4. Assessment of IDA Sector Assistance for Health

4.1. Outcome and Institutional Development

4.1.1. Relevance

Since independence, Burkina Faso has suffered from extremely high mortality and population growth rates. More recently, the country was listed as one of 12 countries with a "generalized" (i.e., most severe) rate of HIV infection (Dayton 1998).[1]

Table 4.1. Health Indicators for Burkina Faso compared with those for All of Sub-Saharan Africa

Indicators	Burkina	All Sub-Saharan Africa
Fertility Rate (births per woman)	6.7	
Annual Population Growth Rate	3%	
Infant mortality (per thousand live births)	99	92
Child mortality (per thousand live births)	164	157
Life expectancy	46	52
HIV—general population	7%	

Source: 1997 World Development Indicators. All statistics for 1995. In, World Bank 1999: 1.

Frustrated by the inability of the country's inherited system of "top down" health services to improve the overall health situation of the country, the Burkinabe government welcomed the new primary health approach proposed by the World Health Organization (WHO) Conference at Alma Ata in September 1978 (Soumbie 1990: 7). The health ministry responded by formulating a **Ten-Year Health Program** (1980-1990) which was approved by the Council of Ministers on 14 March 1979. The Program outlined a five-tier health pyramid that linked one village health post (PSP) in each village with a decentralized series of regional health and social action centers, regional and national health hospitals.

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1. Seroprevalence among the general population is estimated at 7%, while it reaches 13.1% among truck drivers, 8.5% among pregnant women, 29% among persons infected with tuberculosis, and 23% among persons infected with sexually transmitted diseases. About 64% of commercial sex workers in Ouagadougou and 43% of those in Bobo-Dioulasso are estimated to be seroprevalent. The number of AIDs cases among young people has increased from 3% in 1987 to an estimated 7% today. Women are also increasingly infected. While in 1988 women represented 25% of AIDS cases, their proportion has increased to some 40%. Three quarters of those hospitalized for AIDS are of age 15 to 40 (Vitagliano 1998: 1).

Phase I: Early Support for Improving Health Infrastructure and Services (1985-1991)

The first IDA health project, the Health Services Development project or PDSS (*Projet Developpement des Services de Sante*, FY 85-95) was designed:

(1) to strengthen basic health and family planning services by extending the immunization program, developing in-service training at the provincial level, constructing or upgrading 142 health centers and six referral centers, and conducting pilot studies to improve the maintenance of health facilities and equipment, and to improve hospital sector management;
(2) to help formulate national health and population policies and promote their application; and
(3) to strengthen the Ministry of Health's (MOH) institutional capacity in planning, evaluation, and project implementation and monitoring by establishing eight provincial directorates and providing two mobile epidemiological surveillance units (World Bank 1995b: i-ii).

Although the PDSS project approach was relevant when designed, it was quickly superceded by political events which included a six-fold expansion of village health infrastructure that occurred under the "commando campaign" *1 Village=1 PSP*. The short-term results of the commando vaccination and construction campaigns were quite positive. The massive expansion of the health infrastructure, however, quickly surpassed the capacity of the health ministry to either provide or supervise health workers (MSAS 1988:20-21). In addition, few village health committees functioned except in name only and most drug stocks were depleted after a few months. With few exceptions, the PSPs that functioned most successfully were those supported by NGOs which enabled them to avoid an exclusive dependence on the Ministry of Health for drug stocks and village-level training. With both limited drug stocks and qualified personnel, the rate of attendance at the CSPS facilities began to drop (Table 4.2). An even more dramatic drop was observed for vaccination rates, especially for vaccines that had to be administered over a period of time in several doses (from 60-70% to 9% for DPT-polio and 33% for BCH).

Table 4.2. Evolution of the Rate of Frequentation of Public Health Facilities in Burkina Faso, 1986-1996

1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
32%	31%	28%	28%	26%	23%	23%	22%	19%	18%	17%

Source: EU.
Note: Figures are rounded off to the nearest whole number.

Despite the government's formal adherence to decentralization and a single sector strategy, most health programs (including IDA's) continued to be implemented as centrally

managed programs and there was very little potential for IDA-government policy dialogue due to the revolutionary government's reluctance to use borrowed funds for social sector investments. Thus, during this first phase of PDSS support (1985-1991), the role of the Bank was rather marginal with its assistance focused on strengthening health infrastructure.

Budgetary constraints and concerns about the increasing cost of providing health care services, as well as growing awareness of the consequences of rapid population growth led to a change in the government's attitude toward policy reforms, and a more intensified policy dialogue with IDA and other donors began toward the end of the 1980s (ibid: ii). This dialogue contributed to a decision by the government to create 51 new health districts in 1990.

Phase II: More Intensive IDA Involvement in Policy Dialogue (1991-1997).

A major turning point for the Bank's strategy occurred during the 1991/92 restructuring of the PDSS project during which the extension of the project's closing (the first in a series of three) was made conditional to the government introducing an essential drug policy. The same restructuring emphasized the need for full fiscal and administrative decentralization in order to render the 51 health districts operational. In the process, the Ministry's coordination with IDA and other sector donors improved considerably and facilitated the adoption of a national essential generic drug policy and the establishment of a central purchasing agency for these drugs (CAMEG).

This second phase of more active IDA involvement in the health sector was strengthened by the addition of two new projects which more than doubled IDA lending for health-related initiatives (a 140% increase) between 1992 and 1994. These included:

(1) the PDSN (*Projet de Developpement de Sante et Nutrition*, FY 94), under the Ministry of Health, which was designed to the quality and reliability of basic services and infrastructure within the Ministry; and

(2) the PPLS Project (*Projet Population et Lutte Contre le Sida*, FY 94), under the Ministry of Finance ,which was designed to produce the country's first multi-sector family planning and AIDS initiative.

One important component of IDA's health strategy during this period was the decision to link health, education, and infrastructure investment lending with conditionalities built into the major "macro" structural adjustment and economic recovery loans. Especially important was the decision to link "macro" loan disbursements to the government's maintaining or increasing its budget commitments to these priority sectors. This concept of macro-micro linking was further strengthened by the HIPC Initiative's policy of making debt forgiveness contingent upon the government's achieving certain specific benchmarks in education and health (Table 1.2, Chapter 1.0).

The major weaknesses of this second phase of the IDA health strategy for Burkina were:

(1) the initial design of the PDSN project administrative and financial structure gave insufficient attention to decentralization, which became a reality with the passage of a series of laws in 1993 and 1994 that authorized the fiscal and decision-making autonomy of the 51 health districts created in 1990;[2]

(2) neither the Bank nor the government gave sufficient attention to the critical role that monitoring and evaluation could have played in fine-turning and/or modifying these design flaws;

(3) the strategy focused on increasing the quality and supply of health services with little attention focused on increasing the utilization or demand; and

(4) the strategy overestimated the ease with which the nascent health districts could collaborate with the Ministry of Finance directed Population/AIDS Project (PPLS) to supply technical assistance and sponsor training and public information sessions. This lack of inter-sector collaboration between the PPLS (under the Ministry of Finance) and the PDSN (under the Ministry of Health) caused major delays in the implementation of key project components for the PPLS Project.

