be paying 100 percent of recurrent costs by the end of the project. As the project nears its conclusion it is apparent that this will not occur even though the GOB's contribution to the project will exceed the amount called for in the project grant agreement by approximately 30 percent.

The DSP has grown more rapidly than anticipated. It now has a staff of 17 professionals rather than the five originally planned. It is also carrying out a broader range of activities than originally envisioned. As a result, its annual recurrent costs are considerably more than the \$270,000 anticipated. In response to this situation, both USAID and the GOB have contributed more than was expected at the time of project design. Additional GOB expenses have been in the areas of salaries, utilities, building and automobile maintenance, and gasoline.

At the same time, the GOB's ability to finance recurrent costs has not kept pace with the growth of recurrent costs. Drought and poor harvests, declining cotton prices (its most important export), growing development expenditures, changes of government, and reliance on the public sector are among the factors contributing to this situation.

Following the completion of SHPC activities in 1990, the DSP will require limited financial support to assure that critical planning, health information, and donor coordination activities continue until other sources of support for these planning function can be identified.

#### 2. Sub-project Purpose

To complete the process of institutionalizing health planning functions within the MOHSA.

#### 3. Expected Achievements and Accomplishments

Health programs and projects will continue to be effectively planned and coordinated among the donors. Important annual reports and planning documents will continue to be issued in a timely manner.

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#### 4. Outline of the Sub-project and How it Will Work

The project will provide funds to the DSP to finance high priority health planning activities. The following is an illustrative list of such activities:

- producing and printing annual health plans;
- conducting health program evaluations;
- conducting annual conferences for health directors, health donors, and provincial statisticians;
- producing annual health reports;
- printing quarterly epidemiologic bulletins.

The project health economist will assist the DSP in the areas of financial analysis and health financing.

#### B. Factors Affecting Sub-project Selection and Further Development

##### 1. Social Considerations

To the extent the DSP functions effectively, it brings about improvements in the quantity and quality of health care available to all Burkinabe. The list of accomplishments of the DSP, as recorded in the interim evaluation of the SHPC project, makes it clear that this organization is having a positive impact on the country's primary health care system and, therefore, on all Burkinabe. Through better donor coordination, health planning, operations research, and collection and analysis of health data, etc., the DSP is fostering the rational allocation of scarce financial and human resources in the health sector.

##### 2. Economic Considerations

Three specific economic/financial questions apply to this sub-project:

a. Are DEP activities implemented in the most cost efficient manner?

The Mission has conducted an intensive review of the recurrent cost budget with GOB managers which resulted in reductions of approximately 30 percent. Further reductions would require the elimination or curtailment of essential activities.

b. Is there another source of funds immediately available to finance the DSP's activities?

The Mission has held numerous meetings with the responsible authorities during which efforts were made to identify other sources of funds, unfortunately to no avail. The GOB spends about 6.7 percent of its budget on health, which is generous by African standards. As is generally the case, donors do not like to fund recurring costs. The Mission and the DSP will continue to make efforts to locate new sources of support among other donors and through increased budgetary contributions from the GOB in order to reduce the DSP's dependence on A.I.D.

c. Is there a reasonable prospect for finding a permanent sources of funds by the end of the sub-project?

Most of the causes of recurrent cost problems described in the A.I.D. policy paper on this subject can be found to some extent in Burkina. However, there is very little misallocation of budgetary resources, excessive employment of

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government workers, overpayment of government workers or similar problems which tend to reduce the availability of government funds for recurrent costs. The GOB fully appreciates the importance of planning. The health DSP, having proven its value, is being replicated in other ministries. The bottom line then, is that Burkina like many other African countries simply does not have the resources to fund all the high priority activities it must somehow fund, and will have to depend on foreign assistance donors for recurrent cost financing for some time to come.

Within the health sector itself, the GOB's efforts to institute health cost recovery measures is a clear indication that it recognizes the recurrent cost problem and is willing to take steps to correct the situation.

USAID/Burkina has requested the MOHSA to seek to include budget support for DSP activities in grant agreements for health projects funded by other donors.

### 3. Relevant Experience With Other Projects

This sub-project funds a continuation of selected activities from the successful SHPC Project. The same funding mechanism as was used in the SHPC project will be used for this sub-project.

### 4. Proposed Implementing Agency

The Directorate of Studies and Planning (DSP) in the Ministry of Health and Social Affairs (MOHSA) will participate in the design of this sub-activity as well as its implementation. The DSP will also play an advisory role in the implementation of Sub-project 1, Health Care Financing.

### 5. Sub-project Estimated Costs and Method of Financing

The funds required over the five year life of the sub-project are estimated at \$500,000 using current cost estimates and budget levels based on past experience, and allowing for annual increases due to inflation. The total annual estimate of all recurrent cost items, excluding salaries, is \$170,000, of which A.I.D. would finance about 45 percent. The project agreement will contain a covenant requiring the GOB's commitment to finding a permanent source of funds by the end of the project.

