Table 3.3. Agricultural, rural development, and natural resource projects funded by the World Bank in Burkina Faso

Agriculture and Rural Development

1970 Projet Coton Ouest Volta
(West Volta Cotton Project)

1972 1er projet Fonds du Développement Rural (FDR I)
(Upper Volta Rural Development Fund)

1974 Projet de Développement Agricole de la Bougouriba
(Bougouriba Agricultural Development Project)

1975 Projet Elevage Ouest Volta
(Livestock Development Project)

1976 2è projet Fonds du Développement Rural (FDR II)
(Upper Volta Second Rural Development Fund)

1977 Projet Développement Agricole Ouest Volta
(West Volta Agricultural Development Project)

1980 Projet de Développement Rizicole Niéna Dionkélé
(Niena Dionkele Rice Development Project)

1980 2è projet de Développement Agricole de la Bougouriba
(Second Bougouriba Agricultural Development Project)

1982 Projet de Développement Agricole des Hts Bassins (PDA-HB)
(Haut-Bassins Agricultural Development Project)

1982 Projet de Développement Agricole de la Boucle du Mouhoun
(Boucle du Mouhoun Agricultural Development Project)

1982 Projet Pilote Agricole Centre Ouest Koudougou
(Koudougou Agricultural Pilot Project)

1982 3è projet Fonds du Développement Rural (FDR III)
(Upper Volta Third Rural Development Fund)

1988 Projet d'Appui aux Services Agricoles (PRSAP)
(Agricultural Support Services Project)

1988 Projet de Recherche Agricole
(Agricultural Research Project)

Natural Resource Management

1979 Projet Forestier
(Forestry Project)

1986 Pilot PNGTV Project
(Pilot Village Land Management Project)

1992 Burkina Faso Environmental Management Project (PNGTV)

Other benefits included a substantial increase in the technical capacity of the farmers (an estimated 46,000 farmers trained in the new crop production technology), as well as in the number and quality of rural roads, and in the basic infrastructure and extension skills of three affected ORDs. The major criticism of the project was that its interventions focused on cotton monoculture with little attention to cereals, which were the major food crop. Evaluation documents note, however, that the project had an indirect influence on food crops due to the after-effects of fertilizers used on cotton, which increased crop yields by up to 20%.

Based on these early evaluations, a second generation of ORD-sponsored and co-sponsored community development programs were created in the late 1970s. The symbol of this shift was President Lamizana's announcement of a broad national program of *développement communautaire* in 1974. In reality, under the influence of the international community (notably FAO), only the Ministry of Rural Development made an effort to implement the initiative. This led to the elaboration of a program of *développement communautaire* in five villages per ORD that paralleled the mainstream extension activities of the ORD. During the same time, the regular extension programs of the ORDs were expanded to include livestock, reforestation, soil, and water conservation, as well as basic education and an affiliated national program of *Centres de Formation des Jeunes Agriculteurs* (Young Farmer Rural Training Centers, CFJA).[1]

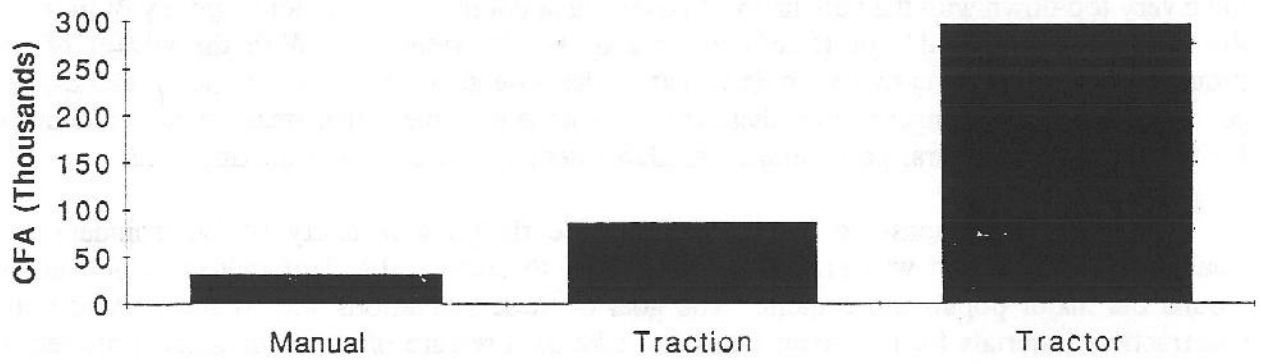
This same period was characterized by a steady increase in the role of NGOs in the agricultural sector. Most NGOs hired their own extension staff, which resulted in a certain amount of overlap of extension themes and participatory approaches. In the Kaya region, it was not uncommon for the same village to include the simultaneous operation of one ORD *groupement* and a second *groupement* served by an NGO like the Association for the Regional Development of Kaya (ADRK) or the international NGO Foster Parents Plan.

The "integrated" or "regional" development projects supported by the World Bank after 1975 reflect the expanded focus of the ORDs. The most participatory of the World Bank-supported initiatives in this period were the Rural Development Funds (FDR I (1972) and FDR II (1976)). These projects emphasized the establishment of a decentralized planning system and the identification of micro-projects by the beneficiaries. The results were spectacular: 230,000 persons affected by the FDR I, 160,000 affected by the agricultural programs associated with FDR II, 125,000 persons benefiting from the improved water supplies developed by FDR II, and numerous people benefiting from the FDR's programs for basic literacy or the other technical services the project provided. FDR I and II emphasized beneficiary involvement in project identification as well as construction.

All of the other large-scale integrated development projects funded by the Bank were in the high-potential west. In contrast to the FDR projects that covered an entire region (the central plateau), these integrated development projects supported the development of one or two adjacent ORDs. As in the earlier Upper Volta Cotton Project, the concept of local participation was defined primarily in terms of the people's execution of the recommended technical package that they themselves did not conceive but may have identified.

The evaluation literature highlights the positive production resulting from these projects. For example, the Haut Bassin and Boucle du Mouhoun Development Projects recorded an almost fourfold increase in the number of farmers affected by crop extension programs--from 10,500 to 38,000. Total cotton production doubled during the same time. With stable cotton prices, the increased cotton production resulted in a parallel increase in living standards for the settlers participating in the new technology. Survey research conducted in two of the target villages covered by the ORD extension programs (Upper Volta Cotton Project (1970), West Volta Agricultural Development Project (1979), and Boucle du Mouhoun Agricultural Development Project (1982)) showed settlers with animal traction having a net agricultural income from collective fields that was 2.5 times higher than for those without (McMillan, Nana and Savadogo 1993:66; Savadogo, Sanders, and McMillan 1989). The net income figures were even higher (even after deducting the substantial costs of mechanized cultivation and fertilizer) for the small percentage of farmers who leveraged their success with animal traction into the purchase of mini-tractors (Figure 3.1). The same projects permitted the realization of basic infrastructure including cereal banks, warehouses, mills, and rural roads, with high levels of local participation in construction and maintenance.

Figure 3.1. Average net crop income per Adult Labor Equivalent (ALE) for households in the major technology groups



Source: McMillan, Nana, and Savadogo 1993:66-67

Another result of early World Bank funding for the Haut-Bassins, Boucle du Mouhoun, and First Bougouriba Projects was the development of new models for improved extension. The evaluation of the program showed that substantial "production increases seemed (sic) to be linked to the increased presentation of impact points by agents and the resultant increase in farmer adoption of the T&V message" (World Bank, AF5AG, n.d.:5). In contrast to the classic Training and Visit (T&V) system that emphasized individual contacts, the revised model emphasized the extension agent meeting with two to three groups of farmers every 15 days.

By far, the major criticism of the World Bank support for these "integrated" regional development projects was that they accelerated the existing immigration to the zone (PDA-HB 1989; PDA-BM 1989). The final evaluation of the Hauts-Bassins Development Project (PDA-HB 1989:19) estimated that 53% of the population increase during the six-year period covered by the project was attributable to immigration. Between 1975 and 1983, the Mouhoun River Basin (ex-Black Volta) experienced a much higher rate of new land clearance than the Nakambe and White Volta Basins (a sixfold versus a threefold increase), in large part because of the much greater potential for commercial cotton production in the zone (Hervouet, Clanet, Paris, and Some 1984). The final evaluation of the Boucle du Mouhoun project concluded that the high rates of uncontrolled, spontaneous settlement (PDA-BM 1989:42):

> is leading to a situation that is endangering the ecological equilibrium of the zone and that risks, over the long-term, to degrade the land capital on which all production activities depend. Under these circumstances there is an urgent need to conceptualize a new approach that would permit us to master this phenomenon and integrate it into a long term program for rational natural resource management.

Natural Resource Management. Prior to 1974, there was little concept of participation in the wider domain of natural resource management; actually, there was little concept of natural resource management at all except for forestry. And even forestry programs continued to be very top-down with the new national government continuing the colonial policy of policing the country's "classified" (protected) forest and wildlife reserves. With the advent of the drought, it became increasingly obvious that in the absence of expensive policing tactics, the government could no longer protect these zones from the growing urban areas' increased demand for firewood and the rural populations' insatiable demand for crop and grazing land.

The initial response to the problem by the fledgling Ministry of Environment and Tourism (MET), which was created in 1976, was to create a band of industrial plantations around the major population centers. The goal of these plantations was to supply wood and construction materials for the major cities and take the pressure off the remaining protected or forest zones. People participated in these projects as paid workers. The local populations understood very little about the objectives of the project, and even sensed that the projects competed with them by reclaiming their fallow fields. The lack of "ownership" resulted in continued practices like illegal burning and cutting. In the absence of responsible ownership, the only way to restrict illegal cutting was through a continuation of the earlier police methods. This resulted in extremely high costs per hectare (between 200,000 and 250,000 CFA/ha). The net result was that, despite colossal investments, the area actually reforested between 1973 and 1977 barely surpassed 17,442 ha (FAO 1978), and even these areas were seldom manageable once special project funding was withdrawn.

From 1976 to 1982, the term *foresterie villageoise* was applied to a wide variety of MET activities concerning trees and their place in the rural context. The medium- and long-term goals of the program were to increase the local population's understanding of natural resource issues; to satisfy the villagers' need for renewable fuel wood; to preserve soil fertility and fight against

erosion; and to increase the farmers' income from renewable forest resources, including the sale of wood, fruit, and gum. In the short-term, the project placed a strong emphasis on training and public information. This information campaign was carried out by the Ministry of Environment in collaboration with the Ministry of Agriculture through the ORDs and the ORD extension agents. Once people agreed to carry out a project, they were provided appropriate varieties (free) from which they were allowed to choose.