Phase III: IDA Support for Full Fiscal Decentralization and Stimulating Demand (1997-2000+)

Between November 1997 and October 1998, the PDSN project was restructured[3] to accommodate decentralization more concretely, especially the financial and technical support to the districts in the implementation of their respective plans of action. One important innovation has been to link disbursement of funds to the health districts' achievement of technical targets. This same restructuring is attempting to address the issue of increasing the weak demand for and utilization of existing health services (despite demonstrated need) by supporting the government's efforts to develop a sector wide approach (Sector Investment Plan or SIP) which coordinates the assistance of all donors around national policies, strategies and plans. This new phase is also marked by the Ministry of Health's establishment of a Technical Secretariat that is charged with preparing a Ten Year Plan of Action (1999-2009) around which all donor assistance can be coordinated. This Technical Secretariat has prepared a draft plan for elaboration of these documents and envisages the involvement of different segments of civil

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2. Specifically, the PDSN project design imposed a highly centralized system of finance that was not well adapted to the newly decentralized system of health districts which became operational with the passage of a series of three legal decisions just prior to final signature of the loan. The hostility and suspicion bred by this centralized system harmed the achievement of the other project objectives for strengthening management and technical capacity of the new health districts through improved training and planning. The same centralized finance and weak management systems made it extremely difficult for the health ministry to collaborate with the ministry of finance-sponsored PPLS in the ways needed to guarantee its sustainability. In 1997 November, the PDSN project was restructured to better address the critical issues of decentralized finance and management.

[3]This restructuring occurred over a series of three supervision missions (March 1998, July 1998, October 1998) in line with recommendations of the national workshop held in Dedougou in November 1997.

society throughout the process, including dialogue with rural communities through the health districts.

IDA is supporting the development of this broad multi-sector approach by: (a) targeted assistance to support the Ministry of Health's preparation of the Ten Year Plan of Action (through PDSN and a special grant from the Japanese trust funds); and (b) developing a health component within the Burkina Faso Community-Based Rural Development Project under the Ministry of Agriculture which is under design.[4]

This shift of IDA and Ministry of Health strategy from developing projects to formulating a more broad based sector strategy is a positive development that captures some of the intra-sector collaborative momentum that was developing (with IDA support) just prior to devaluation (see Section 4.3, footnote 13). For this type of inter-sector collaboration to be sustainable, however, it must be linked to a parallel, ongoing effort to strengthen the training, management, and financial resources of the decentralized health districts. To date, the national health system is still extremely weak, with major deficiencies (World Bank 1999) in terms of: (a) quality and access; (b) sector management and efficiency; (c) community participation and inter-sector coordination; and (d) human resources.

4.1.2. **Health Systems vs. Health Outcomes**

Health Systems

Despite substantial delays, IDA support is providing the major source of capital that has enabled the country to build the basic infrastructure, training and administrative models for the type of decentralized health system advocated by WHO since 1978.

While this new decentralized model has yet to be fully implemented, the basic infrastructure is in place. What remains is to follow-through with the 1998 plan for restructuring the PDSN Project to insure that funds are delivered to and managed by the districts based on district-specific action plans.

A more specific list of achievements under IDA funding during the last decade include:

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[4] This new multi-sector rural development project (PNGT2) aspires to "empower rural communities to take charge of their own rural development and bring about sustainable improvements in natural resource management, rural production and socio-economic infrastructure." Specifically, the project proposes to strengthen local communities' understanding of and willingness to participate in the utilization, management, and construction of social services by developing better linkages between these services and the community land management committees created under the first PNGT project. The project intends for: "Subprojects, spanning a broad range of eligible investments [roads and tracks, water points, schools, health centers, dams, tree plantings, rural energy, etc.] ....[to] be identified, selected, executed, managed, and maintained by the communities themselves (World Bank 1997b). One of five key performance indicators focuses on improving the: "availability of socio-economic infrastructure (e.g., percent of population with access to potable water, to all weather roads, schools per 1000 children, etc.).

(1) supporting a three year (1989-1991) pilot project in the Boulgou province that developed the first model for self-financed health services and the necessary legal changes and financial systems needed to sustain it;

(2) initiating the increased policy dialogue and analytical support needed to promote the government's adoption of the concept of health districts in 1990;

(3) facilitating the revision of the judicial texts governing health finance needed to sustain this new model of decentralized health districts;

(4) providing the background analytical support and technical assistance needed to create CAMEG (the parastatal handling generic drugs) and the country's first pharmaceutical policy for basic drugs;

(5) helping to create the first monitoring and evaluation unit within the Ministry of Health;

(6) catalyzing through its linked conditionalities and the first and second IDA-sponsored Public Expenditure Reviews (PERs) a commitment by the government to prepare its own expenditure reviews for health and education and make them an integral part of its decision-making process (Monga 1997a, 1997b);

(7) starting the process of training ministry personnel in improved techniques for expenditure analysis;

(8) expanding the ministry's decentralized infrastructure through:
   (a) the PSSN Project (FY85-95) which constructed 16 new provincial directorates (vs. 8 anticipated in the project document), 14 operating units in regional referral units (vs. 6 anticipated), and 158 (vs. 142 anticipated) new CSPS centers; with additional extensions through
   (b) the PDSN (FY94) project (of which 70% of project funds are allocated for civil works) which supported additional construction, furnishing and equipment of surgical units and health centers, the construction of storage sheds for drugs, housing for health staff, and the rehabilitation of maintenance centers;

(9) establishing four mobile teams for the epidemiological surveillance of onchocerciasis and trypanosomiasisis, and promoting a system for improved production and distribution of water filters in support of the program to eradicate drancunculiasis;

(10) introducing (through the parallel Food Security and Nutrition, PSAN [FY92] Project) a participatory approach to the identification of nutritional problems and solutions as well as a host of other initiatives not directly related to the health system (e.g., improving the famine early warning system and improving household coping mechanisms by diversifying income sources through partial funding of income generating

activities that reduce famine incidence) that: (a) increase the number of women knowledgeable on key nutritional messages; (b) reduce the percentage of malnourished children; and (c) increase the number of village groups trained in participatory nutritional diagnosis;

(11) training (since 1997) at least 40 district doctors in district management and at least 46 in emergency operations;