Each year the project health economist will work with the DSP to establish an annual budget and work plan, and identify the items which will be financed by A.I.D. A.I.D. funding will not be applied to salaries or utility costs. Funds will be advanced against the budget and liquidated by the submission of vouchers by the DSP. The method of financing is presently in use under the SHPC project. The DSP's system for handling A.I.D. funding has been judged outstanding by the Sahel Regional Financial Management Project.

In addition, funds will be allocated for continued participant training of the DSP staff and for audits and evaluation.

### Sub-project Cost Estimate

1. Recurrent Cost Financing	\$500,000
2. Participant Training	40,000
3. Audits	10,000
Total	----- \$550,000

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## 6. A.I.D. Policy Issue

Should the project component be financed given A.I.D.'s general policy regarding recurrent cost financing?

In deciding whether to continue to finance a portion of the DSP's recurrent costs, we propose a pragmatic view. Simply stated, the funds for important health planning activities will not be available if we do not provide them. The implementation of these activities is important to firmly institutionalizing the planning process within the GOB and also for institutionalizing the role of the DSP in the planning process. Having designed and implemented the successful project which created the planning process and planning organization, it would be prudent to protect our investment by continuing to fund recurrent budget costs while assisting the GOB to find a permanent source of funds.

## VI. A.I.D. Support Requirements and Capabilities

The current staffing pattern of the USAID HPN Office consisting of a USDH HPN Officer, a PSC HPN Officer and two FSN Assistant HPN Officers, will be continued. The PSC will be responsible for coordinating the buy-ins to the S&T projects required to implement MCH/FP project activities and with liaison to the project PVO. Funds for the continuation of the PSC HPN officer have been provided in the budget for sub-project 2. These centrally-managed projects will have technical and administrative responsibilities for their various in-country activities under the supervision of the PSC and the oversight of the USDH HPN Officer. The USDH HPN Officer with the assistance of a regional contract officer and, possibly, a regional project officer, will implement the process of selecting a PVO. The two FSN's will be responsible for the following project management tasks: commodity procurement including contraceptives; participant training; private sector family planning activities; and operations research activities. Finally, the NCP and Pritech buy-ins will jointly fund a local ORT/nutrition adviser who will also be available to work with the project PVO in these areas.

The USAID HPN Office, staffed as described above, has been very effective in managing two bilateral and a large number of regionally and centrally-funded activities, as pointed out by two recent project evaluations. The proposed project does not expand the activities of the HPN office. Both bilateral projects, FPS and SHPC, are terminating in 1990. Only a single activity will carry over from the Health Planning Project to the proposed project. The FP components of sub-project 2 represent an extension of the Family Planning Support Project, with MCH activities formerly implemented outside a project framework, folded into the proposed project. Staff time formerly spent on Health Planning and the Boulgou Study will be available for the management of the Health Financing sub-project. The Program and Project Development Office and Office of Financial Management will support and backstop HPN Office project management.

The proposed project structure, as described in Part II of the PID, will not increase the management responsibilities of the mission beyond what it presently supports. As a way of streamlining project management, the project design team will consider the possibility of having the project PVO undertake all project procurements other than contraceptives. USAID is also considering the hiring of a OE-funded management officer to provide logistic and administrative support to the mission.

## VII. Project Design Strategy

The Project Paper will be drafted by a team composed of the USAID/Burkina HPN Officer (30 days), the USAID Program and Project Development Office staff (30 days), a PDO and Pop Officer from REDSO/WCA (30 days each). A health economist (30 days), a financial analyst (21 days), and a social scientist (14 days) will be obtained through an IQC. The health economist and the financial analyst will review proposed activities for cost-effectiveness and prepare the economic and financial analysis section of the PP. The social scientist will perform the social soundness analysis, review the socio-cultural appropriateness of the proposed activities, examine the potential social impacts, and advise on the qualitative research components of the activities.

Prior to preparation of the PP, a number of special studies and design activities will be undertaken for each of the sub-projects. These special studies will include a survey of potential MCH and cost recovery sites in the targeted provinces. In addition, a survey will be conducted of the availability and utilization of oral rehydration salts at health facilities and pharmacies.

Sub-project 1 - Health Care Financing: A consultant (15 days) experienced in health cost recovery projects obtained from the SHPC Project TA contractor will assist the MOHSA conduct an internal evaluation of the Boulgou Study. The evaluation is planned for this summer. The World Bank will be invited to supply someone to participate in this evaluation. In addition, the services of a pharmaceuticals procurement and distribution expert will be obtained from the same source to prepare a report on SONAPHARM and the national system for procuring and distributing drugs.

Sub-project 2 - MCH/FP: To the extent possible under existing agreements, specialists will be requested from the cooperating agencies that will be involved in project implementation. Each specialist will be responsible for providing a recommended design for the activity that will be implemented through his/her centrally-funded project. He/she will review accomplishments thus far, assess needs and institutional capacity, examine appropriateness of proposed activities, develop strategies and implementation plans, determine resources required, and identify research needs and requirements. The specialists will work in close consultation with the technical staff of the MOHSA who will provide input at each stage of the design.