Despite the short-term record of the these initiative in promoting the concept of village-level forestry and forest conservation, the program was not perpetuated. Two reasons were that the long delay between planting and harvesting produced a sense that the village forests did not respond to immediate economic needs for cash and that the revenues were supposed to be shared by the entire group involved in planting. Even when villages harvested the trees, the selling price was depressed by the lack of laws restricting illegal cutting. Thus the entire enterprise was perceived as something imposed by the government. A 1988 post-evaluation of the project noted that the most successful activities were those undertaken by individuals and families (MET 1988:80).

To complement the national program for industrial plantations and *foresterie villageoise*, a third program was started that focused on fuel conservation, specifically the extension of different models of improved wood stoves design. The program was especially concerned with reducing fuel consumption by women, who were the major wood consumers. Groups of women were trained in the construction and maintenance of the wood stoves by specially trained extension *animatrices* (female extension agents), usually through special donor and NGO-financed projects. The *animatrices* taught women about the benefits of the stoves in terms of increased leisure and more efficient cooking. Here again, the project evaluations showed a high level of initial adoption but relatively little sustainability once special funding for the *animatrices* was withdrawn. The chief criticisms were the large amount of labor involved in maintaining the stove and the lack of any real understanding of the stove's benefits. Again, the summary reason appears to be the same as for the village plantations: these labor and fuel-saving devices did not respond to the settlers' immediate needs.

A fourth set of programs focused on the management of the natural forests with high levels of local participation. In contrast to earlier forest projects that "classified" the forests and forbade local populations to use the protected zones, the objective of these projects was to implicate the local populations living in and near the forests in the sustainable management of the area. To carry this out, most projects included the creation of forestry *groupements*, modeled on the *groupements* used to promote commercial crop production. The forestry *groupements* were charged with the exploitation, protection, and sale of wood and renewable forest products like fruits and honey. The same projects created *groupements* of wholesale wood transporters who were charged with bringing the wood to town to sell. The third component of these projects created a system of resale. Conceived in 1982, the first projects were implemented in 1985. The early results of these projects in terms of income growth and conservation have been quite positive.

1983-present

The revolutionary government brought about a dramatic reorientation of development policies for natural resources in Burkina Faso. The central thrust of these policies were:

- a redefinition of development to include the concept of environmental sustainability;
- a deliberate attempt to expand the focus of "local participation" to embrace the conceptualization and management of development initiatives as well as their execution.

The formal announcement of this new "integrated" concept of environmentally sustainable rural development with high levels of local participation was made in the 1984 *Réforme Agraire et Foncière* (RAF).[2] A second important piece of legislation was the 1985 *3 Luttes* (3 battles) campaign against the evils of unsupervised grazing, illegal bush fires, and illegal wood cutting.

One of the most important developments was the creation of a national extension service in 1985 based on the modified T&V methodology that had been tested in the World Bank-supported Bougouriba, Haut-Bassins, and Boucle du Mouhoun Projects. Under the new model, the themes and activities of extension are identified by regular exchanges between extension agents and farmers. Extension demonstrations on farmers' fields, monthly workshops, training sessions, and periodic technical reviews that group together farmers, researchers and extension agents are the primary means of communication between the groupements and the extension service. This national program is supported by the World Bank through the Agricultural Support Services Project (PRSAP). Our interviews with beneficiaries and technicians, and other studies, suggest that the development of this new system of communication has helped the state structures to be more responsive to the needs of local populations and to better harmonize, coordinate, and evaluate their crop extension methods.

At the national level, the Rural World Department (DMR) (a think tank created under the revolutionary government and attached to the Office of the President) was charged with the task of translating the RAF legislation into a broad-based policy for natural resource management. At the initiative of the DMR, two joint meetings of the World Bank, the *Gesellschaft fur Technische Zusammenarbeit* (German Development Agency, GTZ), the *Comité permanent inter-états de lutte contre la secheresse dans le sahel* (CILSS), and the *Caisse Française de Développement Centrale* were organized in 1986. The goal of the meetings was to define a national program that would help villages and regional development authorities with the implementation of the themes advocated by the RAF and 3 *Luttes* (Guyon 1986). The committee presented a four-step village program that called for high levels of village participation in the conceptualization, execution, and evaluation of natural resource management programs (Box 3.1).

Box 3.1. Four-Stage Model for GTV

Step One: Information and Election of a Village Land Management Committee.
A series of information sessions to inform villagers of the goals and necessity for this type of program precedes the village's election of a land management committee responsible for determining land allocation and dealing with outside authorities. The committee includes representatives of the major social groups living in the village (recent immigrants, the indigenous population and pastoralist).

Step Two: Delineation of the Village Frontiers.
The rights of each group must be represented in the delineation of village boundaries. These boundaries are based on soil and topographic maps drawn from aerial photos. The delineation is organized by the village land management committee working in cooperation with regional authorities and neighboring villages.

Step Three: The Village Contract.
Once the village limits have been identified, the committee negotiates a signed contract between the village community (represented by the committee) and the state. The community agrees to respect certain themes for soil and forestry conservation, improved pasturage, and suppression of bush fires. In return, the state agrees to help the villages with the realization of basic infrastructure and land improvements that they request. In theory, the village contract and land survey guarantee official recognition of the villagers' rights to the land and any future improvements that they make on it.

Step Four: Realization of the Terms of the Contract.
The villagers and state realize their contracted benefits.

A national Coordination Unit was created in 1986 to help the ministry implement a series of pilot projects following the village land management model. The unit provided some limited assistance with the conceptualization of pilot projects. It was first attached to the Ministry of Plan and then to the Ministry of Agriculture, and received support from the World Bank, Caisse Française, and other donors. During the first three years, the unit's activities focused on monitoring the pilot projects in an attempt to refine the program's guidelines and recommendations. The global program was referred to as the *Programme National de Gestion des Terroirs Villageois* (PNGTV). Based on the experiences of the pilot phase, the *Programme National de Gestion des Terroirs* (National Program for Land Management, PNGT) was established in 1992. Since then, the World Bank has supported the development of PNGT in five provinces (Gnagna, Kouritenga, Kenedougou, Bougouriba, and Houet) through the National Environmental Management Project. Similar programs are supported by other donors in another 18 provinces.

Although all of the PNGT projects follow the same general model, there are small institutional and methodological differences.[3] One of the distinctive features of the World Bank-supported programs is the use of interdisciplinary mobile teams (*équipes mobiles pluridisciplinaires*) to work with the village land management associations and the regional ministry offices and NGOs intervening in the target villages. Although it is too early to see measurable results from the PNGT methodology in terms of improved natural resource management, the administrators, beneficiaries, and technicians were effusive in their appreciation of the concept. The major criticisms that were raised had less to do with participation than with the institutional means of achieving that participation and linking it to wider state structures.[4]

Lessons Learned: Key Institutional Issues in Participation

1. Planners need to allow for a long planning phase

The historic analysis underscores that a longer-than-average planning phase is needed to develop appropriate institutional models for popular participation in natural resource management. The early cooperative structures were introduced hurriedly following a European model. These structures were modified over several decades, reaching their current form only in 1974 under the national initiative to promote *développement communautaire*. The World Bank effort to promote the T&V model of extension was able to short-cut at least part of this lengthy process of selective adoption and rejection by sponsoring a "test" period through the World Bank-supported First Bourgouriba, Haut-Bassins, and Boucle du Mouhoun Projects. Based on this experience, the Ministry of Agriculture introduced a modified version of the T&V through the new National Extension Service, which was created in 1985; this national extension services is supported by the World Bank through the PRSAP.

One interviewee described the six-year PNGTV project as a period of "controlled chaos" during which there was free discussion, testing, and evaluation of the basic concepts. One result was a broad based sense of "ownership" of the basic concept by the sponsoring donors and government agencies. This shared conception, shared language, and shared experience accounts for the active exchange of ideas and information between component projects from an early stage.

The PNGTV experience confirms the point made by other studies (Faure 1992) that a long pre-planning design period is absolutely essential if beneficiaries are to understand a program enough to have any real input into the program goals or mechanisms of participation. In the case of agricultural *groupements*, this type of "apprenticeship" occurred in the course of their early participation. It is not by accident, then, that we start to see the beginning of more experimental models of *groupement* activities (such as the farmer-managed markets and village association investments in the development of health and schools) only in the late 1970s, after an initial five to ten year "training" period in the successful regional cotton development programs.

The PNGT pilot projects and follow-up national program hope to shorten the time between passive and active participation in the program by providing for a long up-front period of public information and discussion.

2. Planners need to link the achievement of medium- and long-term development objectives to activities that respond to an immediate economic need

Burkina Faso's historic experience with *groupements* shows that farmers were most likely to be attracted to group activities that offer the prospect of some immediate effect on their families, like the high-yielding cotton program. Conversely, farmers were less willing to participate in activities that invoked their participation in the name of some abstract collective good, like the village forestry initiatives.

The historic analysis notes that if these interventions are successful in the short-run (stage one), they create a group of farmers with greater resources and higher expectations in stage two. Studies show that at this second stage the immigrants and indigenous farmers associated with the successful cotton projects were most willing to invest in a more diversified group of development and environmental activities. For example, by 1990, 48% of the health infrastructure in prosperous southwest Houet province had been established by successful *groupements* (Ciardi et al. 1993:103). This was typical of the southwest cotton "boom" area where groupements had a strong investment record in social infrastructure from schools to health facilities, pharmacies, and hydraulic projects (PDA-BM 1989; PDA-HB 1989). As the concept of the *groupement* is expanded to include other professional groups including foresters, butchers, herders, we are likely to see a similar investment in economic diversification into other areas.

3. Planners need to link participatory environmental management with targeted support to develop reinforcing economic activities and infrastructure

In the absence of some sort of readily understandable, demonstrated economic opportunity--like the cotton production associated with the first and second generation of World Bank-sponsored integrated development projects or the anti-erosion measures, wells, and roads associated with the World Bank-sponsored FDR I and FDR II--it becomes more difficult to mobilize local participation to achieve a collective development goal. This is why the World Bank-supported PNGTV pilot project and national PNGT project developed the concept of the "village contract" (Box 3.1). The village contract obligates the state to work with supportive ministries and NGOs to realize identified projects if the participants in turn agree to follow new intensive land use practices.