(12) developing the first multi-sector initiative to transmit family planning and AIDS messages to local leaders. Despite substantial delays in the initial implementation of this strategy that were directly linked to the lack of effective decentralization to the health districts with whom they were expected to collaborate,[5] this initiative is well on the way to achieving most of its original targets for training and public information. These achievements include: (a) training 1300 local leaders and 2000 Ministry of Health, Social Action, Communication and Culture Agents about population, family planning, and AIDs issues; (b) disseminating Burkina's family code which emphasizes female reproductive rights; (c) training 1532 teachers on how to introduce population issues into their curriculum; (d) equipping a large number of local health facilities in maternal and child health and family planning training materials; (e) providing formal and on the job training for the staff of the more than 70 NGOs and village associations with which the project worked; (f) developing (in 1998) appropriate algorithms for the diagnosis and treatment of Sexually Transmitted Diseases (STDs); [6] and (g) supporting the preparation of first district level multisectoral AIDS plans.[7]

IDA's health sector support has been less successful in:

(1)achieving either the PDSS or PDSN's goals for all health districts having adequately trained doctors;[8] and

(2) translating the SAC and ERC loan conditionalities regarding health and education into increased public expenditure on health. The share of government recurrent budget resources allocated to the health sector in 1998 is 8.9% or about 2 percentage points below the HIPC target

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[5] The PPLS faced three main constraints in its attempts to decentralize its activities at the district level: (a) the extreme managerial weakness of the CNLS (the National AIDS Committee, see section 4.5 and (b) the the delay in making the health districts fully operational under the PDSN Project; and (c) the reluctance of the DSF (*Direction Sante Familiale*), which has traditionally received large amounts of direct financial assistance from bilateral and multilateral donors such as FNUAP to hand over any of their authority.

[6] All districts received training in these algorithms as well as a supply.of appropriate drugs. The algorithms were also adopted by the private sector and all the donors involved in STDs. The activity is now totally decentralized at the district level.

[7] The first such plan was prepared in 1998 for the health district of Gaoua and is the model for the entire sub-region.

[8] Despite important achievements (40 doctors trained in district management and 46 trained in emergency operations), only 20 districts have a trained set of doctors due to frequent turnover in staff due to professional transfers, promotions, and demotions.

of 11% for that year and 1 percentage point below WHO's recommendation of 10%. Projections on health's share of the recurrent budget are 11% for 1999 (one percentage point below HIPC targets) and 11.5% for 2000 (World Bank 1999:4).

Health outcomes

All three health sector investment projects (the PSSN, PDSN, and PPLS) anticipated that the effective implementation of their proposed activities and reforms would have a measurable impact on health standards and practices. To date, however, the lack of a functioning health monitoring system makes it difficult to assess this impact empirically as has been the case in almost all the projects that were studied as part of the 1997 OED Review of HNP support (Stout, Evans, Nassim and Raney 1997: 49). Indeed, recent figures collected by the European Union show a steady decrease in utilization of health services over the course of the project period. This was attributed to the low quality of services provided (1983-1996) (Table 4.2; Box 4.1).

Box 4.1. Principal Factors Affecting Access and Service Utilization in Burkina's Health System

A beneficiary assessment carried out in 1996 showed that Burkina's health personnel are perceived to lack respect and consideration for their clients, and occasionally to lack required qualifications. In addition, drug availability, a top priority for clients of health centers, is unreliable, at best. Weak referral capacities and inadequate support systems (particularly supervision, in-service training, logistical and maintenance support) further compromise service quality. The same beneficiary assessments indicate that many essential services may be unaffordable to certain segments of the population. Other possible impediments to service (gender, cultural, ethnicity, inadequate knowledge/appreciation of services, inadequate outreach/client orientation) should be further explored and addressed. In summary, poor service quality and factors constraining access to services have culminated in low service utilization (World Bank 1999, Burkina Faso, Country Assistance Strategy, Draft Input on HNP Sectors).

There is, however, some preliminary evidence that drug availability in district-level pharmacies has improved since the imposition of the generic drug policy that PDSS helped develop in 1994-1995. Other data suggests that child vaccination coverage and contraceptive prevalence rates may have increased to 55% and 25-30% respectively. It is also highly likely that once the most recent health surveys are fully analyzed, they will show a substantial increase in the percentage of health centers with generic drugs. The current contraceptive prevalence rates for rural areas, however, are estimated at 3% which falls far short of the 8% target set in the CAS and the urban rate of 25-30%.

One output of the 1997-1998 restructuring of the PDSN Project and the October 1998 mid-term review exercise and workshop of the PPLS was to revise the indicators of these projects in order to make them more consistent with the simpler measurement criteria of the HIPC (see 10/98 Supervision Reports).[9] The government's adoption of the first set of HIPC

[9] One conclusion of the PPLS mid-term review was that despite an impressive roster of inputs by component and by implementation agency, the government did not have much information on project outcomes/impact vis-à-vis objectives. This was due in part to the fact that the start of project activities (especially IEC) was considerably

indicators at a workshop in January 1998 which were later adopted at a March cabinet meeting suggests that the Bank's emphasis on "indicators" may in fact create the type of "substantive and constructive feedback to the Government" (Monga 1998: 1) that is needed to improve health performance, impacts, and monitoring. A similar set of "indicators" is being developed by the European Union (see Union Europeene 1998). The fact that disbursement of the remaining PDSN funds to the health districts is linked to the achievement of technical targets creates additional support for the development of sound monitoring and evaluation systems that emphasize results rather than inputs. The Bank is reinforcing this exercise with in-country technical training and research support (Monga 1997a, 1997b). The combination of these macro and micro-level changes improves the prospect that the government will have both the incentive (due to loan forgiveness and linked disbursement) and the capacity (trained manpower and appropriate computer systems) for better monitoring in the future.

One important lesson to be learned from this experience for future HIPC activities in Burkina, and elsewhere, is the critical importance of establishing a solid data base and realistic targets and systems for monitoring and evaluating these targets from the start. The same experience highlights the importance of donor consensus on these targets as well as the best means for evaluating them.

4.1.3. **Summary Rankings: Outcome**

The issue of subdivided impact— a substantial impact on the initial conceptualization and funding of the country's first decentralized national health system that cannot yet be verified empirically—was characteristic of all the health projects studied by OED in a recent international review. For this reason they (Stout, Evans, Nassim, and Raney 1997: 55) concluded that future evaluations should: "focus primarily on how the Bank has influenced health systems through HNP lending and policy advice, taking account of both the supply and demand for health services." A similar finding was made in a recent OED review of a World Bank health project which concluded that the Bank should therefore evaluate IDA's impact on health systems (including services and institutions) as well as its impact on measurable health outcomes.

Following Stout et al.'s (1997) proposal of a dual rating system for "outcome" for IDA-funded health projects, we ranked the impact of IDA assistance on the health system as marginally satisfactory due to its substantial impact on the institution, but more limited impact on medical doctor training, government budgets for health, and monitoring. The impact on health outcomes was rated as marginally satisfactory (but likely to improve) due to early evidence for substantial improvements in certain areas (urban condom use, vaccination rates, distribution of generic drugs) which could not be fully verified due to the lack of an effective monitoring system.