Sub-project 3 - Health Planning: No special requirements are foreseen for the design of the Health Planning sub-project. The Mission HPN Officer, Regional PDO and the health economist will conduct a final review of projected recurrent costs and potential sources of funds with DSP personnel to firm up the total cost estimate and prepare the necessary project budget and project expenditure tables for the PP. A covenant will be discussed with officers of the MOHSA and the Ministry of Planning. The situation will also be reviewed with other donors.

Design Schedule: The special studies required for PP preparation will be conducted in September 1989. The PP design will take place October-November 1989. Obligation will be in the second quarter of FY 90.

ATTACHMENT A  
 FAMILY HEALTH AND HEALTH FINANCING (686-0275)  
 LOGICAL FRAMEWORK

SUB-PROJECT 1  
 HEALTH CARE FINANCING

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
PROJECT GOAL	<ul style="list-style-type: none"> <li>- REDUCED INFANT AND MATERNAL MORBIDITY AND MORTALITY RATES.</li> <li>- IMPROVEMENTS IN OTHER KEY HEALTH INDICATORS, DISEASE MORBIDITY RATES, ETC.</li> </ul>	<ul style="list-style-type: none"> <li>- 1985 AND 1995 CENSUS</li> <li>- DEMOGRAPHIC AND HEALTH SURVEY</li> <li>- SPECIAL STUDIES</li> <li>- HEALTH STATISTICS REPORTS</li> </ul>	<ul style="list-style-type: none"> <li>- GOB HUMAN AND FINANCIAL RESOURCES AVAILABLE TO MEET OBLIGATIONS AND ASSURE SERVICES.</li> <li>- GOB FAVORABLE POLICIES IN HEALTH SECTOR REMAIN UNCHANGED.</li> </ul>
SUB-PROJECT PURPOSE	END OF PROJECT STATUS	OUTPUTS	<ul style="list-style-type: none"> <li>- POLITICAL AND FINANCIAL SUPPORT FOR PROJECT ACTIVITIES FROM GOB AND COMMUNITIES CONTINUE.</li> <li>- ECONOMIC CONDITIONS WHICH PERMIT PEOPLE TO PAY FOR HEALTH CARE CONTINUE.</li> <li>- OTHER DONORS CONTINUE TO SUPPORT COMPLEMENTARY ACTIVITIES.</li> </ul>
TO IMPROVE THE FUNCTIONING OF PHC BY INSTITUTING COMMUNITY-BASED HEALTH COST RECOVERY MECHANISMS.	<ul style="list-style-type: none"> <li>- 50 % INCREASE IN UTILIZATION OF PHC FACILITIES.</li> <li>- 25 % REDUCTION IN MEDICAL EVACUATIONS.</li> <li>- DECREASE IN MORTALITY RATES DUE TO DEHYDRATION.</li> </ul>	<ul style="list-style-type: none"> <li>- HEALTH STATISTICS REPORTS</li> <li>- SPECIAL STUDIES</li> </ul>	
OUTPUTS	MAGNITUDE OF OUTPUTS	<ul style="list-style-type: none"> <li>- ON-SITE VERIFICATION</li> <li>- HEALTH STATISTICS REPORTS</li> <li>- MANAGEMENT INFORMATION SYSTEM REPORTS</li> <li>- TRAINING CURRICULA AND REPORTS</li> <li>- PVO REPORTS</li> <li>- EVALUATION REPORTS</li> </ul>	<ul style="list-style-type: none"> <li>- THE MOHSA MAINTAINS TRAINED HEALTH CARE PERSONNEL AT PHC FACILITIES.</li> <li>- APPROPRIATELY QUALIFIED PERSONNEL ARE AVAILABLE FOR EMPLOYMENT BY COMMUNITIES.</li> </ul>
<ul style="list-style-type: none"> <li>- COMMUNITY-OPERATED PHARMACIES SELLING ESSENTIAL DRUGS WHICH GENERATE SURPLUS INCOME.</li> <li>- IMPROVED PHC FACILITIES CAPABLE PROVIDING IMPROVED PRIMARY HEALTH CARE SERVICES.</li> <li>- IMPROVED DIAGNOSTIC AND DRUG TREATMENT PROCEDURES.</li> <li>- LOGISTICS, FINANCIAL AND SUPERVISIONS SYSTEMS FOR MANAGEMENT OF HEALTH COST RECOVERY MECHANISMS AND PHC SERVICES.</li> <li>- HEALTH COST RECOVERY MECHANISMS GENERATING SUFFICIENT INCOME TO COVER ALL RECURRENT COSTS (OTHER THAN SALARIES OF PERMANENT STAFF) AT PHC FACILITIES.</li> </ul>	<ul style="list-style-type: none"> <li>- 75</li> <li>- 75</li> <li>- HEALTH WORKERS TRAINED IN THE USE OF NEW DIAGNOSTIC AND TREATMENT PROCEDURES.</li> <li>- SYSTEMS INSTALLED IN TEN HEALTH ZONES.</li> <li>- HEALTH COST MECHANISMS IN ADDITION TO DRUG STORES AT 75 PHC FACILITIES.</li> </ul>		
INPUTS - A.I.D.	MAGNITUDE	<ul style="list-style-type: none"> <li>- A.I.D. REPORTS, VOUCHERS</li> <li>- PVO REPORTS</li> <li>- PROJECT EVALUATIONS AND AUDITS</li> <li>- SITE VISITS</li> </ul>	<ul style="list-style-type: none"> <li>- GOB, A.I.D. AND COMMUNITY RESOURCES ARE AVAILABLE ON SCHEDULE.</li> </ul>
U.S. PVO AUDIT AND EVALUATION	<ul style="list-style-type: none"> <li>\$2,885,000</li> <li>\$40,000</li> <li>\$2,925,000</li> </ul>		
GOB & COMMUNITY ORGANIZATIONS	MAGNITUDES TO BE DETERMINED DURING PP DESIGN		
PERSONNEL HEALTH FACILITIES			

