

What is the impact of the measures taken by the Burkinabé government to improve the access of the poor to healthcare services?



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“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

Article 25.1, Universal Declaration of Human Rights

Preface

From September 2006 to February 2007, I was in Ouagadougou, Burkina Faso, to do an internship at the “Centre pour la Gouvernance Democratique”. Here, together with my co-intern, Ms. C. van Duyn, it was our task to research and write a report entitled “*Quel est l’impact des mesures prises par le gouvernement Burkinabé pour favoriser l’accès des pauvres aux services d’éducation et de santé?*”, which translates as: What is the impact of the measures taken by the Burkinabé government to improve the access of the poor to education and healthcare services.

This report took the entire internship to write, and once completed was handed over to the head of the organisation: Professor A. Loada. To the best of my knowledge, the report is now being used to further elaborate on the impact of government measures with respect to the PRSP (Poverty Reduction Strategy Paper), which was the professor’s main reason for making us write that report.

Once back in the Netherlands, it was my task to adapt our report to become my thesis. As Ms. C. van Duyn mainly focused on the education aspect, and I on that of healthcare, it was obvious that I would hand in a version of our report that had to do with what I had mainly researched.

I first went about translating our original report from French to English, and then edited it for it to shrink from the 80 page manuscript that it was to the document you hold in your hands today.

The thesis you are about to read is the fruit of a five month research project, which uncovered the impact of the measures taken by the Burkinabé government to improve the access of the poor to healthcare services. Most of the research was done through the reading of government and organization reports, but some was also done with use of interviews and location visits.

Obviously, this is a vast subject to research, and we only began to scratch the surface of what could potentially be done, but with limited time and resources, I feel confident that we made a good start to what could later become groundbreaking research.

Summary

This report aims to analyse the impact of the measures taken by the Burkinabé government to improve the access of the poor to healthcare services.

This is done with a series of chapters, each aiming at a specific sub question.

The first chapter defines the target group and its characteristics. It clarifies the notion of 'poor', the relationships between healthcare and poverty, as well as the obstacles the target group need to overcome to access healthcare services. This chapter sets a basis on which to elaborate the central question.

The second chapter describes the structure of the healthcare system. When analyzing the measures taken to improve the access to healthcare services, a complete understanding of the services available is necessary in order to form a clear picture of what the possibilities are, and where there is room for improvement.

The third chapter focuses on what the measures are that have been taken by the government. Here, the programs in place to improve the access are described, as well as their goals, and where they originated from.

The fourth chapter is about financing. In order to see where the priorities lie, it is important to know who finances the measures, and in what way. In this chapter, there is also an overview of the budget available for the development of access, which is also compared to the total state budget.

The fifth chapter is an in-depth analysis of the impact of the measures taken to improve the access of the poor to healthcare services, which covers the main points of the programs targeting it. The measures are described, and then compared against results obtained from various sources.

Finally, the sixth chapter is made up of the conclusion as well as some recommendations. Here, the findings are discussed, and some possibilities given for the improvement of the programs.

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Introduction

Throughout the last decades, poverty in the developing world has become an increasing concern for those with a conscience, and as a result of this, many plans have been written up to fight this phenomenon. The most significant of these, the Poverty Reduction Strategy Paper (PRSP), is an initiative taken by the governments of these countries together with the Bretton Woods institutions, the World Bank and the IMF.

In Burkina Faso, things are no different. Ranked 174th out of 177 in the Human Development Index and 101st out of 102 in the Human Poverty Index (Ministerie van Buitenlandse Zaken, 2007), there is no questioning the depth of poverty in this country.