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delayed and that the government sponsored DHS (Demographic Health Survey) which would have given nation-wide data on relevant aspects of population and AIDS and better insight into the impact and effectiveness of the PPLS Project was not completed in time.

4.2. **Sustainability**

One major achievement of World Bank assistance to Burkina's health sector has been to support the health ministry in its attempts to develop a more supportive economic policy, legal and regulatory framework. The government has also shown a strong commitment to moving forward with the recommendations for developing more effective institutional arrangements and project monitoring systems that were key recommendations made during the 1997 restructuring workshop follow-up supervision missions (Bere,Nougtara,Koutou 1998; Vaillancourt 1998a, 1998b). Despite major progress, the prospects for sustainability are still far from certain and are therefore classified as "uncertain."

A more sustainable future must be linked to the Ministry of Health and IDA's willingness:

(1) to execute the recommendations for decentralized finance[10] and administration and improved monitoring that are outlined in the restructuring workshop and two follow-up supervisory missions;

(2) to design future support to facilitate integration of IDA-supported health activities: (a) to take into consideration Bank-wide lessons and best practices on cost-effectiveness and impact that have emerged on this fast evolving AIDs issue since the initial PPLS Project was designed; and (b) to develop improved coordination between the health ministry, other ministries, IDA and donors at all levels of the health system.

The government's decision to embark on a Ten Year Action Plan in October 1998 is a major step in the right direction toward achieving more widespread consensus between the Ministry of Health and other government, NGO, private sector, multilateral and bilateral aid donors on the relevant actions and policies that are needed to support this type of broad multi-sector approach.

4.3. **Bank Performance**

A recent OED review identified three areas as "windows" through which the Bank can influence health systems and health outcomes (Stout, Evans, Nassim, and Raney 1997: 38): sector work and policy dialogue, investment; monitoring and evaluation.

Sector Work and Policy Dialogue: Burkina's discussion of the AIDS epidemic in its two most recent Country Assistance Strategies was considered one of the best (see Dayton 1997: 23-24). Specifically, Dayton's review of the CASs in 25 of the most severely affected countries

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10. The restructuring is centered around the decentralization of project financing which would allow the disbursement of project funds directly into accounts opened for health districts and regional health directorates to support them in the implementation of their action plans.

showed that the the Burkinabe CAS was one of only three (the others were Uganda and Burundi) that addressed three or more of the key issues that the team felt were obligatory to a comprehensive CAS.[11] The same study shows that despite the prominence accorded to the issue of AIDS in the 1996 CAS, there was almost no mention of the AIDS epidemic in the major economic sector analyses (Dayton 1998: 22-29). The country team needs to reflect on Dayton's (1998) guidelines for how Country Assistance Strategies might incorporate concerns about the AIDS epidemic into sector work and lessons learned from other regional and international experiences into the formulation of the next country assistance strategy. At the very minimum, French versions of relevant sector work should be circulated to the teams responsible for these analyses.

Our interviews and literature review revealed that key national actors in the health sector were generally unfamiliar with recent examples of comparative World Bank sector work in general (such as Stout, Evans, Nassmi and Raney [1997] as well as the many published and external reviews cited in this document [ibid: 38-47]) and some of the high quality commissioned sector papers on Burkina, such as Ciardi, Poloni,Kinda, Ouedraogo and Ouedraogo (1993). More active dissemination and discussion of this literature (in French) could facilitate the types of participatory policy dialogue needed to strengthen the second phase of fiscal decentralization through the PDSN and PPLS projects. This would appear to be a priority given several recent studies (notably World Bank 1995c) that show a high correlation between the intensity of economic analysis and other types of sector work in the three years preceding a project and the project's probability of success.

Investment: One major achievement of the Bank's investment record in Burkina was to link disbursement on the major economic loans and debt forgiveness programs to the achievement of measurable benchmarks in the priority sectors (health, education, infrastructure). This "model" created an incentive for the Ministry of Finance to develop the types of budgetary support and monitoring systems that are needed to sustain these health investments over time. The same linked conditionalities helped the Ministry develop the types of high level judicial support that it needed to revise key legal texts. Similarly, the heightened Bank supervision associated with the preparation of and supervision of the three tranche SAC and the preparation of the ERC (which was disbursed in one tranche) provided an external incentive for and means of monitoring the government's progress in carrying out this difficult decentralization process. Future planning for the HIPC initiative in Burkina, and in the other highly indebted countries benefiting from this program, could profit from the many "lessons learned" from this experience.

The same historic analysis, however, shows ways that World Bank performance in the difficult transition period immediately prior to and just after devaluation reduced the overall effectiveness and efficiency of this effort. Especially important, the Bank administration made the decision to speed project preparation by developing the emergency credit for basic drugs and

11. The four areas identified were: (a) describes incidence/prevalence or means of transmission of HIV/AIDS, (b) recommends analysis of HIV/AIDS, (c) recommends STD/AIDS prevention or care; (d) recommends targeted programs for vulnerable groups (e.g. aid for widows and orphans).

two investment projects (PDSN and PPLS) as separate projects with separate administrative structures. One unintended consequence of this development of separate projects and project administrative structures--however well-intended in terms of the urgent post-structural adjustment health crisis-- was to perturb the shared vision of decentralization that was just starting to emerge at the highly participatory workshop on reinforcing primary health care in Burkina that took place May 5-8, 1992. [12] The same design flaws made it very difficult for the PPLS (under the Ministry of Finance) to develop of collaborative programs with the Ministry of Health.[13]

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12. The 1992 workshop was attended by representatives of every level of the ministry as well as all the major bilateral and multilateral donors active in the sector. The principal output was the formal amendment and endorsement of a national action plan for reinforcing primary health care that included a detailed plan for decentralizing the Ministry's management, personnel, and fiscal management. This plan was adopted by the Council of Ministers in July 1993, five months after the government's signing the second legal decision (February 4, 1993) that authorized this autonomous management. In August 1994 (Ministere de la Sante 1998: 6) a third decree was signed which clarified the characteristics and function of 11 Regional Directions (*Directions Régionales*) and 53 Health Districts (*Districts Sanitaire*).

Unfortunately, a number of factors complicated the efficient translation of the 1992 health strategy into the second health services project (know as the Health and Nutrition Project or PDSN, FY94) including a series of actions by the Bank that fostered the impression that IDA acted in isolation from the agreed upon strategy and other sector actors. These actions included the Bank's speedy design of a much needed emergency medical program, *Programme d'acceleration de la mise en oeuvre de l'initiative de Bamako* financed by the Bank through an emergency credit (*Credit d'urgence* or CRE) as part of the Economic Recovery Credit (FY94)in collaboration with UNICEF. The goal of this emergency credit was to reduce the impact of the CFA devaluation on access to emergency drugs. One result was that the Ministry had to quickly set aside its original plans for an orderly program of training to make the health districts operational in order to launch quick 14 -day training programs on drug prescription and stock management. One consequence of the poorly designed training and management programs was that a high percentage of the generic drugs didn't get out before they expired.