While all PNGTV programs share this general concept, they differ about the most appropriate means of achieving it. One model, exemplified by the German-funded UP10 in Bougouriba and the French-funded UP1 project in the Ganzourgou Province, provide the project administration with a fund with which to finance activities outlined in the village contracts. A second model, which is followed by the World Bank-supported PNGT program (in five provinces), requires the interdisciplinary mobile teams to work with the regional ministry and

NGOs to fund these activities through their existing budgets. The administrators, technicians, and beneficiaries we interviewed expressed strong feelings about both models. Although the UP10 model of autonomous finance is more efficient in the short-run, it poses questions about the willingness of the ministries to shoulder the recurrent costs of these operations. An additional concern is that the presence of autonomous funding tends to perpetuate a "project" mentality and to discourage the willingness of the ministry offices to support the recurrent costs of maintaining and staffing these facilities. This was a persistent problem in many of the "integrated" development projects of the late 1970s. The counter-argument that emerged from many of the interviews was that the lack of targeted funding for these complementary inputs--such as is characteristic of the World Bank-sponsored PNGT program--made it unrealistic to think that the project could rally any short-term support.

Conclusion

This historic analysis shows a slow but steady evolution of the concept of participation in the execution of agricultural programs in Burkina Faso. This evolution has been supported by a parallel process of judicial, macro-institutional, and local institutional change (Table 3.2). This is a process that the World Bank supported through almost 20 years of investment in large-scale, regional development projects in Burkina Faso's southwest. Since 1983, the concept of participation has been expanded to address agriculture within the wider context of natural resource management through the national PNGT and PRSAP initiatives.

The early "success" of the World Bank-sponsored integrated development projects in Burkina Faso's west built on more than 50 years of French-sponsored research, extension, and legislative reform supporting pre-cooperative *groupements* and commercial cotton production. There was never any strong economic incentive for a similar body of research and legal reform for natural resource management. Nevertheless, there is a growing body of evidence that many of the spectacular results of the early cotton programs are not sustainable. Some of the most damning evidence is the growing evidence that many of the "cotton boom" provinces that were immigration zones 10 to 20 years ago, such as the northern zones of the Mouhoun CRPA, are now emigration zones as people move to the south (World Bank 1990:9). These immigrants are not returning to the deforested Mossi Plateau, but moving into the still forested Bougouriba and Comoe areas (McMillan, Nana, and Savadogo 1993).

This long evolutionary process needs to be considered when policy makers compare these earlier projects with current programs like the PNGT. We can anticipate that the measurable results in terms of increased production and living standards will be less spectacular than for the previous generation of regional development projects. No one argues that the earlier World Bank-sponsored regional development projects to promote cotton were bad. Their economic impact was quite positive. And, as a result of these projects, large numbers of limited resource farmers are better off than they would have been if these projects had never existed. The same goes for the Burkinabè government.

The central argument of this chapter--which is also an important lesson for the Bank-wide Learning Process--is that, while many aspects of these early participation development models were good, this type of sectoral project that focuses exclusively on increased production set in motion a series of environmental changes that threatened the long-term sustainability of the results. Although the PNGT project is still in an infant stage, it shows promise as a methodology for linking individual aspirations for increased productivity and higher living standards to national goals of sound natural resource management.

Chapter Four

Health

For most of the colonial period and the first 20 years of independence, Burkina Faso's rural populations participated in the formal health sector as passive beneficiaries of disease vaccination and diagnostic services. In 1979, the country embarked on a major decentralization of health infrastructure and personnel. The ultimate goal of these policies was to raise rural health standards by developing a sustainable system of participatory health services at the village and district level. The implementation of this new decentralized system was accelerated by two mass mobilization campaigns to increase the rate of vaccinations (1984) and to construct *Postes de Santé Primaire* (Primary Health Posts, PSP) (1985).

Although these "commando" health campaigns had an immediate and dramatic effect on health standards and infrastructure—for example, increasing the rate of vaccination coverage from 2% to over 60%, and increasing the number of PSPs from 964 to 5,992 (Savadogo and Wetta 1991:31; Sombié 1990)—these results were not sustainable. The primary reason was that, except in a few isolated cases, the local populations where not able to fully participate in the management of their primary health system. Even in the cases where the beneficiary organizations, NGOs, or ministry structures did succeed in establishing a system of autonomous management to ensure sustainability, the scope for action of these systems were often reduced by a law requiring the central management of all financial revenues coming into the clinics, pharmacies, and hospitals. The Burkinabè government has just enacted new legislation that permits more decentralized health management and accounting. This legal reform is being supported by the World Bank and other donors as part of a more broadly based initiative to improve the health and living standards of the population by developing sustainable, low-cost rural health systems.

The paradigm shift that has resulted in changes from a top-down ministry of health care services and drugs to village participation in defining and developing its own health care systems has not been easy. A variety of factors have encouraged or discouraged the process (Table 4.1). These factors need to be understood in a historical context.

History

Traditional Medicine and Local Participation

While Western medicine is perceived as coming from the outside, the concept of local participation is deeply enmeshed in the traditional health care system, which continues to serve as the main source of medical knowledge for a high percentage of the Burkinabè population. The universe of traditional medicine is highly diversified and includes all-purpose healers as well as specialists such as herbalists, bonesetters, old women who treat

Table 4.1. Factors affecting local and national level dialogue toward more participatory approach to health care distribution

Factors Encouraging Dialogue	Factors Discouraging Dialogue
National and international recognition of participatory paradigm (e.g. Alma-Ata Declaration and Bamako Initiative)	False conceptions in these participatory paradigms which encouraged planners to execute them in a naive fashion, such as: 1) village communities are "homogeneous" and therefore inter-village disputes do not occur; 2) increased understanding leads to increased acceptance of ideas and changes in behavior; 3) village community leaders will place needs of village ahead of personal needs; 4) the evolution toward participatory approaches will be a peaceful process without conflict between planners and local communities
National and international financial support for participatory paradigm (e.g. World Bank)	Treasury Laws which require central management of all funds earned from the sale of services and drugs
Open analysis and critique of early attempts to develop participatory approaches by the health ministry and supportive donors (WHO, UNICEF, World Bank) and NGOs	Insufficient research and exchange of research findings analyzing factors that contributed to or detracted from successful village health committees' activities;
Increased literacy rates (commando literacy campaigns) which reinforced the capacity of the village health committees to manage their local health facilities	Low literacy rates which impeded the ability of village committees to manage funds in a sustainable fashion
Presence of NGO (in the central and north) and Village Association (predominantly in the south and southwest) community development structures that take an active interest in the development of health services for their members	Village health committees and/or Ministry staff which do not coordinate with existing institutions to mobilize participation
Ability of the national health ministry or an NGO to reinforce local level initiatives with needed training, equipment and drugs	Heavy concentration of services in the urban areas making it difficult to supply rural and district units with the quality of services they expect
Pilot Projects or Studies (like the Boulgou Study) which give planners and beneficiaries enough time to understand the project goals and to adapt the management structures to local social and political realities	Projects which introduce the village management committee concept quickly with insufficient time for explaining their goals or how they should operate
Presence of start-up funds (seed money) to stimulate and reinforce local interests in participatory approach to the execution or maintenance of health projects	

children's diseases, Moslem therapist diviners (*marabouts*), and an emergent category of protestant "pastors" (faith healers) (Ciardi et al. 1993:24; B. Ouedraogo 1993). In the past, as today, the local healer is generally integrated into the patients' community or into a social network (in another village) that is linked to the patients' community. With rare exceptions, payment is in-kind, and the entire family takes responsibility for the sick person, participates in the different sacrifices and rites, and searches for medicinal plants.

Colonial Period

With the increase in French soldiers, their families, and native auxiliaries in the colony, the French government introduced a health care ministry that was top-down, based on the health care system in France. Western allopathic medicine was introduced and traditional native medicines were theoretically outlawed. The urban health system revolved around a series of military and Catholic hospitals and dispensaries. In the rural areas, a series of *équipes mobiles* (mobile health units) monitored and treated the major epidemic diseases in the rural areas. These health services were provided free of charge to citizens, but there was no notion of patient participation. The colonial health service worked through the chiefs and traditional leaders to convoke villagers for diagnostic sessions (to monitor disease incidence) and vaccinations campaigns with virtually no explanation as to what was happening or why. Despite local resistance, the imposition of these top-down, non-participatory health services had spectacular results in reducing the major epidemic diseases like meningitis and sleeping sickness. However these same top-down methods inculcated an attitude of passive (and sometimes active) resistance to Western medicine.

1960-1980

Between 1960 and 1978, the different national governments worked to reinforce the basic infrastructure and personnel to promote a better health coverage with the system of hospitals, dispensaries, and mobile health units that they inherited from the French. One result was a modest increase in the ratio of doctors to population: from 1 to 100,000 inhabitants in 1960 to 1 to 58,824 inhabitants in the early 1980s (Table 4.2). The rate of nurses showed only minor increases (1 nurse to 4,090 persons in 1960 increasing to 1 nurse to 1,387 in 1981). Census figures estimated that the average life span increased from 33 in 1960 to 43 years in 1981, due in large part to a substantial decrease in child morality that none-the-less still remained one of the highest in the world (Savadogo and Wetta 1991).

The 1968-1973 drought was an important turning point. Most notably the health and nutritional crises provoked by the drought provided a vivid illustration of the inability of the impoverished health ministry to provide adequate health services at the regional and village levels. The same period was associated with the massive arrival of international NGOs like CARE, OXFAM, Foster Parents Plan, and Save the Children, many of whom had a strong interest in basic health and sanitation. While some NGOs only intervened in the health sector, others were interested in general community development, of which health was one aspect.

The early NGOs were especially interested in infant and maternal nutrition (almost 50% of the children examined by health personnel in 1978 showed signs of malnutrition) (Sombié 1990:6), increasing sanitation to control communicable diseases, and establishing village- and regional-level community health systems. Since then, a number of international and national NGOs have created highly successful village and district level health programs (see Boxes 4.1 and 4.2).