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ATTACHMENT A  
 FAMILY HEALTH AND HEALTH FINANCING (686- 0275)  
 LOGICAL FRAMEWORK

SUB-PROJECT 2  
 MATERNAL CHILD HEALTH/FAMILY PLANNING

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<b>PROJECT GOAL</b> ----- TO IMPROVE THE HEALTH STATUS OF THE PEOPLE OF BURKINA FASO, ESPECIALLY WOMEN AND CHILDREN.	- REDUCED INFANT AND MATERNAL MORBIDITY AND MORTALITY RATES.  - IMPROVEMENTS IN OTHER KEY HEALTH INDICATORS, DISEASE MORBIDITY RATES, ETC.	- 1985 AND 1995 CENSUS - DEMOGRAPHIC AND HEALTH SURVEY - SPECIAL STUDIES - HEALTH STATISTICS REPORTS	- GOB HUMAN AND FINANCIAL RESOURCES AVAILABLE TO MEET OBLIGATIONS AND ASSURE SERVICES. - GOB FAVORABLE POLICIES IN HEALTH SECTOR REMAIN UNCHANGED.
<b>SUB-PROJECT PURPOSE</b> ----- MAXIMIZE MATERNAL AND CHILD HEALTH BY INSTITUTING IMPROVED PROGRAMS OF FAMILY PLANNING, DIARRHEAL DISEASE CONTROL AND NUTRITION.	<b>END OF PROJECT STATUS</b> ----- - CONTRACEPTIVE PREVALENCE RATE INCREASE TO 8 %. - FAMILY PLANNING SERVICES AND INFORMATION AVAILABLE AT MC'S AND M/D'S IN 15 PROVINCES. - ORT AND DDC INFORMATION AVAILABLE IN ALL HEALTH FACILITIES IN 10 PROVINCES. - REDUCED DIARRHEAL DISEASE CASE FATALITY RATES AT HOSPITALS. - INCREASED NUMBER OF DIARRHEAL CASES TREATED WITH ORT. - 100 % INCREASE IN ORS USE. - NUTRITION SERVICES AND INFORMATION AVAILABLE IN MEDICAL CENTERS IN 10 PROVINCES. - INCREASED NUMBER OF CHILDREN UNDERGOING GROWTH MONITORING. - INCREASED NUMBER OF CHILDREN RECEIVING APPROPRIATE WEANING FOODS.	<b>OUTPUTS</b> ----- - DEMOGRAPHIC AND HEALTH SURVEY - HEALTH STATISTICS REPORTS - KAP SURVEYS - SPECIAL STUDIES	- POLITICAL AND FINANCIAL SUPPORT FOR PROJECT ACTIVITIES FROM PUBLIC AND PRIVATE SECTORS CONTINUE. - SUPPORT FOR AND ACCEPTANCE OF SERVICES BY INDIVIDUAL COUPLES AND PARENTS CONTINUES. - OTHER DONORS CONTINUE TO SUPPORT COMPLEMENTARY ACTIVITIES.