Other actions that contributed to donor and government perceptions that the Bank was not functioning as a fully collaborative partner included:

(1) the abrupt temporary suspension of funding for all World Bank projects, including the PDSS project, in 1993 for nonpayment of earlier loans;
(2) the overwhelming predominance of international experts on the PDSN design team;
(3) the fact that the lower levels of the health ministry were not consulted about the proposed project plan until just before negotiations;
(4) the massive hasty deployment of health personnel (from central posting in Ouagadougou and Bobo-Dioulasso to more peripheral posts in the month prior to negotiation; and
(5) the imposition of various stipulations for collaborative partnerships including the Ministry's obligation: (a) to work with UNICEF for the supervision of decentralization activities; (b) to work with GTZ on bio-medical maintenance; and (c) to work with Faso Baara (the autonomous public works contracting agency created under the IDA Public Works and Employment Project) for the realization of health infrastructure.

[13] It should be noted, however, that the same separation of the two projects had some positive outcomes as well. Operating under the Ministry of Finance may have given the PPLS the freedom to carry out certain community activities through NGOs, CONAPO, social workers, agricultural agents, teachers etc. that may have been impossible under the Ministry of Health which was focusing on internal restructuring.

There is also widespread agreement that the Bank staff's well-intended rush to design the two follow-up health sector projects (PDSN and PPLS) encouraged:

(1) low levels of input into the design of the PDSN from other levels of the Ministry of Health until just prior to signature; and

(2) the introduction of an overly-centralized financial management system for the PDSN and an unrealistic timetable for decentralizing health staff from central provincial offices to smaller towns within the same provinces in the month before negotiation.

Given the deep disagreements between the different sector actors over the PDSN Project's objectives, management, and financial structure, the task and cluster managers' decision to organize a highly participatory restructuring workshop (November 1997) was a wise decision. A similar restructuring process appears to have played a major role in helping the earlier Health Services Development Project (PDSS, FY 85-94) improve during its final years.[14] Unfortunately, the sudden appointment of two new task team leaders in quick succession (March and July 1998) and a special mission from Washington in the period immediately after the restructuring workshop (March 1998) seems to have created confusion among government officials and the other donors about the Bank's willingness to support some of the proposed changes. The task manager and cluster leader's decision to emphasize the public discussion and amendment of the next two supervisory mission's *aide memoires* (July and October 1998) is viewed as a positive innovation. Other innovations that were very positively viewed include the reconfiguration of Bank supervision (six months ago) to include a health team member based in the resident mission and a cluster manager based at Headquarters.

Monitoring and Evaluation: The lack of an effective monitoring and evaluation system on all three of the investment projects reflects a large and "disturbing" trend that was observed in the majority of the HNP PCRs, ICRs, and PARS reviewed by OED (ibid: 39). In Burkina, as in the other projects, the blame must be shared between the Bank and government staff who were often inadequately trained and/or motivated to conduct adequate monitoring. The revision of project indicators to make them more consistent with those of the HIPC and target ratings during the 1999 mid-term review and restructuring to focus on how well a system is performing is a positive development. Another positive development is the Bank's willingness to provide technical assistance and training to facilitate the government's development of its own public expenditure reviews (PERs) and to make it an integral part of its decision-making process (Monga 1997a, 1997b; Morris-Hughes 1997).

Summary Ratings: Based on this analysis, Bank performance on the design of sector assistance is rated as unsatisfactory despite very positive performance on specific elements of innovative, experimental projects like the PPLS (Population/AIDS Project). These design flaws,

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14. The OED review of the PDSS ICR laments the fact that this restructuring is not documented more fully in the ICR.

combined with the gross deficiencies in support from the government for the PDSN project complicated supervision which is rated as marginally satisfactory.

4.4. **Borrower Performance**

The government's performance on the follow-up PDSN project has been hampered by a widespread perception that many ministry appointments have been politicized. This widespread perception was exacerbated by: (a) a long hiatus in staffing; (b) general disgruntlement with the highly centralized financial structure of the project; (c) widespread Ministry and other donor dissatisfaction with the AGETIP Faso Baara's supervision of project-sponsored construction; (d) an inappropriate definition of the coordination unit's administrative role; and (e) an insufficient number of project coordination unit staff with the appropriate technical skills to administer the project.

Borrower performance has been especially remiss in the PPLS Project. The lack of strong effective leadership from the National AIDS Committee (CNLS), under the Ministry of Health, has been a major constraint on implementation. This weak leadership, combined with the low level of decentralization in the health districts, has increased the difficulty of developing a strong multi-sector policy to address AIDS. The project has also suffered from a lack of public appreciation of the problem by the country's highest officials. The overall level of government performance is therefore rated as unsatisfactory. It should be emphasized, however, that recent evidence (in the last six months) for strong governmental commitment to restructuring the PDSN Project, to improved monitoring, and developing the country's first ten year, multi-sector health plan suggest that performance is improving.

5.0 Lessons Learned

5.1.1 IDA Policies and Procedures

Probably the single most important lesson to be learned from the Bank's experience with social sector development in Burkina is the need for high standards but high levels of flexibility in the design, negotiation and execution of IDA-funded projects. The most successful social sector initiatives in Burkina built on and reinforced the country's emerging base of participatory urban infrastructure, education, and health initiatives.

5.1.1. Administrative processes that contributed to success

Composition and Continuity in the IDA Country Team

One of the most important factors that contributed to the design of innovative social sector programs was the existence of a strong IDA sector team, with minimal turnover, for most of the period under study. This high degree of cohesion was forged through regular communication between the country economist and the task manager, regular team meetings and frequent exchange of information between staff. The fact that many of the long-term task managers were recruited to the Bank as mid-career professionals and/or had long-term experience in the relevant sectors further reinforced the team's strength. Conversely, the high rates of poorly orchestrated turnover in the country team after 1996 delayed many promising joint initiatives.

High Levels of Participatory Dialogue in Strategy and Project Planning

A second important factor was the country team's emphasis on regular, transparent discussions with the government and key actors after 1994. This approach (for individual projects as well as the entire Country Assistance Strategy) built on the strong Burkinabe cultural preference for participatory dialogue and consensus- building.

The same tradition contributed to a number of long, frustrating administrative delays between the preliminary studies for and negotiation of the major loans for urban development, education, and health. Bank staff emphasized, however, that there were rarely problems in the execution of any loan for which there was full, transparent agreement among the different actors from the start. When problems emerged, it was typically when some series of events (like the devaluation, the emergency start-up of the basic drugs program, or the forced deployment of the central ministry personnel, as in the case of the PDSN Health Project) created a breakdown in consensus-building .