In September 2000, the 189 member states of the United Nations adopted the eight Millennium Development Goals (MDGs) in the Millennium Declaration at the Millennium Summit. The Millennium Declaration, which resolves to pursue poverty reduction using the Comprehensive Development Framework (CDF) principles, sets global targets for the year 2015 for reducing poverty and achieving sustainable development. The Millennium Development Goals are (CDF Secretariat, n.d., p.8):

Developing Country Responsibility

1. To eradicate extreme poverty and hunger
2. To achieve universal primary education
3. To promote gender equality and empower women
4. To reduce child mortality
5. To improve maternal health
6. To combat HIV/AIDS, malaria, and other diseases
7. To ensure environmental sustainability

Developed Country and Development Assistance Agency Responsibility

8. To establish a global partnership for development

The MDGs are targets that can galvanize countries and communities into action and help them to achieve greater accountability for development results, but they are not in themselves a strategy on how to achieve goals. Translating them into action requires an operational framework at the national level. In more than 70 low-income countries, this operational framework is increasingly being provided by a country-led poverty reduction strategy. In designing these strategies, individual countries incorporate those aspects of the MDGs that fit their own situations (CDF Secretariat, n.d., p.7).

In the year 2000, Burkina Faso adopted the PRSP, and has as a consequence of this, benefited from a debt reduction, and now receives a large amount of financial aid from various sources. The reason for which the PRSP is mentioned, whereas it has no direct link to the title of this paper, is that it is the base document for all development, and therefore directs the efforts towards, amongst others, improving the access of the poor towards healthcare services.

In this report, the main question to be answered is: “What is the impact of the measures taken by the Burkinabé government to improve the access of the poor to

healthcare services?”. This will be done with a series of chapters, based on the following sub-questions:

1. Who is the target group and what are its characteristics?
This chapter is necessary in order to define who the measures are taken for, and what their specific needs are.
2. What is the structure of the healthcare system?
In this chapter, the current healthcare system is described. This is necessary in order to understand the developments discussed in later chapters.
3. What are the measures taken?
As this document describes the impact of the measures, it is necessary to know what these measures are, and where they come from. This will be done in this chapter.
4. How are the changes financed and by whom?
As the world’s third poorest country cannot finance all these developments by itself, it is necessary to identify the main financial backers, and the ways in which they are financed.
5. What is the impact of the government’s measures?
The answer to the central research question will be given in this chapter.

This report, as well as the document it is based on, was compiled with the use of desk research to evaluate the present situation, the measures taken and the impact of these measures, as well as with an interview and location visits to see the theory put in practise.

During the desk research however, it became clear that finding consistent data to use for this report was not an easy task. In the reports produced by the government, the data seems to have been adapted for whichever organisation is going to use the document. This leads to extremely low morbidity rates in documents intended for those keeping an eye on the healthcare situation, and high illiteracy rates for documents intended for those funding the development of education. In this report, there will be references to the validity of certain data, but for most of the document, the data that was either the most recent, or most trustworthy was used.

Another point that needs to be clarified is the absence of any real referencing to AIDS in this report. This was done for two main reasons:

1. Apart from a proposed Strategy Paper for the fighting of AIDS, apparently, no real measures have been taken by the government to fight this disease.
2. AIDS is a global threat which has been the centre of such a high number of studies that including it in this short report would not even give the reader the slightest perception of the global efforts to cure and eradicate the disease.

1. The target group and its characteristics

1.1 The characteristics of poverty

In its fight against poverty, the government engaged itself to improving the accessibility of the poor to basic social services. It seems important to define the notion of 'poor' and clarify the characteristics of this group.

In the case of Burkina Faso, the threshold of poverty has been established at 82,672 F CFA per person per year, which is approximately 126 Euros a year, or 35 Eurocents a day (UNCCD, 2005, p.23). This implies that this sum is necessary to satisfy the minimum of nutritional needs as well as other basic spending such as clothing and household products. Almost half of the population of Burkina Faso lives below this threshold (UNCCD, 2005, p.23).

Poverty is divided in two dimensions, namely monetary poverty and humane poverty. Monetary poverty is measured by income, whereas humane poverty is established by the repartition of resources amongst the individuals who together make up society. This can be explained by the report on the questionnaire dealing with the evaluation of poverty conducted by the Ministry of economy and Development in both 1998 and 2003 (Ministère de l'Economie et du Développement, 2004a, p.15): here it is said that the access to food, employment/revenue generating activities and healthcare services determine the poverty situation of the population (Ministère de l'Economie et du Développement, 2004a, p.13-15). The other manners in which the population perceive their poverty are shown in figure 1. (Ministère de l'Economie et du Développement, 2004a, p.14).