EG

ATTACHMENT A  
FAMILY HEALTH AND HEALTH FINANCING (686-0275)  
LOGICAL FRAMEWORK

SUB-PROJECT 2  
MATERNAL CHILD HEALTH/FAMILY PLANNING

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OUTPUTS	MAGNITUDE OF OUTPUTS		
A. FAMILY PLANNING	(NOS. TO BE DETERMINED DURING PP DESIGN)	- ON-SITE VERIFICATION	- EXPERIENCED MOHSA AND PRIVATE
1. FP SERVICES WIDELY AVAILABLE IN 15 PROVINCES	- SERVICES SITES RENOVATED, EQUIPPED AND SUPPLIED WITH CONTRACEPTIVES.	- SERVICE STATISTICS REPORTS	SECTOR PERSONNEL REMAIN IN PRESENT
	- MOHSA SERVICE DELIVERY PERSONNEL TRAINED OR RETRAINED.	- MANAGEMENT INFORMATION SYSTEM REPORTS	JOBS OR ARE ASSIGNED TO
	- PUBLIC AND PRIVATE FACILITIES WITH FP SERVICES AND INFORMATION AVAILABLE.	- MOHSA REPORTS	APPROPRIATE POSTS WHICH UTILIZE
	- MANAGEMENT, SUPERVISORY AND LOGISTICS SYSTEMS IN PLACE.	- SURVEY AND STUDY REPORTS	THEIR TRAINING.
		- TRAINING CURRICULA	- PERSONNEL WILL BE RELEASED FOR
		- TRAINING REPORTS	TRAINING
		- CONTRACTOR REPORTS	- PUBLIC AND PRIVATE FACILITIES
		- EVALUATION REPORTS	CAN ACCOMMODATE INCREASED
		- PROTOCOLS AND PROCEDURE MANUALS	ACTIVITIES.
			- PEOPLE ARE WILLING TO PURCHASE
			CONTRACEPTIVES.
			- PEOPLE ARE WILLING TO ADOPT
			INTERVENTIONS ONCE INFORMED.
2. VSC SERVICES AVAILABLE AT NATIONAL AND REGIONAL HOSPITALS.	- HOSPITALS EQUIPPED FOR VSC SERVICES.		
	- PERSONNEL TRAINED TO DELIVER VSC IN THESE HOSPITALS.		
3. STD CONTROL PROGRAM EXPANDED.	- STD CENTERS WHERE DIAGNOSIS AND TREATMENT ARE AVAILABLE.		
	- PERSONNEL TRAINED TO PROVIDE DIAGNOSIS AND TREATMENT.		
4. CONDOM SOCIAL MARKETING PROGRAM ESTABLISHED.	- OUTLETS FOR CONDOMS.		
	- PROMOTIONAL CAMPAIGNS ON CONDOMS FOR AIDS CONTROL.		
5. FP IEC PROGRAM IMPROVED AND EXPANDED.	- MASS MEDIA PROGRAMS AND IEC PRINT MATERIALS PRODUCED AND DISTRIBUTED.		
	- AWARENESS RAISING CAMPAIGNS CONDUCTED IN 15 PROVINCES.		
	- IEC EQUIPMENT SUPPLIED TO TRAINED SOCIAL WORKERS.		
	- SOCIAL EDUCATORS TRAINED OR RETRAINED.		
6. PROGRAM DATA COLLECTION AND RESEARCH CONDUCTED.	- OPERATIONS RESEARCH STUDIES CONDUCTED.		
	- DEMOGRAPHIC AND HEALTH SURVEY CONDUCTED.		
B. DIARRHEAL DISEASE CONTROL			
A FUNCTIONING DDC PROGRAM IN 10 PROVINCES.	- PERSONNEL TRAINED TO PROVIDE ORT AND DDC SERVICES.		
	- HEALTH FACILITIES WHERE ORT SERVICES AVAILABLE.		
	- A NATIONWIDE ORT IEC STRATEGY DEVELOPED.		
	- IEC ACTIVITIES IMPLEMENTED.		
	- ORS DISTRIBUTION IMPROVED.		

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ATTACHMENT A  
FAMILY HEALTH AND HEALTH FINANCING (686- 0275)  
LOGICAL FRAMEWORK

SUB-PROJECT 2  
MATERNAL CHILD HEALTH/FAMILY PLANNING

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<b>C. NUTRITION</b>			
1. A FUNCTIONING GROWTH MONITORING SYSTEM IN 10 PROVINCES.	<ul style="list-style-type: none"> <li>- PERSONNEL TRAINED TO CARRY OUT GROWTH MONITORING AND PROMOTION.</li> <li>- HEALTH CENTERS IMPLEMENTING GROWTH MONITORING AND PROMOTION ACTIVITIES.</li> <li>- AN INFORMATION SYSTEM IN PLACE.</li> <li>- A REVISED CHILD GROWTH CARD PRODUCED.</li> </ul>		
2. A NUTRITION IEC PROGRAM IMPLEMENTED.	<ul style="list-style-type: none"> <li>- IEC MATERIALS PRODUCED.</li> <li>- PERSONNEL TRAINED IN IEC AND USE OF MATERIALS.</li> <li>- MASS MEDIA PROGRAMS PRODUCED AND DISTRIBUTED.</li> </ul>		
INPUTS - A.I.D.			
TECHNICAL ASSISTANCE (BUY-INS)			
FAMILY PLANNING			
- PAC II B			
- JHP/IEGO			
- SEATS			
- AIDSTECH			
- JHU/PCS			
- DHS			
- OR			
DDC - PRITECH			
NUTRITION			
- NUTRITION SURVEILLANCE			
- MCP			
PARTICIPANT TRAINING			
COMMODITIES			
- CONTRACEPTIVES			
- CLINICAL EQUIPMENT AND SUPPLIES			
OTHER COSTS			
- RENOVATION OF SERVICE SITES			
- PSC - SUB-PROJ. MANAGER			
- AUDITS			
- EVALUATIONS			
SUB-PROJECT TOTAL			
GOB & PRIVATE SECTOR ORGANIZATIONS			
PERSONNEL			
HEALTH FACILITIES			
OPERATING COSTS			