Table 4.2. Social indicators for the health sector, 1960-1987

Indicator	1960	1981	1984	1987
Deaths per 1000 Live Births	252	134	--	--
Life Expectancy	33	43	44.7	48.5
1000 Inhabitants per Physician	100	59	46	28
1000 Inhabitants per Nurse	4	3.8	--	a
Percent of Births per Qualified Assistant	--	--	20	32

-- Information not available to the author at time of publication

[a] One health agent per 26 inhabitants
Sources: Sombié 1990; Savadogo and Wetta 1991

Box 4.1. Indigenous NGOs and Participation in the Health Sector, Department of Saponé

The Department of Saponé includes a community-based NGO that was founded by native intellectuals and civil servants who, through their connections, have access to both government and international organizations. This NGO provided most of the funds for the construction and equipment of a spacious CSPS. In the same area, another local NGO, which has a strong performance record in various development sectors through the Department of Saponé and other outlying departments, has significant financial resources and is willing to contribute funds to initiatives, projects, or infrastructures in the health sector. The latter NGO also served as the main intermediary between the Department of Saponé and the city of Brest (France), which donated the funds for a medical analysis laboratory (now part of Saponé Medical Center) (Ciardi et al. 1993:102-103).

Box 4.2. Community and NGO Participation in the Development of Primary Health Care in the Sissili Province

Soubeiga (1992, 1994) argues that the chief reason for the recent low levels of use of the district CSPS and village-level infrastructure for primary health care in the Sissili Province can be traced to the state's systematic introduction and imposition of its own structures for community mobilization in the health structure through the Committees for the Defense of the Revolution (CDR) after 1984. He bases this argument on a comparison of current levels of participation with the high levels of participation and success that the Village Health Posts (PSP) enjoyed under the SNV (Netherlands Development Assistance) program, *Projet Soins de Santé Primaire* (SSP). SSP's focus was to develop PSPs in three departments in the Sissili Province between 1978 and 1982. After the revolution, the commando "1 Village=1 PSP" campaign established PSPs in the province. However, the PSP that were established through the commando campaign enjoyed low levels of success and, in some cases, were completely abandoned.

The SSP pilot project was implemented in three stages: 1) an initial information and training phase that associated all the key actors (traditional leaders, elders, etc.) to develop a plan for the community participation in the construction and management of the health centers, 2) an implementation phase that consisted of the creation of the PSP structures, selection of the village health agent, election and training of the health committee, and establishment of the first village pharmacy, and 3) a management phase that included periodic retraining of the village committee and health agents.

The results of this particular model for participation were known nationally. Local leaders supported the program and the villages, with rare exceptions, were able to maintain the basic services and drug stocks.

With the advent of the "commando" program, "1 Village = 1 PSP", the zone of the SNV Primary Health Project (SSP) was expanded from the three villages to cover the entire province. In contrast to the earlier pilot project, the commando project worked directly with the CDR, with virtually no attempt to involve the traditional leaders. In addition, no attempt was made to prepare the local people via public information campaigns or training. Once the community participated in the construction of the PSP building, there was a two-week training course for the village health agent. In addition, the PSP was equipped with a stock of basic drugs and equipment including a wheelbarrow and a bicycle for the health agent.

Many of the new PSPs functioned for the first six months. Most, however, ran into difficulties when their initial supply of drugs ended. With few drugs, and agents who were perceived as poorly trained, the PSP gradually lost their credibility and attendance dropped.

Because of the weak health situation and the seeming inability of the top-down system inherited from the French, the government enthusiastically welcomed the primary health care approach adopted at the international World Health Organization (WHO) Conference at Alma-Ata in September 1978 (Sombié 1990:7).[1] The Health Ministry responded with a Ten-Year Health Program covering the period 1980-1990, which was approved by the Council of Ministers on 14 March 1979. The Program outlined a five-tier health pyramid comprising:

- 2 national hospitals (Ouagadougou and Bobo-Dioulasso)
- 10 regional hospitals
- one medical center for every 150,000 to 200,000 inhabitants
- one health and social action center (CSPS) for every 15,000 to 20,000 inhabitants, serving a maximum area of 20 km
- one primary health post (PSP) in each village

This new structure aspired to establish one PSP in each village staffed with one volunteer village health worker and one volunteer village midwife. These two would be responsible for simple health activities such as applying dressings, treating malaria and diarrhea, normal deliveries, and hygiene advice/education. A village committee would oversee the building of the PSP facility and the in-kind compensation of the health care workers. Money and supplies would continue to be distributed through the centralized health ministry, but the villages would provide in-kind compensation to the PSP workers (such as help in the workers' family fields, food, and some of the profits from the sale of pharmaceutical) and the actual construction labor of health care facilities.

Despite this formal decentralization of the health infrastructure, information continued to be from the ministry to the population through the traditional leaders. The villages provided little, if any, communication back to the ministry. Especially important, the government returned only 75% of the income from medical charges to the Ministry of Health to pass on to the Provincial Health Boards (Sombié 1990:9). Profits from the drug sales were returned to the central treasury, making it difficult to fund replacements and recurrent costs.

The First World Bank Supported Health Project

The first contacts between the Burkinabè Health Ministry and the World Bank came about as the government was seeking funding for its 1980-1990 Ten-Year Health Program. Although planning started in 1982, the execution was delayed until 1986. The final project plan outlined five priority areas: 1) extension of the vaccination and family planning programs, 2) retraining personnel, 3) construction of around 120 district level Health and Social Promotion Centers (CSPS) serving several villages each, 4) reinforcement of the central ministry staff, especially in the field of planning and evaluation, and 5) a pilot project/study on cost recovery and the distribution of basic drugs.

In the original project plan, the construction and rehabilitation of the CSPS would be done by the local populations under the supervision of the government's *Fond de l'eau et de l'équipement Rural* (Rural Equipment and Water Fund, FEER). FEER was responsible for providing the cement, iron clamps, and iron roofing materials; the local populations were responsible for providing sand and gravel and the non-specialized construction labor. FEER encountered enormous difficulties in transporting these materials and in supervising the work. This resulted in the construction contracts being transferred to private firms.

A second important component of community participation in the World Bank-sponsored 1980-1990 Ten-Year Health Program was the pilot testing to explore the development of a system for partial self-financing of health services. This pilot study was conducted in the Boulgou province. The first step was informing the local authorities and populations about the ultimate goals. The second step consisted of organizing a *cellule de santé* (health committee) that included an elected president, vice president, secretary, treasurer, and accountant. The health committee was responsible for managing the village health unit and pharmacy based on the money accrued to the centers through consultations and drug purchases. The Ministry of Health's research team established contracts between the government and the village *cellules* to provide personnel, supplies, and drugs in exchange for the *cellules'* management of a sustainable PSP, the finances for such to come through the sale of drugs at the village pharmacies. A second contract was signed between the *cellules* and the manager of the village pharmacy, the health care worker, and the midwife (each recruited by the community) stating the grounds for dismissal (such as theft or poor quality work). While the final evaluation of the Boulgou project identified a number of weaknesses, the basic program allowed the population to participate in the management of its local health system. Based on the pilot study, the government outlined a series of recommendations for the type of fiscal decentralization and local training that would be necessary to create a similar system of community health management nationwide.

1983-1987

Despite the severe budgetary constraints caused by Burkina's "self-imposed" program of structural adjustment (Savadogo and Wetta 1991), total funding for the health sector remained between 6.90 and 5.80% of the national budget. The funding levels rose from 0.91% to 1.13% of GDP between 1980 and 1987, and per capita health care expenditure in 1980 prices advanced from 388 CFA frances in 1983 to 491 francs in 1987 (UNDP and World Bank 1989 in Savadogo and Wetta 1991:31).

In theory, the formal institutional structure of participation in public health was the same as that established during the 1980-1990 Ten-Year Health Program. The primary difference was the use of the revolutionary committees as the principal mechanism for the transmission of the "participatory messages" in three key areas:

- *Planning*: the identification of village needs in the *Plan Populaire du Développement* (Popular Development Plan, PPD) (1984-1985) and the *Plan Quinquennal* (Five Year Plan) (1986-1990)

- *The Commando Vaccination Campaigns* (1984): a massive two-week national campaign to elicit popular participation in expanding the number of children presented for vaccination against measles, yellow fever, and meningitis

- *Operation 1 Village = 1 PSP* (1985): a massive campaign to elicit local participation in the construction of village level health centers[2]

Despite the rhetoric of "participation," the local participation in project planning and the implementation of these "commando" campaigns continued to be top down. The long process of referral from village to district to province meant that few of the villages' identified health needs were reflected in the actual PPD or *Plan Quinquennal*. In general, the final decisions about community participation continued to be taken by the political/administrative authorities and the structure of the participation was defined by the government or health ministry professionals. In addition, this participation was primarily defined in terms of the execution of project activities, like vaccination campaigns or construction.

Nevertheless, the short-term results of the commando vaccination and construction campaigns were quite positive (Table 4.2). The number of PSP increased from 964 to 5992 between 1981 and 1986 (Savadogo and Wetta 1991). In addition, the population contributed to the construction of 24 district-level CSPS, 6 birth centers, 90 pharmacies, 28 dispensaries, and 1 medical center. During the same time a total of 14,000 village health agents and midwives were trained. Between 1983 and 1987 the number of regional hospitals increased from five to nine; the number of CSPS from 42 to 55 and the number of dispensaries and birthing centers (*maternités*) from 253 to 396. In a one year period, the number of village drug stocks (*trousses*) increased sixfold—from 2,400 to 12,667 (MSAS 1988:18). By the end of 1987, 6,932 of the 7,285 villages counted in the 1985 census (95.15% of the total) had a PSP (MSAS 1988:30).

The commando vaccination campaign was a major success, increasing immunization coverage for measles, yellow fever, and cerebrospinal meningitis to an unprecedented 60-70% children between 9 months and 14 years of age (Sombié 1990:20). This compares with the earlier rate of 2% in 1981, the year after the Expanded Immunization Program started (ibid).