More flexible IDA lending instruments and procedures which encourage national ownership

These trends were reinforced by a new generation of more flexible procedures that made the Bank more "user friendly" and encouraged national ownership. Four innovations that were

highly valued by the national task managers include:

(1) the introduction of a participatory mid-term review as a routine procedure into all projects designed after 1990;

(2) the publication and open discussion/amendment of an official *aide-memoire* at the end of each of the Bank's quarterly supervision missions that summarizes the mission's observations and priorities for follow-up action;

(3) the simplification of project accounting and procurement procedures [1] and resident mission procedures for assisting project administrators with the resolution of this type of administrative problems when they did arise;[2] and

(4) a steady increase in the use of ministerial and private sector experts on project design teams.

Another positive development has been the shift toward broad based support for an entire sector or subsector (rather than individual projects); and the introduction of more long-term (10 year) flexible funding instruments that minimize the disruptions caused by starting and stopping projects. Other changes helped support a shift away from funding individual projects to broader support for an entire sector or sub-sector such as was pioneered by IDA's assistance to primary education after 1994. The shift toward sector strategies that have greater national ownership was encouraged by:

(1) the organization of an increasingly participatory portfolio review to which all project directors were invited as a mechanism for soliciting the resident mission's assistance in resolving administrative and financial problems that impair project efficiency, impact, and sustainability;

(2) an emphasis on simplifying accounting and procurement procedures, organizing in-country training sessions on procurement, and identifying individuals within the resident mission who are trained to assist project administrators with the resolution of these problems; and

(3) a steady increase in the use of ministerial and private sector experts to design new projects.

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[1] One of the greatest attestations to the ownership of these new procurement and accounting procedures is that a high percentage of the Bank's procedures have been adopted by the ministries for routine operations as well as for the administration of other types of donor assistance.

[2] Especially important was: (a) the organization of an increasingly participatory process of portfolio reviews in which all project directors were invited to solicit the resident mission's assistance in resolving some of the administrative problems that the managers' felt were impairing project efficiency, impact, and sustainability; and (b) the identification of individuals within the resident mission who were trained to assist project administrators (across the sectors) with the resolution of procurement and accounting problems.

5.1.2. Administrative processes that detracted from success

Five issues that were the source of delays that could be better addressed in the design and supervision of the next generation of IDA-funded projects include:

(1) ensuring that any contributions by other donors be negotiated before the negotiation and signing of the grant;

(2) reducing the number of conditionalities for starting disbursement on a loan by obligating the government to fulfill any key project elements prior to negotiation and signing of the loan;

(3) working with the government to encourage the selection of an appropriate Ministry to oversee the project and a project director with the appropriate mix of technical training and budgetary experience prior to or in conjunction with the first preliminary studies;

(4) allocating sufficient project budgets for the periodic review of the project statement of expenses as part of routine supervisory missions in order to address accounting errors and misunderstandings before they become major problems; and

(5) posting a sector specialist[3] to the resident mission with real power to act on behalf the Bank in regard to: (a) regulating personnel disputes; (b) approving special exceptions to procurement or accounting procedures; (c) collaborating with national colleagues in getting political support for key public expenditure and policy reforms; and (d) in coordinating with other donors and the Ministry on the formulation and reformulation of sector strategies.[4]

5.2. IDA Social Sector Development

Link key policy and expenditure reforms for social programs conditions of adjustment and post-adjustment lending

IDA's experience in Burkina provides clear evidence that one of the best ways of protecting the social sector is to integrate the main issues of education and health into the macro-economic policy dialogues such as those that characterized the SAC and the ERC loans. The same "micro-macro" linking process helped elevate national discussions about the need for targeted investment in social sector development to the level of the country's most important macro-economic policy dialogues.

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[3] This individual could be a task manager who is also a cluster leader (as is currently the case for education) or work as a task manager under a cluster leader who is posted at headquarters.

Foster team composition and management styles that link Bank expertise in translating adjustment lending commitments to social programs into line funding and reforms.

The same historic experience highlights the need to capitalize on this type of macro-level commitment to social sector investments by linking: (a) Bank expertise in macro-economic and budgetary reform with (b) Bank expertise in social sector institutional development and management. In the absence of this type of macro-micro linking on the country team, it is difficult to translate loan conditionalities for increased government funding into the types of line budgetary support that ministries need to finance social services over time. This type of macro-micro dialogue was encouraged in Burkina, during the time period under study, by high levels of communication between the country team economist and the social sector task managers, with the country director/officer and/or resident representative serving as the go-between.

Strengthen analytical support for reflection on the economic and social implications of particular policy choices

For this type of macro-micro linking to be sustainable, however, it needs to be reinforced by strong analytical support which helps administrators gain political support for major policy shifts. One of the best illustrations of this was the Bank's support for the development of a computer simulation model of the education sector.[5] Similarly, it is possible to see a strong link between Bank analytical support and guidance (in the form of structured discussions with Washington-based staff) and the Burkinabe government's willingness to conceptualize a new model of urban services that linked basic investments to a parallel investment in strengthening of the communal governments' ability to manage urban infrastructure investments.

Encourage pilot studies as a means to test, amend and forge consensus for new policy models

Burkinabe leaders in all three sectors emphasized the critical importance of pilot studies in helping them test and amend new models for participatory social sector development that could later be expanded on a larger scale.[6] The same pilot studies increased the political ownership of the

[5] One of the best measures showing the high levels of ownership of the simulation model is the fact that a revised version of it and a new variation adapted from Senegal is still being used by the government as the basic framework for strategy analysis and planning in the ministry. Bank support for two short-term group visits to examine similar experiences in Senegal is another factor that appears to have played a key role in the Ministry's willingness to conceptualize a 10 Year Plan and to concert various types of alternative contractual arrangements for the elementary school teachers.

[6] The critical pilot projects for the urban sector include: (a) the UNDP sponsored Habitat Project (1974-1976) to promote site and service and squatter upgrading in the Cissin quartier of Ouagadougou, (b) IDA's First Urban Project in the Cissin and Zogana quartiers of Ouagadougou and the squatter quartier of Sonsoribougou in Bobo-Dioulasso (1978-1983), and (c) the Dutch-sponsored MAP Development method (1979-1983) in four neighborhoods in Ouagadougou (see McMillan, Ouedraogo, Sanou, Sombie, Compaore, and Drabo 1994).

The Ministry's organization of a highly participatory pilot study to develop its new plan for increasing girls participation seems to have increased the central and district-level education ministry officials' input into and ownership

models by involving ministry technicians and officials in their execution and analysis.