MAGNITUDES TO BE DETERMINED DURING PP DESIGN

MAGNITUDE  
\$4,800,000  
\$400,000  
\$200,000  
\$600,000  
\$1,250,000  
\$500,000  
\$200,000  
\$150,000  
\$750,000  
\$350,000  
\$400,000  
\$200,000  
\$600,000  
\$500,000  
\$100,000  
\$925,000  
\$100,000  
\$725,000  
\$20,000  
\$80,000  
\$6,525,000

- A.I.D. REPORTS, VOUCHERS  
- CONTRACTOR REPORTS  
- PROJECT EVALUATIONS AND AUDITS  
- SITE VISITS  
- GOB REPORTS  
- REPORTS OF PRIVATE SECTOR ORGANIZATIONS

- GOB, A.I.D. AND PRIVATE SECTOR INPUTS WILL BE AVAILABLE ON SCHEDULE.  
- BUY-IN CONTRACTORS WILL BE ABLE TO RESPOND TO REQUEST FOR ASSISTANCE.

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**ATTACHMENT A  
FAMILY HEALTH AND HEALTH FINANCING (686-0275)  
LOGICAL FRAMEWORK**

**SUB-PROJECT 3  
HEALTH PLANNING**

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
PROJECT GOAL			
TO IMPROVE THE HEALTH STATUS OF THE PEOPLE OF BURKINA FASO, ESPECIALLY WOMEN AND CHILDREN.	<ul style="list-style-type: none"> <li>- REDUCED INFANT AND MATERNAL MORBIDITY AND MORTALITY RATES.</li> <li>- IMPROVEMENTS IN OTHER KEY HEALTH INDICATORS, DISEASE MORBIDITY RATES, ETC.</li> </ul>	<ul style="list-style-type: none"> <li>- 1985 AND 1995 CENSUS</li> <li>- DEMOGRAPHIC AND HEALTH SURVEY</li> <li>- SPECIAL SURVEYS</li> <li>- HEALTH STATISTICS REPORTS</li> </ul>	<ul style="list-style-type: none"> <li>- GOB HUMAN AND FINANCIAL RESOURCES AVAILABLE TO MEET OBLIGATIONS AND ASSURE SERVICES.</li> <li>- GOB FAVORABLE POLICIES IN HEALTH SECTOR REMAIN UNCHANGED.</li> </ul>
SUB-PROJECT PURPOSE	END OF PROJECT STATUS		
TO COMPLETE THE PROCESS OF INSTITUTIONALIZING HEALTH PLANNING FUNCTIONS WITHIN THE MOHSA.	A FUNCTIONAL, SELF-SUSTAINING HEALTH PLANNING ORGANIZATION.	<ul style="list-style-type: none"> <li>- MOHSA BUDGETS</li> <li>- DEP REPORTS, PUBLICATIONS, CONFERENCES</li> <li>- SITE INSPECTIONS</li> </ul>	THE MOHSA CONTINUES TO GIVE PRIORITY TO HEALTH PLANNING AND TO PROVIDE FINANCIAL AND HUMAN
OUTPUTS	MAGNITUDE OF OUTPUTS		
<ul style="list-style-type: none"> <li>- ANNUAL HEALTH PLANS</li> <li>- HEALTH PROGRAM EVALUATIONS</li> <li>- DONOR COORDINATION CONFERENCES</li> <li>- PLANNING CONFERENCES FOR MOHSA DIRECTORS, STATISTICIANS, ETC.</li> <li>- ANNUAL HEALTH REPORTS - QUARTERLY</li> <li>- EPIDEMIOLOGICAL BULLETINS</li> <li>- ANNUAL STATISTICAL REPORTS</li> <li>- TRAINED PERSONNEL</li> </ul>	(TO BE QUANTIFIED DURING PP DESIGN)	<ul style="list-style-type: none"> <li>- ON-SITE VERIFICATION</li> <li>- MOHSA BUDGETS</li> <li>- DEP REPORTS, PUBLICATIONS, CONFERENCES</li> <li>- TRAINING REPORTS</li> <li>- EVALUATION REPORTS</li> </ul>	<ul style="list-style-type: none"> <li>- DEP PERSONNEL REMAIN IN THEIR PRESENT POSITIONS OR IN OTHER APPROPRIATE POSITIONS WITHIN THE ORGANIZATION.</li> <li>- ADDITIONAL PERSONNEL ARE MADE AVAILABLE FOR TRAINING.</li> </ul>
INPUTS - A.I.D.			
FUNDING FOR DEP ACTIVITIES PARTICIPANT TRAINING AUDITS	MAGNITUDE	<ul style="list-style-type: none"> <li>- A.I.D. REPORTS, VOUCHERS</li> <li>- PROJECT AUDITS</li> <li>- SITE VISITS</li> <li>- GOB REPORTS</li> </ul>	- A.I.D. AND GOB RESOURCES ARE AVAILABLE ON SCHEDULE.
TOTAL	<ul style="list-style-type: none"> <li>\$500,000</li> <li>\$30,000</li> <li>\$10,000</li> <li>-----</li> <li>\$540,000</li> </ul>		
GOB & PRIVATE SECTOR ORGANIZATIONS			
PERSONNEL			
OPERATING COSTS	TO BE QUANTIFIED DURING PP DESIGN		