The chief problem was the long-term sustainability of these positive gains. Once the commando campaign ended, vaccination rates dropped dramatically, especially for vaccines that had to be administered in several does (from 60-70% to 9% for DPT-polio and 33% for BCG) (Sombié 1990:20). The massive expansion of health infrastructure surpassed the capacity of the health ministry to either provide or supervise the health workers (MSAS 1988:20-21). In addition, few CDR or village health committees had either the literacy or accounting skills to manage the money earned from the sale of health services and drugs. Indeed, very few of the *cellules* functioned except in name alone. With few exceptions, the PSPs that functioned most successfully were those that were supported by NGOs or *développement groupements* (Boxes 4.1 and 4.2). However, even these NGO programs (by their own analysis) defined their role primarily in terms of program execution with very little real participation in the conception or management of the local health units (MSASF 1992:25).

1987-Present

The Ministry's reflection on the sustainability of the commando campaigns coincided with announcement of the WHO's Bamako Initiative in September 1987. The Bamako Initiative emphasized the need to create management systems that allow local communities to recover the costs of the essential drugs that are an absolute necessity for the sound functioning of rural health systems. The government of Burkina Faso subscribed to the Bamako Initiative and instigated a long process of research and reflection on how best to achieve this type of decentralized health system. One result was a series of Ministry sponsored and co-sponsored studies and seminars to identify the key constraints to participation. The World Bank and various World Bank-supported activities (including the design, supervisory missions, and evaluation of the first Health Services Development Project and the Preappraisal Mission of the new Health and Nutrition Development Project) played a major role (see World Bank, AF5PH 1985, 1991).

An important recent event was a national workshop on primary health care that the Ministry organized at Bobo-Dioulasso May 5-8, 1992. The goal of the workshop was to define the general orientations for a national policy on primary health care (MSASF 1992). Some of the identified constraints to achieving increased participation within the existing decentralized structure were: the high concentration of personnel in the two major urban centers, Ouagadougou and Bobo-Dioulasso; and the lack of any real decentralization of decision-making. By far, the major constraint was the lack of any real decentralization of health finance due to the treasury finance laws that required funds earned from the sale of health services to be remitted to the central Ministry.

This lack of decentralized finance emerged as a key factor in this and other studies' analyses of successful health programs. Ciardi et al. (1993) note that the lack of decentralized financial management crippled the non-pharmacy components of the "participatory" model for CSPS management, which was being supported by the World Bank, USAID, CUAMM (an Italian NGO) and the Italian government in the Boulgou Province. To counter this problem, the successful program to create Inter-village Health Committees (CSIV) in Houet Province (1986-1990) had to obtain special permission from the provincial high commissioner (Box 4.3; Sondo, Traore, Sangare and Youl 1993). The final evaluation of Project BKF/83/CO4 and BKF/4/001 (PNUD-UNICEF) in the central north Sanmetenga Province (Kaya) noted that a substantial portion of their program (70% costs of the renewing the drug stocks, 20% of hygiene products purchased, and 70% of the costs of building maintenance) were financed by the "illegal" procedure of keeping a portion of the funds earned from drug sales and consulting fees at the provincial level (Galland and Vignal 1989:76). The same evaluation noted that the issue of financial decentralization needed to be given top priority "otherwise it would severely compromise the medium term achievements of the project" (Galland and Vignal 1989:79, translation).

Box 4.3. Inter-Village Health Committees (CSIV), Houet Province, 1980-1986

Inter-village Health Committees (CSIV) was an innovative idea tried in the Houet Province between 1986 and 1990. Community participation was through the CSIVs that were set up in nearly all CSPS health zones (27 out of 29) in 1986 (Ciardi et al. 1993). These committees were given the mission of informing the local population about the services that could be provided by the CSPS, especially the advantages of preventive care. In accordance with the principal of community self-determination, this scheme--implemented by Dr. Sondo, the DPS of Houet--charged the committees with responsibility for setting the fees for child and maternal health care (pre-natal visits and vaccines administered to women, infant care including periodic check-ups and immunizations, etc.) (Ciardi et al. 1993; Sondo, Traore, Sangare, and Youl 1993). Thus the CSIVs were required to organize debates in each village of the health zone to decide upon the appropriate fees to be charged. Out of this, a system of community self-financing emerged whereby different fees were applied to different CSPS health zones. Since the old laws necessitating central deposits of receipts were still in force, the province had to seek special permission from the high commissioner to retain and administer the funds generated by these medical fees.

The results were quite positive, especially in increasing participation in health activities that required repeat visits--like vaccinations and prenatal care (Sondo, Traore, Sangare, and Youl 1993:26):

- 53% of the pregnant women received an initial prenatal examination during which they were vaccinated against tetanus
- 67% of these women were seen a second time and received a second vaccination
- 92% of the children less than one-year-old and 88% of those less than five-years-old received a preventive checkup
- 50% of the children less than five-years-old received the three polio vaccines at the prescribed intervals
- 70% of the children who received the first and second vaccine showed up for the third dose

By 1990, this system had been discontinued in all areas. Although no systematic evaluation has been conducted to date, some of the major hurdles encountered are widely known. These include mismanagement of funds (embezzlement and poor accounting, the latter due to the insufficient skill of the treasurer/secretary) and conflicts over their use (between the head-nurses in charge of the CSPS and the CSIV). Moreover, even with this level of community participation in setting fees, some people still could not afford the charges imposed for preventive health care (although the precise numbers are not known). (Ciardi et al. 1993: 103-104)

With strong support from the World Bank (Burkina Faso, World Bank, Health Services Development Project, Supervision Report, July 24, 1991; World Bank, Burkina Faso, Proposed Health and Nutrition Development Project, Pre-appraisal Review Meeting, March 2, 1993) and other donors, the Ministry was finally able to bring about a change in these treasury laws. The first decree (Decree no. 9301/PRES/MFPL/SASF/MAT, January 28, 1993) permitted the autonomous management of regional and village health services of the state.[3] A second legal decision, dated February 4, 1993, specified the means by which this autonomous management was to occur.

Within this new legal framework, the responsibilities of the Ministry focus on the need to create district-level structures that are capable of being managed by the community; establishment of a national policy on essential drug that permits the local populations to have access to drugs at an affordable price; and decentralization of the ministry staff in ways that reinforce this decentralized district and village-level system.

Lessons Learned: Key Institutional Issues in Participation

The recent macro-level changes in the treasury laws, personnel deployment, and essential drugs set the stage for increased participation in health in the mid-1990s. They do not, however, resolve the basic institutional issues of how this participation will be organized.

One of the chief lessons to be learned from this study's historic analysis and the recent World Bank-sponsored beneficiary assessments of health services in the Boulgou and Houet provinces (Ciardi et al. 1993) is that one cannot arbitrarily propose structures of participation like the village health committees and expect that these will function as truly representative bodies operating for the well-being of the whole community. An approach in which the institutional structures of participation are "adapted to the social practices prevailing in the societies under consideration" will be more accepted. These same local structures can be adapted to the presence of other parallel vehicles of participation, like NGOs and village associations created for other purposes.

Three major lessons are clear from evaluating the past 30 years of health care in Burkina Faso:

1. Need to "demystify" the concept of community participation

Ciardi et al. (1993) and J-B Ouedraogo (1994) argue that the first step to grappling with the base institutional issue of participation in the health sector is to "demystify" the concept of community,

> The term "community" is a misnomer: villages are administrative units which often comprise different ethnic groups and competing lineages. Thus "community participation" is an unfortunate choice of terms and what it is meant to signify is no simple affair. When it is not the outright dominance of one lineage and one ethnic group over others, it is a laboriously orchestrated negotiation whereby each group's interests are taken into account but always with a different weight according to the power relations obtaining in the "community" (Ciardi et al. 1993:100).

Case study research in the Boulgou and Houet show how local rivalries affected the response to national health initiatives (Box 4.4). The same study showed that beneficiaries living outside the limits of the village where the CSPS was constructed felt little allegiance to that facility. While this lack of allegiance could often be traced to historic factors, the fact that only one village in a district would be awarded a CSPS could actually increase animosities.

Box 4.4. Social Structures and Health Activities in Boulgou Province

The local populations in three Boulgou Province villages, where a recent World Bank-sponsored team conducted beneficiary assessments, expressed their interest in and willingness to support the new network of decentralized health services. Nevertheless, the rates of participation were very different between the three villages. J-B Ouedraogo (1994) argues that the key factors influencing these different levels of participation were the power struggles between different sub-village groups (clan and lineage based) and individuals. Moreover, despite their geographical proximity to one another, each village had a distinctive pattern of social and political conflict (and power) that was shaped by history. Ouedraogo argued that the three villages represented three patterns of social conflict that were common to the region.

The first village had a traditional political hierarchy and a ruling family interested in maintaining its social control. The chief's family exert power over local units of participation like the agricultural association (*groupement*) and religious groups. All individual or group strategies needed to pass via the chief or the chief's family.

In the second village, the authority of the traditional political hierarchy was questionable. In contrast to the first village, the traditional chief and his family exercised little control over the village. Instead, the village was characterized by a group of active sub-village leaders (what Ouedraogo calls "micro-powers"), each of whom wanted to lead the entire community. Under these circumstances, any attempt to promote health participation through the chief was rejected by the "rebel" villagers. Therefore, any attempt to mobilize participation needed to enlist the support of the sub-village leaders in a consortium fashion that did not pit them against one another.

In village three, the chieftaincy had been imposed by the Mossi chieftaincy at Tenkodogo on the Bisa people. Although the chief's family was Bisa, his power was perceived as having been imposed by the alien Mossi warriors, and was therefore not widely accepted. The erosion of the traditional political hierarchy was further weakened by massive influx of highly motivated "individualistic" agricultural immigrants from other parts of Burkina Faso since 1975. With little hope of restoring its former power, the ruling Bisa family showed little leadership in developing health or any other sector. Ouedraogo argues that the high heterogeneity of the community and the lack of any historic pattern of legitimate, centralized leadership made it virtually impossible to imagine that the different groups could be mobilized to work for a single community goal.

One result was that villagers living outside the "host" village where the CSPS was constructed were generally unwilling to participate in either the construction or management of the facility; the same lack of "ownership" affected their use of the services as well (Ciardi et al. 1993:101).

J-B Ouedraogo's (1994) research in the Boulgou province showed how deep historic rivalries between ethnic groups were being exacerbated by the high rates of spontaneous immigration into the zone. The net result of this was to make it totally unrealistic to direct health information or to organize health programs through structures representing the entire "community" (Box 4.4).