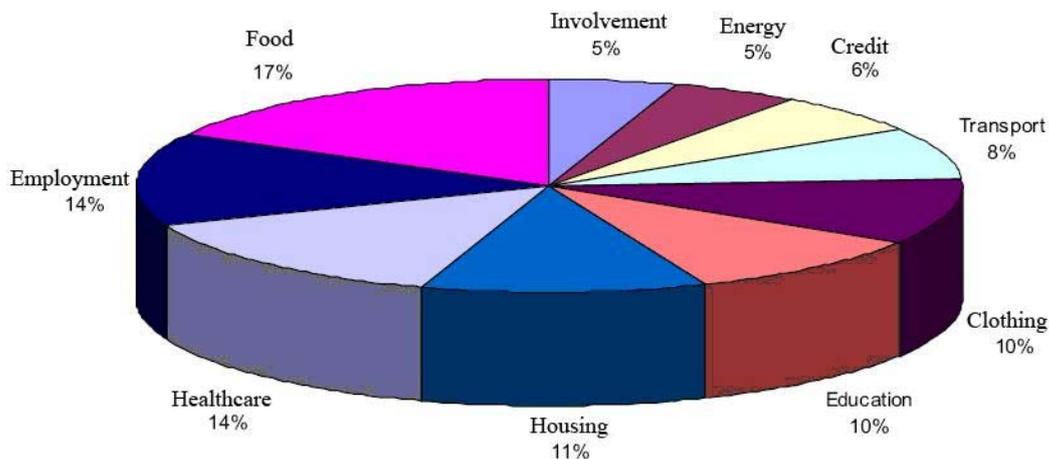


Figure 1 (Source: Ministère de l'Economie et du Développement, 2004a, p.14)

The classification of the determining factors of poverty differs between the urban and rural environments. In urban areas, it is the climate, the low purchasing power, old age and large families that determine the poverty situation. In rural areas, the principal factors of poverty are the lack of initiative, permanent failure, physical handicap and social degeneration (Ministère de l'Economie et du Développement, 2004a, p.13-15).

In addition to the residential environment, the regions also have different priorities regarding the perception of poverty. A good example is that the region '*Centre Sud*' finds that the health and inactivity aspects need more attention, whereas in the region '*Est*', the most preoccupying problem is that of accessibility to basic social services for the poor (Ministère de l'Economie et du Développement, 2004a, p.13-15).

The poverty situation in Burkina Faso is mainly to be noticed by the inequalities between the sexes, the different regions and the residential areas. First, the incidence of poverty is much higher for women than for men. The main cause is that much fewer women than men participate in the economy (WHO, n.d., p.9). This results in a poor access to funds. Second, they are limited in their access to healthcare and schooling. Also, fewer women than men have a voice in national politics and in decision-making (Ministère de l'Economie et du Développement, 2004a, p.20-21). In the case of the regions, the disparities are mainly caused by the lack of natural resources as well as high demographic growth.

Finally, poverty in Burkina Faso is mainly a rural phenomenon, as more than half of the rural population (52.3%) lives below the poverty threshold, against a figure of 19.9% for the urban areas (Ministère de l'Economie et du Développement, 2003, p.15). This phenomenon can be partially explained by the low productivity of agriculture and other activities, fluctuations in price and the fact that villages have little access to exterior markets.

To understand the poverty of the poorest groups in Burkina Faso, it is important to understand the dimensions, perceptions and inequalities present. The knowledge of these facts is necessary in order to fight poverty effectively.

1.2 Poverty and health

Health and poverty are inextricably linked. Poverty is often associated with ill-health, while ill-health can lead to poverty. More importantly, however, good health can lead people out of poverty. And that alone is sufficient reason for global efforts to focus on this area (Hyder, A. A., 1999, p.85).