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CATEGORICAL EXCLUSION

Project Country: Burkina Faso  
Project Title: Family Health and Health Care Financing  
(686-0275)  
Funding: DFA FYs 90 - 96 US\$10 Million

Prepared by: Augustin A. Ouattara  
Engineer and Environmental Officer  
USAID/Burkina

Environmental Action Recommended:  
Categorical Exclusion

Summary of Findings:

A categorical exclusion of AID Environmental procedures is recommended on the basis that this project consists of "programs involving nutrition, health care or population and family planning services," under 22 CFR Part 216.2 (c) (viii) of A.I.D.'s Environmental Procedures (A.I.D. HB 3 Appendix 2D). The project does not anticipate any activities "directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)." Limited funding (about \$475 Thousand) will be made available for renovation of existing facilities.

Clearance:

Mission Director: J. M. Ull DATE: 6/6/89

Concurrence:

Bureau Environmental Officer:

APPROVED: \_\_\_\_\_

DISAPPROVED: \_\_\_\_\_

DATE: \_\_\_\_\_

Clearance:

GC/Africa: \_\_\_\_\_ DATE: \_\_\_\_\_

## Attachment C

### The Social Context of the Project

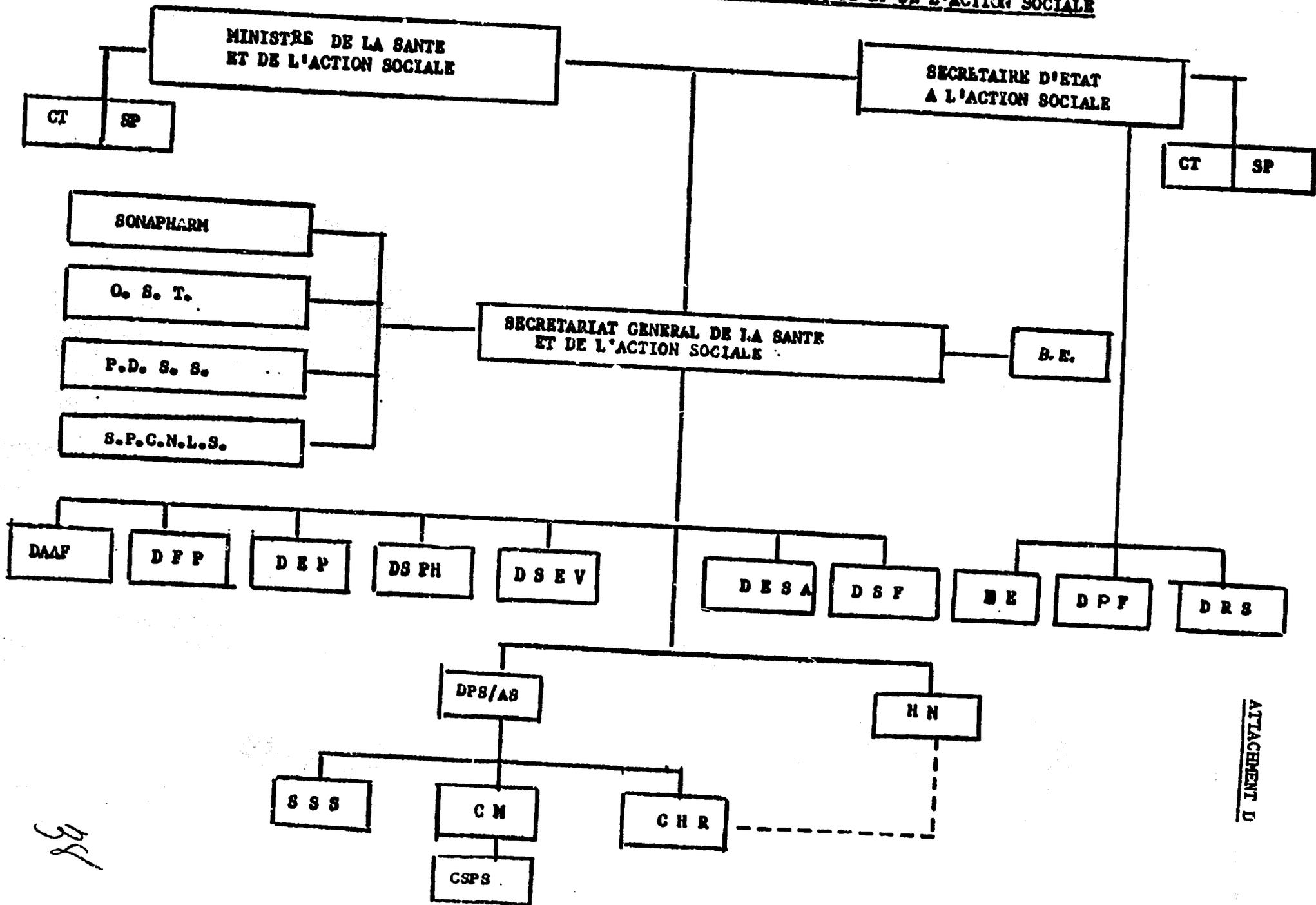
Burkina Faso is ranked among the least developed countries with a GNP of \$150 per capita. It had an estimated population of 8.0 million in 1985, 48% of which are under 15 years of age. The country has one of the highest infant and maternal mortality rates in the world (1985 estimates of 134 per 1000 and 6 per 1000 live births). The illiteracy rate is 85.5% and only 21.7% of eligible children attend primary school. There are vast unmet needs in education and health care, and the problem is exacerbated by the high population growth rate and recurrent financing constraint.