The lessons to be drawn from this and other studies (Ciardi et al. 1993; Soubeiga 1992, 1994; J-B Ouedraogo 1993) is that:

> One cannot propose structures of participation (such as village committees) and expect that these will function as truly representative bodies and democratic mechanism operating for the well-being of the whole community. Unless a complex process of arbitration between group interests is undertaken under costly external supervision, this is simply not a realistic scenario (Ciardi et al. 1993:100).

A key problem for the health ministry then is to increase their internal understanding and capacity of working in collaboration with "the rules, social practices and internal dynamics" of the societies they are working with and how these are changing.

2. Need to work with the pre-existing base of "participatory" institutions in an area

Health planners must be willing to work with pre-existing structures, if they exists, for mobilizing local participation in development. Two of the most important of these "alternative" vehicles are NGOs and village associations.

Ciardi et al. (1993) notes that local and international NGOs are disproportionately concentrated in the Mossi plateau and some of the northern regions. There are isolated studies that show the positive role NGOs can play in supporting national efforts (Boxes 4.1 and 4.2). In the Sissili Province, for example, where the Dutch NGO SNV has been an active supporter of the government sponsored network of health services since 1971, the rate of vaccination coverage is 62% versus 32% nationally (MSASF 1992:8). In contrast, the west has a very weak network of NGOs but financially stronger village associations due to the presence of profit-making activities such as commercial cotton production. In the west, 48% of all infrastructures in the health sector were built and financed by village associations (Ciardi et al. 1993:103). On the negative side, the administration and allocation of village association funds in the areas studied was fraught with problems, from embezzlement to mismanagement.

3. Need for targeted training and educational programs to increase the capacity of *groupements*, NGO, and health committees to manage village and district level health facilities

The high propensity for mismanagement and embezzlement of funds managed by the village health committees and village associations (*groupements*) is directly related to the low levels of education and training in these groups. One well known example of this is the highly

successful program of Inter-village Health Committees (CSIV), which was discontinued after only four years (Box 4.3) for "mismanagement of funds (embezzlement and poor accounting, the latter due to the insufficient skill of the treasurer/secretary) and conflicts over their use (between the head nurses in charge of the CSPS and the intervillage committees)" (Ciardi et al. 1993). A new effort to develop *mutuelles* (cooperative mutualistic schemes in which the population pays an upfront membership fee that entitles them to unlimited free services) in the Houet Province are being threatened by the same low level of basic literacy and accounting skills (Ciardi et al. 1993:105).

> This is compounded by the fact that, given the history of embezzlement in many areas, the local population often has little faith that the monies contributed will not disappear into the pockets of dishonest individuals.

For all of these reasons, it is absolutely essential that any attempt to develop participatory health management be linked to efforts to teach the accounting and literacy skills that are needed to manage these systems.

4. Need to reinforce the capacity of ministry staff to work in a more participatory fashion

The World Bank-sponsored beneficiary assessments highlight the critical role that ministry personnel have played in modifying the ministry model of local participation to local realities. In the Boulgou Province, the physician in charge of the Medical Center in Garango (which is partially supported by a joint World Bank/USAID effort) has made a "valiant effort over the course of the last year to meet with the representatives of the communities as well as with various organizations/institutions in his health district (e.g. the Catholic Mission of Garango, a sister-city committee, an Association of Mothers Against Cholera)" (Ciardi et al. 1993:106). However, the case study notes, it is the head nurse who is in the frontline position of helping the community establish the local management system and fees to be charged. As the CSIV case study shows (Box 4.3) this "education" process can be so conflict ridden that it can sabotage broad based participation.

Given the current interest in developing participatory approaches there is a strong need to expand the traditional context of nursing training and retraining sessions to include more on-site experiences with participatory approaches to working with health committees, NGOs, and development associations. This recommendation is in line with the Ministry's intention that all health personnel should receive instruction in the GRAAP participation methodology.

Conclusion

To conclude, this study shows that considerable progress has been made toward the development of more participatory approaches to health in Burkina Faso. Especially important is the creation of a new five-tier, decentralized "health pyramid" in 1979; the recent changes in the national treasury laws will provide a more effective means to finance and staff this decentralized system.

Nevertheless, the same analysis highlights the fact that these macro-level changes do not resolve the issue of developing the local mechanisms and institutions for participation. More likely to be successful will be Health Ministry initiatives that are sufficiently flexible and supple to identify and reinforce effective institutions that already exist. Examples of this might be for the CSPS health staff to accept the sociological necessity of regular visits to the villages served by their facility rather than expecting the villagers to be willing to visit a district level CSPS facility that is not in their village. This sort of flexibility in the short run is likely to provide the mechanism for developing new "forms of participation" over the long run (Ciardi et al. 1993). In sum Ciardi et al. (1993:110) conclude:

> It would be a grave mistake to conceive a single program or model of participation for the whole country. Strategies of participation must be based on local conditions: as local conditions vary, so must strategies of participation.

The key principle, then, is to reinforce the capacity of the regional and national level staff to identify and reinforce appropriate local strategies and institutions.

Some of the concrete recommendations for immediate action include:

- Reinforce the training and fieldwork experience of the social scientists working with the ministry
- Improve training and staffing to support sociological sensitivity at the regional level
- Improve the distribution of studies and student theses on health by reinforcing the existing documentation centers and by organizing mini-seminars to disseminate research results
- Encourage active donor and NGO support for the central documentation center and mini-seminar series to disseminate research results in French.

Chapter Five

Urban Infrastructure

Burkina Faso is justly proud of its recent record in urban development. One of the unique features of this history has been a series of innovative "self help" squatter settlement upgrading and sites-and-services programs. This is a process that the World Bank has reinforced through the First, Second and Third Urban Projects.

History

Pre-Colonial Period

Pre-colonial Burkina Faso did not have urban centers in the modern sense. There were, however, a few dense administrative centers that were allied to powerful provincial chiefs and kings. Although the non-state "lineage" societies of the south contained larger-than-average villages, few of these could be considered "urban."

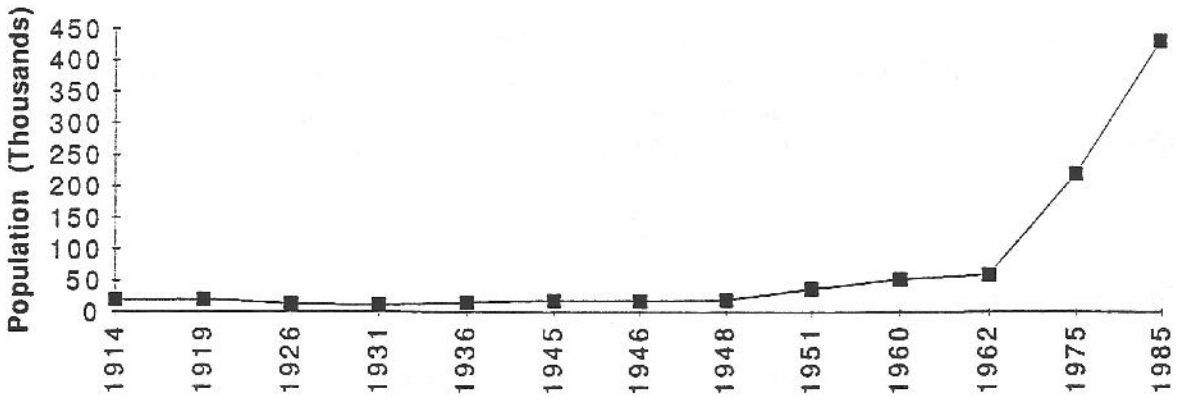
Colonial

During French colonization, the urban areas were significantly expanded to accommodate the increasing number of government servants and military personnel. Nine thousand five hundred (9500) urban parcels were laid out and developed in Ouagadougou during the colonial period (Ardjouma 1993:24-25). Most of the beneficiaries of this infrastructure were the civil servants of the colonial government. Through forced labor and later through low-wage labor, the population built the necessary infrastructure (railroads, roads, plantations, water systems, etc.) to the colonial government's specifications. The number of developed land tenure parcels far outstripped the demand as thousands of people fled Ouagadougou to escape forced labor and taxes (Figure 5.1).

1969-1980

After independence, the state developed a number of specialized agencies to coordinate urban infrastructure development. The institutional mechanism for coordinating local participation in this process (i.e. for processing land title and zoning requests) was the mayor's office. The laws regulating the designation of urban land rights were Law 77/60/AN dated 12 July 1960, modified by Ordinance 68/47/PRES dated 20 November 1968, which remained in force until August 1983. These documents recognized five land tenure categories: traditional, residential, administrative, commercial, and military. The primary difference between the traditional and residential zones was the amount of infrastructure. Zones classified as traditional habitat were equipped with basic infrastructure; in contrast, the zones classified as "residential" benefitted from more elaborate investment in running water and electricity, and were eligible for construction loans.

Figure 5.1. Population changes in the City of Ouagadougou, 1914-1985



Source for 1914-1975: Agunbiade 1976:31.
Source 1975-1985: World Bank, AF5IN 1978: Annex I, p.1.

The procedures involved in acquiring urban land rights and starting neighborhood development projects were extremely long, cumbersome, and expensive. Since there was no attempt to recover any of the base development costs, these operations were typically undertaken only when there was a source of external financing.

The chief beneficiaries of these land registration procedures were the traditional chiefs, earth priests, and family heads who could demonstrate large areas of traditional land rights.[1] The second category includes the upper-income individuals who could afford to buy land tenure rights from the traditional leaders and/or to create pressure on the local administration to zone their neighborhoods. A third category was the civil servants who were given parcels in two well-equipped neighborhoods, the *Zone du Bois* (1971-72) and *Patte d'Oie* (1978), when austerity measures forced the government to suppress their traditional housing allowances.

Frustrated by their inability to acquire serviced plots, low- and middle-income groups started to settle at the city perimeters. By 1970, 50% of the capital's population lived in non-improved squatter zones; by 1980 this figure had increased to 71%. Most squatter areas were completely unserviced, with no piped water,[2] garbage collection, waste disposal, storm water drainage, schools or clinics.

1983-1990

Urban development quickly emerged as one of the principal themes of the revolution. Less than two months after taking power, the President described urban development as a "domain of crucial importance." This period was characterized by the implementation of new texts and new institutional structures to coordinate urban development and services.