The first phenomenon to link these two is malnutrition. Almost 45% of Burkinabé children have a weight deficiency (Ministère de l'Economie et du Développement, 2004a, p.29). Except for the fact that a weight deficiency implies retarded growth, a malnourished body is much less resistant to illness, which, in turn, leads to other health problems. The second phenomenon is maternal health. Close to 30% of children do not reach the age of 5, with one third of these not surviving birth. This can be directly linked to the fact that only 44% of births take place in the presence of qualified personnel, and that only 27% of women having given birth to a live child in 2003 received prenatal care (Ministère de l'Economie et du Développement, 2004a, p.28). This low percentage is due to the high cost of healthcare, as well as the difficulty in accessing the necessary facilities.

Utilisation of essential healthcare services by Socio-economic group (%)

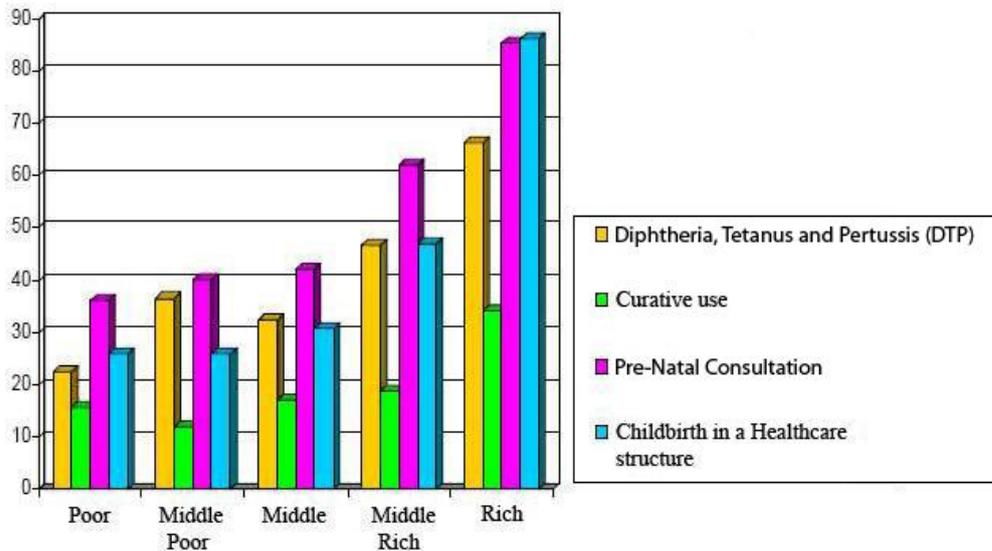


Figure 2 (Source : Ministère de l'Economie et du Développement, 2004a, p.29)

When one looks at figure 2, it becomes clear that the poor cannot afford essential healthcare services, whether it be child delivery or vaccination. This can explain the high infant mortality rate in this group that we can observe in figure 3. Even though these rates do not show very great discrepancy, there is a clear difference.

Child mortality and malnutrition rate by socio-economic group

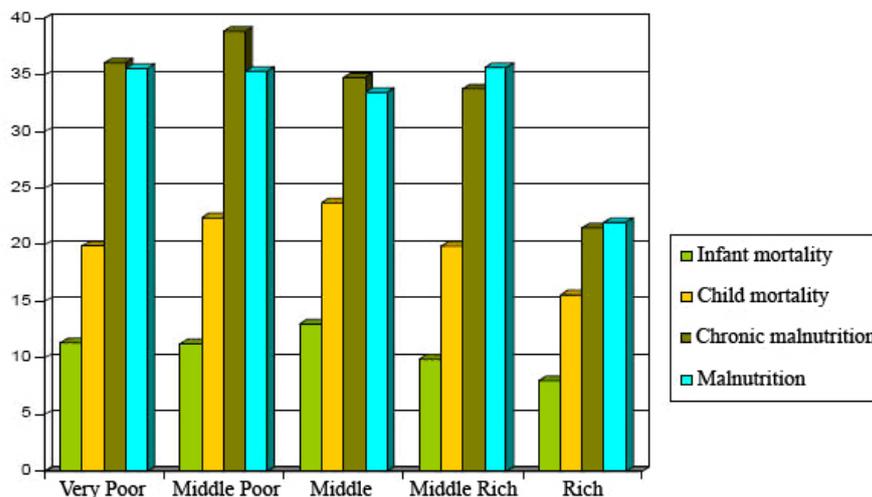


Figure 3 (Source: Ministère de l'Economie et du Développement, 2004a, p.27)