Encourage on-the-job training via high levels of communication between national directors and the World Bank task managers, cluster leaders and group leaders

One sees a steady increase in the quality and level of IDA's initiatives in education and urban infrastructure development during the last decade. Most Project Directors attributed this in large part to the short-term and on-the-job training they received on earlier projects in the late 1980s and early 1990s. Although formal training (through formal overseas programs) was perceived as important, it was ranked lower in importance than the informal training they received "on-the-job." An unfortunate series of events which short-changed the proposed model for medical doctor training under the Health Services Development Project was cited as a major factor for their low levels of input into the design and execution of the follow-up Health Services and Nutrition Project (PDSN).

Encourage a wider distribution and documentation of critical sector work documents on Burkina as well as comparative research on other countries

The Burkinabe leaders we met emphasized the critical role that World Bank studies played in helping them conceptualize new approaches to social sector development. This impact was especially important in allowing them to construct the arguments that they needed to defend major policy shifts. To date, however, the policy impact of this research has been muted by the fact that most comparative documents are published only in English. Their impact is further dampened by the lack of a central library, core collection or annotated bibliographies of key IDA and non-IDA studies in the resident mission. The same lack of a central, organized documentation center with strictly controlled access and circulation of core documents and bibliographies seems to increase the time and administration of design and supervision missions.

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of the resulting strategy. Conversely, the use of a foreign consulting firm (with very little input from the Ministry of Basic Education) to conduct a pilot project to test lower cost construction materials under Education III seems to have decreased the Ministry's willingness to have reduced the policy impact of this study.

Although a pilot study to test and amend a new model for cost recovery was conducted as part of the Health Services Project (FY85-95), its impact on their impact on the design of the follow-on PDSN project does not appear to have been all that great. The reasons for this lack of "connection" appear to have less to do with the quality of the studies than a series of leadership and timing issues that seem to have short-circuited the wider ownership of the recommendations stemming from them.

Annex A. Additional Background Information

Annex A, Table 1 Consideration of Poverty Reduction in Different Components of the IDA Program in Burkina, 1992-present

	All Pro-Grams	Adjust-ment Lending	Infrastruc-ture (Roads, Urban)	Educa -tion	Health	Ag.Ext. & Res.	NRM	Forthcoming Rural Developmet Project
HQ backed Analytical Support (Participatory Poverty Review)	X							
CAS	X	X	X	X	X	X	X	
PER	X	X	X	X	X	X	X	
Linked Poverty Goals to Adjustment Lending targets in:								
a.national budgets		X	X		X			
b.expenditure shifts		X	X	X	X			
c.performance indicators		X	X	X	X			
Investment Lending Considered poverty in:								
a.analysis potential impacts on poverty in design			Urban	X	X	X	X	X
b.analysis potential impact poverty on participation			X	X	X	X	X	X
c. supervision reports			X	X	X	X	X	X
Evaluation: impact of a sector strategy on poverty				X	Starting	Partial		

Annex A, Box 1. OED Benchmarks for evaluating the Effectiveness of the World Bank Operational Directive on Poverty Reduction in Relation to Poverty Assessments CAS Exercises,and Lending

Criteria for Assessing the Content of Poverty Assessments (based on OED 4.15 and the World Bank Poverty Reduction handbook)

1. Inclusion of a comprehensive profile of poverty and poverty indicators, the diagnosis of poverty, and a set of prescriptions for poverty reduction.
2. An assessment of the operational content of prescriptions for poverty reduction (e.g. list priorities and pinpoint government policy actions needed to redress the worst manifestations of poverty).

Criteria for Assessing the Influence on Country Assistance Strategies

1. The overall priority accorded to poverty reduction
2. The promotion of labor-intensive growth to reduce poverty
3. The improvement of the human resources of the poor
4. Safety nets of protect vulnerable groups and the very poor

Criteria for Assessing the Influence on the volume of lending

1. Classified as PTI or poverty targeted lending [1]
2. Classified as poverty reducing (see World Bank 1996: 39)

Source: World Bank 1996.

[1] The basis for the PTI designation is found in paragraph 52 of OD 4.15. Lending is considered to be poverty-targeted if it is: (a) for a project that specifies mechanisms for targeting the poor, or (b) for a project where the proportion of the poor among the project's beneficiaries is significantly larger than their proportion in the overall population.

Annex A. Table 2. Bilan des réalisations physiques des lotissements au Burkina Faso, 1983 à 1995

VILLE OU PROVINCES	NOMBRE DE PARCELLES
OUAGADOUGOU	66 526
BOBO-DIOULASSO	25 994
AUTRES PROVINCES:	
BAM	4 057
BAZEGA	926
BOUGOURIBA	4 650
BOULGOU	4 570
BOULKIEMDE	14 429
COMOE	9 514
GANZOURGOU	4 206
GNAGNA	2 686
GOURMA	2 892
HOUET (sans Bobo)	2 420
KENEDOUGOU	4 225
KOSSI	3 700
KOURITENGA	2 072
MOUHOUM	6 783
NAHOURI	1 923
NAMENTENGA	875
OUBRITENGA	5 595
OUDALAN	2 111
PASSORE	6 336
PONI	1 855
SANGUIE	3 743
SANMATENGA	3 249
SENO	791
SISSILI	1 407
SOUM	1 356
SOUROU	3 503
TAPOA	3 405
YATENGA	3 158
ZOUNDWEOGO	145
TOTAL	**199 102**

source: Direction Généralede l'Urbanisme et des Traveaux Fonciers-DGUTF, février 1995

Annex A, Table 3. Bilan des réalisations de logements

NATURE DE L'OPERATION	TYPE DE REALISATION	OPERATEUR	COUT en millions FCFA	LOCALISATION
Cité 4 AOUT	500 villas	Etat + participation populaire	800	25 provinces
Cité AN II	238 villas + équipement collectif	Etat + Banques + opérateurs économiques divers	1 600	Ouaga: 188 Bobo: 50
Cité SIG-NOGHIN (1988)	88 villas	Fonds Habitat	363	Ouaga
Cité AN III (1987-1988)	205 villas, 92 appartements, 96 commerces	CNSS + Fonds Habitat + divers	2 540	Ouaga
Cité AN IV A (1988)	50 villas, 16 appartements, 22 boutiques, 1 bâtiment à usage de bureaux	Fonds Habitat	963,5	Ouaga
Cité AN IV B (1988-1989)	398 villas	Fonds Habitat	1 644,5	Ouaga
Cité 1200 Logts (1989)	1 200 villas	Etat + Banques	4 766,5	Ouaga
Réalisations Socogib	789 villas, 72 apts	Socogib	6 691,3	Ouaga + Bobo
Cités de la CNSS	162 villas	CNSS	162	Ouaga +Autres villes
Cité Song-Taaba (1990)	Cité Song-Taaba (1990)	Fonds Habitat	245,5	Ouaga

Annex A, Table 3. Bilan des réalisations de logements (continued)

Cités Provinciales (1990-1991)	130 villas	Fonds Habitat	653,3	Autres villes
Projet Socogib	100 villas	Socogib	250	Ouaga
Cités Locomat (1992- 1996)	77	Locomat	292,4	Ouaga: 34 Tougan: 20 Zorgho: 20
TOTAL GENERAL	**- 4034 villas** **- 180 appartements** **- 119 boutiques** **- 1 restaurant**		**20 972**	

Sources: (1) DGUTF- Ministère des Travaux Publics de l'Habitat et de l'Urbanisme. (2) Politique de l'Habitat au Burkina Faso; Groupe-Huit, BCEOM, Union Des HLM, 1989.