The two key governmental texts were: 1) the National Agrarian and Land Tenure Reform (RAF), Ordinance 84-050, dated August 4, 1984, and 2) Decree No. 404, dated August 4, 1985, concerning the application of the RAF. These two texts provided the legal mechanism for overriding customary land rights and the long, cumbersome land registration procedures that had impeded earlier development efforts.

During the same time, the government expanded the mandate of the national urbanism office *(Direction de l'Urbanisme)* to be the chief agency in charge of the conception, execution, and control of urban development activities. Parallel to this process, the government simplified the administrative procedures involved in executing urban development projects and registering land.

Local Participation in Major Urban Projects

The UNDP Habitat Project (1974-1976)

In 1973, the government, with UNDP assistance, started a two-year experiment to improve the housing conditions of the urban poor. The UNDP Habitat Project was actually two projects that occurred simultaneously in Cissin, one of Ouagadougou's large squatter neighborhood (Table 5.1). The "pilot" part of the project converted 53 hectares of sparsely inhabited land into 658 equal-sized land parcels (the sites-and-services approach); the "restructured" (squatter upgrading) zone developed 9 hectares of settled parcels (containing 250 families) with minimal destruction of the existing roads and buildings. Initial infrastructure included roads, minimal drainage, pit latrines, and wells.

Households were given urban occupancy permits as a guarantee of tenure. The low- and middle-income beneficiaries were expected to contribute both financially (by paying a portion of the development costs and joining a neighborhoods savings and loan cooperative) and physically (by volunteering their labor to construct basic infrastructure).

Working through the neighborhood chief, project planners conducted a series of socio-economic studies to better understand the population, its goals and needs. The same institutional mechanism was used to organize large meetings to exchange ideas about the project design and to keep the population informed about the evolution of the work once development started (Kibtonré 1993). These activities were reinforced by special training sessions for beneficiaries as well as government technical staff.

In general, the lower-cost squatter upgrade (restructured) part of the project benefitted a higher portion of the low-income groups. The same low cost model resulted in a higher percentage of construction self-financing and greater group participation in the development of collective infrastructure (Table 5.1). Nevertheless, within five years, 56.5% of the original beneficiaries had sold their plots for 10 to 50 times the original cost (Kibtonré 1981:23,53).

In November 1975, the Ministry of Public Works, Transport, and Town Planning convened an international conference to evaluate the Cissin experience and to determine is applicability on a larger scale. While this evaluation was not totally positive (cost recovery and recovery on housing loans needed improvement), the government endorsed the Cissin concept as the cornerstone of its policy for providing urban services to squatter areas.

The First Urban Project (1978-1983)

In 1976 the government proposed a massive *tenfold* expansion of the Habitat Project model for squatter upgrades through the World Bank-supported First Urban Project. This project was the Bank's first experience in the country's urban sector and one of the early urban development projects in Africa (World Bank, AF5IN 1987). This project also was designed to reinforce the capacity of the municipal governments to manage urban land development, meet recurrent costs, and provide maintenance of public facilities. The most immediate objective of this administrative strengthening was to enable the government to recoup a higher percentage of the urban development costs. It was anticipated that the proposed project would be carried out over 3.5 years (1978-1982) and include the provision of basic infrastructure, including water supply, drainage and roads, to 7,000 households in squatter neighborhoods of Cissin and Zogana in Ouagadougou and 3,000 households in the squatter neighborhood of Sonsoribougou in Bobo-Dioulasso. Other components included more expensive sites and services program to develop 1,100 new plots, improved water distribution in three additional squatter neighborhoods, construction and home improvement loans, construction of community facilities and social services (World Bank, AF5IN 1978a, 1978b).

The project model for participation in the squatter upgrade component of the project was borrowed directly from the squatter upgrade (restructured) portion of the Habitat Project (World Bank 1978b). The original proposal envisioned a demolition of no more that 10% of existing buildings with a road network of narrow streets adapted to the organic layout of the settlements (Table 5.1). The beneficiaries were expected to contribute financially by paying the "real" costs of the development and by pooling funds to develop a savings and loan cooperative (*caisse populaire*) that would make collective and private loans. Beneficiaries were also expected to volunteer labor to develop collective social (dispensaries, schools, social centers) and sanitation (rainwater canals) infrastructure.

Table 5.1. Models for participation in major squatter upgrade and site-and-service projects

	Pilot Cissin	Cissin Restructured (74-76)	First Urban (76/78-85)	MAP (79-83)
Number of benefiting households	53 ha 658 parcels allocated	9 ha 250 households	10,000 parcels anticipated 11,831 parcels allocated	4 Established Quartiers 30,000 parcels allocated
Principal components	"Classic" planning of a sparsely settled zone with high levels of financial and physical participation in follow-up development. Active participation in research and conceptualization phase.	"Restructuration" with minimal destruction of existing housing and roads with higher expectations for the beneficiaries physical contribution to infrastructure development. Active participation research & conceptualization.	Initial Plan to Extend Cissin "restructured" model changed to a more expensive "classic" model Limited Participation of local population to renegotiate payments and technology	Associate populations from the start in the conceptualization of the methodology to be used for their quartier (3 development options entailing different amounts of demolition)
Base structures	Chieftaincy	Chieftaincy	Chieftaincy; CDR	Chieftaincy; CDR
Financial (savings and loan cooperatives) (*Caisses Populaires*)	Plan: Pool 500 CFA/person Result: 1500 contributors within 5 years; successful record for short-term loans and the development of social infrastructure	Same as Pilot Cissin	Expanded funds of Cissin Savings and Loan Cooperative	Planned
Financial (repayment costs)	25,000/person	15,000/person (average 25,000 total per family)	210,000 CFA, payable over 5 years (300 CFA/m²)	45,000 (25,000 deposit; 20,000 later payments)
Financial (construction loans)	300,000 CFA construction Bank loans (75% households received loans)	300,000 CFA Bank Loans available (20% households received loans; 80% self-financed)	Plans to finance construction loans canceled	No special provision for construction loans?
Collective construction	Less than in restructured where more homogeneous indigenous population	Extensive	Strongest in quartiers with high percentage of indigenous inhabitants	Extensive
Beneficiaries salaried (%)	78%	44.5%		
Beneficiaries monthly income below 40,000 CFA/mo (after 5 yrs)	55.5%	88%		

Convinced of the validity of the Habitat Project model and in a hurry to launch the 3.5-year project in a timely fashion, project planners did not emphasize the need to involve the beneficiaries in the conceptualization of the project or its activities. There do not appear to have been any detailed baseline social or economic studies nor did planning documents emphasize the role of public information sessions. A community development technical assistant was hired to facilitate communication between planners and the beneficiaries. The initial institutional mechanism for communication was through the chiefs and then, after 1983, through the CDR.[3]

Almost immediately the planners became embroiled in a series of misunderstandings and disputes with the beneficiaries as well as with the multiple institutions[4] that intervened in the sector. These disputes resulted in long delays and technological changes that dramatically increased the total costs of the project. These higher costs were initially passed on to the settlers, then reduced after another drawn out period of renegotiation.[5]

In spite of its many problems, the project was eventually able to surpass the number of units that were anticipated for the sites and services and squatter upgrading (restructuration) components of the project by 25% (11,831 vs. 8,096 units) (World Bank, AF5IN 1987:7). On the basis of this experience, government undertook large-scale subdivisions for self-help housing on the outskirts of Ouagadougou and Bobo-Dioulasso.

The ability of this project to finally achieve its general objectives was influenced by the willingness of the World Bank to adapt to many time-consuming modifications in the project design. The Project Completion Report (World Bank, AF5IN 1987:19-20) highlighted the need for future projects to be simpler in terms of the number of project components and to anticipate a longer implementation period (the project ultimately closed after 6.5 years vs. the 3.5 years that were anticipated). The same completion report emphasized the importance of designing projects that "follow-up on positive pilot experiences [like the Habitat Project] that provide a clear reference for what the expected outcome of the project is, such as the original UNDP-supported squatter upgrading." (World Bank, AF5IN 1987:20)

Kibtonré (1993), however, attributes many of the problems encountered by the First Urban Project to the planner's unquestioning enthusiasm for the Habitat Project pilot that encouraged them to overlook the special institutional arrangements and social policies that made the original work. Especially important, he argues, were:

- The pilot project's small size and special donor funding which permitted it to forge a temporary alliance among the different offices and ministries that intervened in the urban development

- The need to adapt the model to the social and economic specificities of different neighborhoods and subgroups

- The need for a concerted effort of public information and dialogue about project procedures and the costs and benefits of different technological options

Progressive Development Method (MAP) (1979-1983)

The Dutch-sponsored MAP (Méthode d'Aménagement Progressif) was able to profit from the lessons learned from the Habitat and First Urban Project (Table 5.1). Two unique features of this project vis-à-vis these earlier efforts were the policy decisions: 1) to award land tenure rights *before* development started (as an incentive for the beneficiaries to participate in the physical development of the sites), and 2) to involve the beneficiaries in the conceptualization of the development project as well as its execution (Table 5.1). When presented with three options involving the amount of destruction of the established buildings (one conserving as many buildings as possible, similar to the restructured zone of the Habitat Project, one demolishing all existing parcels and redividing and rebuilding, and one between the extremes) the beneficiaries chose the most destructive option, which would produce the most regular layout and evenly sized parcels (much to the planners' surprise).

The financial cost of participation was set at 45,000 CFA (25,000 CFA down payment to receive a land title followed by 20,000 CFA to be paid in 9 installments). Costs were controlled by the beneficiaries' contributing labor and by recuperating building supplies from the demolished houses. In addition, the beneficiaries were expected to contribute to a neighborhood savings and loan cooperative.

MAP was first tested 1982 in the Larlé neighborhood where 260 parcels were developed and then expanded to the Wagadogo-Nossin, Gounghin-Sud, and Tampouy neighborhoods for a total of 3,000 parcels. The first phase was coordinated through the traditional chiefs. During the project's second phase (after the 1983) MAP became the model for the "commando" campaigns of the new revolutionary government.

The Urban "Commando" Campaigns (1983-1987)

Using the MAP program as their model, the new government embarked on a "commando" subdivision operation to register the land outside Ouagadougou and Bobo-Dioulasso. Attribution committees, composed of a mapping specialist and representatives of the CDR, treasury, and neighborhood social affairs committees, were established to register land tenure. Each committee was instructed to give priority to low-income families. And, as a means of controlling fraud, the local population was encouraged to observe the committees' activities. The beneficiaries were expected to contribute either physically or financially to the development of water pipes and then other types of collective infrastructure. The settlers financial participation was calculated at 300 CFA/m^2. In two years the government distributed three times more parcels than in the preceding 23 years: 64,000 versus 20,300. In addition, the transparency of the attribution committees' activities restricted fraud and increased real access for low- and middle-income families.