The morbidity rate in Burkina Faso is difficult to evaluate. In 1995 it was evaluated at 15.8% (Ministère de l'économie et du développement, 2002, p.16), while in 1998, in another document, it was evaluated at 7.1% and at 5.8% in 2003 (Ministère de l'Economie et du Développement, 2004a, p.25). If one believes these figures, the improvement was rapid, even though this rate is still much too high. It is a strange fact that the morbidity rate is higher in urban than in rural areas (Ministère de l'Economie et du Développement, 2004b, p.27). This is also the case when one compares the poor

to the rich. This can be explained by the fact that a poor person considers himself ill when he is seriously suffering, whereas the rich declare less extreme suffering as serious (Ministère de l'économie et du développement, 2002, p.7). The paradox of the difference between urban and rural areas can be explained by the way in which inhabitants of urban areas perceive illness, with a greater tendency to declare it, unlike the rural households whose members are used to putting up with illness, for reasons which may be economical, social, cultural or geographical accessibility. A benign pain in a poor person can be considered as an illness in a rich person (Ministère de l'économie et du développement, 2002, p.42).

With a median annual spending on healthcare of F CFA 80,268 in urban areas and of F CFA 27,042 in rural areas (Ministère de la santé, 2006, p.11), it is clear that these figures are much too high for most Burkinabé households, for the absolute threshold of poverty is F CFA 82,672 per person per year, and 46.4% of Burkinabés live below this level (Ministère de l'Economie et du Développement, 2004a, p.15).

1.3 Obstacles in accessing healthcare services

In the field of healthcare services, the obstacles are: household poverty, inadequate distribution of healthcare infrastructure, inadequate offer of services and considerable increase in the size of the vulnerable population. In this section these obstacles will be described in more detail.

First, the economic obstacles. In Burkina Faso, the population has very low purchasing power and this severely limits the possibility of accessing healthcare services for most of the population, especially women, children and the elderly. The devaluation of the CFA franc in 1994 worsened this situation, for the cost of medicines and pharmaceutical equipment then increased drastically (Ministère de l'économie et du développement, 2002, p.57-61). Similarly, the higher cost of private sector services and of transfer abroad for medical care rendered these services virtually inaccessible. This led to a degradation in the state of health of Burkinabé citizens, as they could no longer afford adequate healthcare.

In line with the Bamako initiative (See text box below), the population now participates in the cost of medical treatment according to three different methods of payment: for medicine (the patient only pays for the prescribed medicine), fixed rate payment per episode (the patient pays a fixed rate representing the cost of all care including medicine for an illness) and payment per act (the patient must pay for all contact with a healthcare professional) (Principes de l'initiative de Bamako, n.d.). For

The eight principles of the Bamako Initiative

- *Improving primary healthcare services for all*
- *Decentralising the management of primary health services to district level*
- *Decentralising the management of locally collected patient fees to community level*
- *Ensuring consistent fees are charged at all levels for health services – whether in hospitals, clinics or health centres*
- *High commitment from governments to maintain and, if possible, expand primary healthcare services*
- *National policy on essential drugs should be complementary to primary healthcare*
- *Ensuring the poorest have access to primary health care*
- *Monitoring clear objectives for curative health services.*

(Providing essential drugs – The Bamako Initiative, 2005)

the poor, direct payment and payment per act are the greatest obstacles to the use of healthcare services.

Another economic obstacle is the budget allocated by the government. The healthcare budget is slightly over 8% of the national budget and seems to be increasing very slowly. So government resources are obviously insufficient to carry out the necessary reform and a better distribution of the available resources is needed. Also, the help of financial and technical partners is needed in order to accomplish the desired objective of accessibility for all to healthcare services (Rapport de présentation : Deuxième tranche, 1999).