Burkina Faso has an agrarian based economy with 92% of the population engaged in subsistence farming and animal herding. The agricultural system is largely based on small scale subsistence farming units that depend primarily on human labor and human skills to assure a minimum level of productivity. Approximately 600,000 family farms are the characteristic unit of social and economic life. Agricultural production is constrained by unfavorable climatic conditions, poor soils and scarcity of water.

The poor resource base and the limited amount of available arable land have led to a high rate of emigration to neighboring countries, reducing the gross population growth rate by 18%. The emigration of predominantly young males changes the demographic make-up of the rural population which has a considerable social impact. Women, for example, are increasingly under pressure during peak seasons of the agricultural cycle. Burkina is beginning to lose this important safety valve for population pressures as the richer neighboring countries are experiencing economic decline and are taking measures to reduce immigration.

About 68% of the population are animists and 27.5% are Moslem. Both groups practice polygamy which is legal. Polygamy is viewed as necessary for the traditional practice of long abstinence after child birth, which may offset the effect of child spacing on the birthrate.

ORGANIGRAMME DU MINISTRE DE LA SANTE ET DE L'ACTION SOCIALE



ATTACHMENT D

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**L E G E N D**  
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- S.P. : Secrétariat Particulier
- C.T. : Conseiller Technique
- B.E.. : Bureau d'Etudes
- SOKAFELAM : Société Nationale d'Approvisionnement Pharmaceutique
- O.S.T. : Office de Santé des Travailleurs
- P.D.S.S. : Projet de Développement des Services de Santé
- S.P.C.N.L.S. : Secrétariat Permanent du Comité National de Lutte contre les effets de la Sécheresse.
- D.A.A.F. : Direction des Affaires Administratives et Financières
- D.F.P. : Direction de la Formation Professionnelle
- D.E.P. : Direction des Etudes et de la Planification
- D.S.PH. : Direction des Services Pharmaceutiques
- D.S.E.V. : Direction de la Surveillance Epidémiologique et des Vaccinations
- D.E.S.A. : Direction de l'Education pour la Santé et l'Assainissement
- D.S.P. : Direction de la Santé de la Famille
- D.E. : Direction de l'Enfance
- D.P.F. : Direction de la Promotion de la Famille
- D.R.S. : Direction de la Réinsertion Sociale
- DPS.AS. : Direction Provinciale de la Santé et de l'Action Sociale
- H.N. : Hôpital National
- S.S.S. : Services Sociaux Spécialisés
- C.E.R. : Centre Hospitalier Régional
- C.M. : Centre Médical
- C.S.P.S. : Centre de Santé et de Promotion Sociale.

Attachment E

Social and Health Indicators  
Source: 1985 Census

Total Population:	1985	7,964,705
Natural Rate of Increase:	3.21%	
Population by Age Group		
0 - 14 years:	48.3%	
15 - 64 years:	47.6%	
65 plus :	4.0%	
Crude Birth Rate:	49.6 per 1000	
Crude Death Rate:	17.5 per 1000	
Infant Mortality Rate:	134 per 1000	
Life Expectancy:	48.5 years	
Literacy Rate:	14.5%	
Primary School Enrollment:	21.7%	
Secondary School Enrollment:	4.3%	
Number of Households:	1,274,546	
Average Size of Household:*	6.2 persons	
Urbanization Rate:	12.7%	
Population Density:	29 per sq. km.	

\*Excluding households in the major cities of Ouagadougou and Bobo-Dioulasso.