The combination of the "commando" land allocation campaigns, the First Urban Project, and the MAP program increased the ratio of zoned to non-zoned land from 28.6% of the total land area in 1980 to 72.9% in 1990, according to the information released by the Office of

Urban Statistics (DASU). The mere process of zoning and registering the squatter areas did not, however, resolve the root problems of primary and secondary infrastructure and sanitation services. The level of fees paid was such that it was possible to finance only very rudimentary amenities.

Second Urban Project

The difficulties encountered in the First Urban Project confirmed the World Bank's conviction that (World Bank, AF5IN 1989:8):

> improvements in municipal financial and technical services cannot be achieved through a piecemeal approach in a first effort in the urban infrastructure sector...[therefore] institutional development and policy reform need to be taken as part of a medium to long term strategy for the sector.

In light of this analysis, the objectives of the Second Urban Project were to:

- Develop the organizational, technical, and financial capacity of the local governments of Ouagadougou and Bobo-Dioulasso to assume full responsibility, as contracting authorities, for the maintenance of urban infrastructure and the provision of urban services in the face of increasingly high growth rates for the urban population

- Upgrade infrastructure in these two cities to a satisfactory overall standard, enabling effective, regular maintenance

To date, the concept of local participation in municipal activities has been almost totally lacking. The long tradition of state intervention in municipal affairs means that the municipalities have had little autonomy to respond to the constituency that elected them. In addition, the local population typically has little sense of commitment or ownership of the city-provided services or infrastructure. Past participation has been mostly "financial" through the payment of taxes, water and electricity fees, bicycle registration, and market fees. Planners argue that the urban residents' growing frustration with the quality of urban services combined with the weak capacity of the state to keep track of current and overdue tax revenues were key factors behind a 48% decrease in per capita urban revenues between 1980 and 1985 in Ouagadougou and a 42% decrease in Bobo-Dioulasso.[6] This weak willingness of beneficiaries to support urban services contrasts with their demonstrated willingness to contribute to the development of social infrastructure and the neighborhood savings and loans cooperatives.

The ultimate goal of the Second Urban Project is to "incite" the local population to participate financially in the maintenance of the infrastructure and services through taxes and permit feeds. The Second Urban Project's model of participation is thus best characterized as a "demonstration" model: offer services that convince people to support these services both financially and physically. Theoretically, the operations (service provision and local

participation) would occur simultaneously. To date, however, the provision of basic services[7] like naming Ouagadougou's streets, providing sanitation infrastructure, and rehabilitating urban roads has taken precedence over eliciting local participation in the conceptualization or maintenance of these activities--probably because the latter process is more complex and will inevitably take longer.

Third Urban Project

The Third Urban Project, which will soon be appraised, is designed to complement the activities of the Second Urban Project by: 1) further strengthening the institutions responsible for current operation, management, and control of urban services, 2) targeted investment to restore urban sanitation services, and 3) reinforcing the capacity of the local authorities to elicit local participation in the conceptualization and execution of urban sanitation services. Although the ultimate goal of the project is basically the same as the Second Urban Project (improved urban living conditions), the approach is different. The Third Urban Project takes participation as the point of departure--not the result--of urban services and infrastructure development. This perspective has special relevance to urban sanitation programs that require high levels of local participation and behavior modification to succeed.

To date, project preparation has supported an extensive research program to assess the state of basic sanitation services in Ouagadougou and Bobo-Dioulasso (storm water drainage, wastewater, household wastes, latrines), the measures already being used to address these problems, and the willingness and ability of the local population to participate in solving these problems.

One of the unusual aspects of the project is the decision to pair research activities with a pilot project to test the research methodology as a strategy for conceptualizing sanitation services. Planners argue that this type of on-site pilot project is the only real means of testing the motivation of the population to support the proposed measures (Nigg 1993:1). If the pilot project is successful, it will provide a model for the identification of sanitation problems and policy options to address them that can be tested city-wide.

The Burkina Faso Public Works and Employment Project (Faso Baara)

Like the Second Urban Project, the Burkina Faso Public Works and Employment Project (Faso Baara) was designed to increase the country's capacity to execute infrastructure projects through the use of local enterprises and consulting firms. The project also was considered to have a variety of "social" objectives that included the creation of temporary employment and improving the competence of the workers and enterprises associated with the project.

The concept of local participation in the project was understood to mean that:

- Municipalities would present sub-projects based on the priority needs of their constituents

- Once a project was selected for execution, Faso Baara would disseminate information on the sub-projects through a media campaign designed to increase participation in infrastructure maintenance (World Bank, AF5IN 1991:13)

In carrying out its public awareness campaign, Faso Baara employs a community promotion officer (a trained sociologist) who is accorded the same standing as the technical and financial directors and reports directly to the director general. The officer recruits additional staff as needed for the different public awareness activities.

Faso Baara's performance has been evaluated as outstanding (World Bank, AF5IN 1994:5). Two years after starting, 222 sub-projects have been executed by 126 small contractors for a total cost of 3.77 billion CFA in the cities of Ouagadougou and Bobo-Dioulasso. Total wages distributed represent 852 million CFA or an average of 55,000 CFA per job created. The execution of the sub-projects led to the creation of about 700,000 person-days of temporary work (15,405 persons were employed in jobs for an average duration of 44.2 days). Finally, with an overhead cost of less than 5%, Faso Baara has proved to be very efficient in managing small contracts (275 in 1992, of which 150 for works and 125 for consulting services) and has been able to pay contractors and consultants within a week.

The recent mid-term evaluation shows that the municipal governments have been less successful in eliciting local participation in the preparation of proposals that are submitted to Faso Baara. Nachitigal, Thieba, and Badini's (1993) analysis of interviews with a random sample of beneficiaries associated with 25% of the 146 Faso Baara projects that were completed as of April 30, 1993 (26 projects representing 39 sub-projects) noted that, while the majority of the projects appeared to respond to the beneficiaries perceived needs (73%) and expectations for quality (50%), the urban governments made very little attempt to elicit the beneficiaries' participation in the identification of project priorities (30%) or the execution of activities (11.5%). Nachitigal, Thieba, and Badini argue that over the long run, this lack of participation is likely to diminish the willingness and ability of the local population to engage in the necessary maintenance or support activities.[8] The World Bank has asked Faso Baara, as the implementing agency of the project, to take up this issue with the municipalities (Watson 1994).

Lessons Learned: Key Institutional Issues in Participation

1. Need to associate local people from the start

Perhaps the principal lesson to be learned from this historic analysis of Bank and non-Bank projects is the critical importance of associating local people in the initial conception of urban planning. Positive examples include the MAP and Third Urban Projects. Although costlier in the short-run, this type of "up front" communication avoids the sorts of costly downstream delays that stymied execution of the First Urban Project.

2. Need for special targeted assistance for limited resource households

Vigilance is needed to ensure that low-income groups are able to participate in project planning and benefits. Their exclusion was most blatant in the first generation of urban development projects between 1960 and 1983. The Habitat and MAP projects tried to increase participation by enforcing selection criteria that gave preference to low-income groups. The "commando" campaigns tried to achieve greater equity through national laws that assured universal land tenure rights. To date, however, there is very little documentation about the extent to which low-income peoples have actually benefitted from these initiatives. Such information could be used to develop more effective means of targeting low-income groups.

3. Need to qualify project goals for "cost recovery"

By far the primary factor that affected low-income households was cost. Although the concept of total "self-financing" and "cost recovery" are attractive notions, neither worked exactly as planned in any of Burkina Faso's large squatter upgrade or site-and-service projects. Repayment rates were typically low for all income groups.[9] This poor repayment record contrasts sharply with positive loan repayment record (98%) to the Cissin savings and loan cooperative (*caisse populaire*).

4. Need for strong, decentralized urban government

The very success of the new self-help squatter upgrade models provoked a crisis in the prevailing systems for urban administration. The administrative problems were further complicated by the different urban functions being performed by different offices within different ministries (zoning, infrastructure development, land registration, tax collection, permits). The turf battles that erupted over which ministry would direct the First and Second Urban projects are examples of this problem. The issue of strong, decentralized administrative structures must be addressed at two levels. First, the fiscal, judicial, and administrative autonomy of the municipal governments needs to be reinforced. Second, a decentralized system of urban administrative structures needs to be developed to work with the evolving base of beneficiary, public, and private sector institutions.

Conclusion

To summarize, the historic analysis of the urban sector highlights how Burkina Faso has been a pioneer in the development of "self-help" sites-and-services and squatter upgrading projects. The World Bank has played a major role through its support of the First, Second, and Third Urban Projects. The experience illustrates that some urban functions (like access road, large water conduit, sanitation, and drainage canal construction) are not amenable to a "participatory" approach. While local participation can facilitate long-term maintenance, their support needs to be coordinated by a strong system of decentralized urban governments.

The current trend toward decentralization changes the "rules of the game" by giving more responsibility to the local urban governments. To be elected, the local government officials need to mobilize their electors and be more focused on the needs of the electing population. To be successful, however, these democratic trends need to be reinforced by an effective mobilization and management of the financial resources that permit the elected governments to supply high quality services.

The Burkinabè state is currently in the process of developing new "tools" for convincing and inciting local populations to support urban development both physically and financially. One set of "tools" is the new participatory methodology being developed by the Third Urban Project. A second tool is Faso Baara.

The case study highlights that no single tool for mobilizing local participation or creating infrastructure is effective in all circumstances. If a key solution exists, it is likely to be the creation of strong, decentralized urban governments that are capable of welding these tools within a context that takes voluntary, democratic participation as both the point of departure and the goal of urban public policy. To be effective, this type of democratic participation (and the urban government's obligation to respond to it) has to be politically endorsed. All urban projects should support this national initiative from their own point of view. The power of the donors, in this case, is enormous. Donors open "windows" by targeting their assistance. This assistance should therefore be handled with great care. In deciding to support or not to support a specific type of request, and thus a specific segment of the population, a donor can inadvertently create a disequilibrium and endanger a local, new and fragile dynamism.