Annex B. Burkina CAR Social Sector Analysis: List of People Interviewed

Banque Mondiale (Cross-sectors)

Manga Kuoh-Moukouri, Resident Representative, Ouaga

Celestin Bado, Operations Officer, Ouaga

Korka Diallo, Operations Officer, Ouaga

Yildiz Goetze, Economist, Ouaga

Makha Ndao, Sr. Education Specialist, Ouaga

Whitney Foster, Former Country Officer, Wash

Ann Doize, Former Country Economist, Wash

Cynthia Cook, Long-time Country Team Member, Wash

Isabel Girardot-Berg, Rural Sector Coordinator, Wash

Gender

Elizabeth Morris-Hughes, AFTH3

Katrine Saito, former coordintor

Mark Blackden AFT11

Geri Dell, EDI

Ministere de Finance

Patrice Nkiema, Directeur Generale de la Cooperation, Ministere de Finance

Dieudonne Gbimgpimga. DAF, DG-Coop, Ministere de Finance

Tertius Zongo, Minister de Finance

Urbanisme

Richard Dion, Directeur de Projet, Federation canadienne des municpalites, Projet d'appui a la consolidation de la decentralisation

Gilbert Kiptonre, Directeur Troisieme Projet Urbain

Souleymane Zerbo, Consultant, World Bank, Ouagadougou (Ancien Directeur d'Archtechture)

M. Alain S. Bagre, Directeur, Direction Generale de l'Urbanisme et des Travaux Fonciers (DGUTF), Direction de l''nalyse et Des Statistiques urbaines (DASU)

Tiemtore P. Victor, Directeur General, Direction General de l'Urbanisme et de la Topographie

Denise Belemsagha, Ancien Directeur Deuxieme Projet Urbain, Coordinatrice Technique, Federation canadienne des municipalites, Projet d'appui a la consolidation de la decentralisation

Arbi Hama, GTAH, Ingeniurs Conseils

Teomoko Drabo, GTAH, Agent Bureau

Freddy Filippi, Departement Afrique de l'Ouest, Division Infrastructures et Industries

Gilbert Kiptonre, Directeur de Projet, 3me Projet Urbain, Amelioration des Conditions de Vie Urbaines (PACVU)

Seydou Idani, Directeur, Alpha Consulting and Training

Christian Diou, Division Infrastructures et Industries, Groupe Agence Francaise de Developpement

Peter Watson, Division Chief

Dencentralisation

Claude Ouattara, Responsible Service Socio-Economiste, Commission nationale de la Decentralisation

Innocent Coulidiati, Secretaire Permanent, Commission national de la Decentralisation

Paula Donnelly-Roark, AFTI1

Peter Easton, Professor of Adult Education, Florida State University

Autres Bailleurs (Cross Sectors)

Sylvestre Ouedraogo, Charge des Programmes, PNUD, Ouagadougou

Raymond Sawadogo, Directeur, ADRK, Kaya

Daniel Zongo, ADRK, Kaya

Patrice Nikiema, Directeur General, Direction Generale de la Cooperation, Ministere de l'Economie et des Finances

Sante

Roland Koudouyamba Kabore, Directeur, Projet de Developpement Sante et Nutrition (PDSN)

Seydou K. Kabre, Coordinateur, Projet Population et Lutte Contre le Sida (PPLS)

Paul Hubert, Programme d'Appui Intesifie au Burkina, OMS, Burkina

Harouna Ouedraogo, Economist National, PNUD, Ouagadougou

Dia Timmerman, Premier Secretaire, Ambassade Royale des Pays-Bas

Maurince Yien, dircteur national de la Sante, Coordinateur CADSS

Adelai Ouedrogao, Treasurer, Comite, CSPS, Delga (pres de Damesma)

Stanislaus Paul Nebie, Ministere de la Sante, Ancien Directeur de la Planification Familial, Consultant for the CAR

Abdou Salam Drabo, AFTI1

Denise Vaillancourt, AFTI1

Bruna Vitagliano, Sr. Health Specialist, Banque Mondiale, Ouaga

Helen Ribe, Technical Manager, Human Development

Education

Issa Diallo, Ministry of Basic Education, Consultant for the CAR

Yelemou Bougui Robert, DEB Public, Ministere de l'Enseignement de Base et de l'alphabetisation (MEBA)

Aissata Celine Coulibaly, DPEBA-DREBA, MEBA

Madou Alphonse Traore, Inspecteur de l'Enseignement du 1er Degre, Directeur General de l'enseignement de Base, MEBA

Zoundi Tanga Paul, Chef de Project Ecoles Satellite et et Education de Base non Formelle, DEP/MEBA, Interm Directeur, DEP

Zala Lagnonon, Directeur, de la Recherche de la Programmation de la Evalatuion et du Suivi (a la DGINA, Direction Generale de l'Institut National d'Alphabetisation)

Catherine Kabore, DGINA/ZANU, MEBA

Zongo T. Jean-Baptiste, DAFPA/DGINA, MEBA

Kabore Jean-Baptiste, DPD/ENA, MEBA

Kafando Issou, Directeur del'Ecole, Ecole Wend la Mita le Savoir (Private School)

M. Sandwidi Yamba, Directeur/Fonadateur, Ecole Primaire Privee Mixte Saint Joseph (Private School)

Adama Jean-Pierre G. Coulibaly, Secretaire Generale, Ministere de l'Enseignment de Base et de l'Alphabetisation

Servace Maryse Dabou, Attache de Presse, Minsitere de l'Enseignement de Base et de l'Alphabetisation

Issa Joseph Diallo, DEP, Ministere de l'Enseignement de Base et de l'Alphabetisation

Gouem Idrissa Celestin, Ministere de l'Enseignement de Base et de l'Alphabetisation (MEBA), Directeur des Affaires Administrative et Financiere

Ouedraogo Adlaye, Instituteur A Damesma (Ecole, construit project Education III)

Daouda Ouedraogo, Chef Coutumier, Damesma (site, Ecole construit par projet Education III et servi par CSPS)

Irene Xenakis, AFTH3

Transportation

Hedi Larbi, AFTT2

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