In order to illustrate the problems of accessibility, it is important to note that the government has put in place a norm of maximum travel time between a domicile and a sanitary facility. This limit is thirty minutes (Ministère de l'Économie et du Développement, 2005, p. 28). In reality, only 35.3% of the Burkinabé population benefit from such a short travel time. Also, the median range of action of a CSPS (Centre Sanitaire et de Planification Sociale) is 8.19 km (Ministère de la santé, 2006, p.18), which means that to be able to keep to this limit, the sick must have access to a motorised vehicle, and must be fit enough to use it!

Regarding travel times, there is of course an enormous disparity between the rural and urban areas. In the region '*Centre*', the median action range of a CSPS is 3.12 km, compared to the region '*Est*', where this range is 13.28 Km (Ministère de la santé, 2006, p.17). These are the two extremes, but the concentration of poor people is much higher in rural areas than in urban areas, which means that the poor have less access to medical centres than the rich.

As for socio-cultural obstacles, one should bear in mind that more than 50% of the Burkinabé population is female, and that the traditional role of a woman in the family renders her situation difficult, and difficult to improve. Indeed, they take care not only of the children, but also of the family economy. So they do not have the time for paid activities as men do. Men are thus more financially independent, with better access to healthcare services (Rapport de présentation : Deuxième tranche, 1999).

On top of all this, a low literacy rate reduces accessibility to healthcare services. According to the Dutch embassy, in 2004, only 27,8% of the population could read and write, the majority of which was male (Ministerie van Buitenlandse Zaken, 2007). This low literacy rate complicates the communication between the government and the population regarding the offer and use of available healthcare services. Unfortunately the women have the least knowledge of available facilities and medication, while they are actually the group most in need of such services. Their needs are aggravated by the fact that they are the victims of traditional practices such as circumcision and precarious marriage. In view of the harm caused by these activities, it is imperative to improve the accessibility, quality and information regarding medical facilities.

The population has greatly increased in Burkina Faso over recent years, at a rate of approximately 2.7% per year. The Burkinabé population is now estimated to be 13.228 million, of which 48.3% are male, and 51.7% female (Ministère de la Santé, 2003, p.7). Over 49% of the population of Burkina Faso are under the age of 15, and the population is constantly getting younger. The prospect for 2010 is an increase in the vulnerable groups, notably children up to the age of 15, and women of child-

bearing age. This increase will lead to greater need for medical care, i.e. doctors and medicine. In this case, one can say that active demand will increase more rapidly than the offer of healthcare services. There is already a deficit of material and human resources, as well as infrastructure. On top of this, the available infrastructure is unevenly distributed in the different regions, as the offer is greater in urban than in rural areas. An example is the personnel in the public healthcare sector. Whereas the two big cities, Ouagadougou and Bobo-Dioulasso, account for only 10% of the total population, this is nevertheless where 53.7% of doctors, 57.3% of midwives, 59% of pharmacists and 33% of nurses are employed. There is also much more infrastructure available in these cities (Ministère de la Santé, 2003, p.22-33).

2. The structure of the healthcare system

2.1 The administration of the healthcare system

Since 1991, Burkina Faso has been engaged in a structural readjustment programme, which has led to the restructuring of the administration service. By decentralising the administrative framework, the government is trying to satisfy the needs of its population (strengthening the capacity of intervention) and the accessibility to healthcare services, now evaluated to be 35.2%. The first phase of the decentralisation process has as an outcome the three following levels of administration (Ministère de la Santé, 2000, p.13):

- The central level is made up of the central services and national hospitals. This level is under the authority of the Ministers' Cabinet and the Secretary General.
- The intermediate level is made up of the 13 Regional Healthcare Departments that have implemented the healthcare policy in their sanitary district.
- The peripheral level is made up of 55 sanitary districts that are the most decentralised entities of the healthcare system.

Unfortunately, the decentralisation process has not completely achieved what it was supposed to. This is mainly due to the administrative organisation in the field of hierarchic and operational relations between the different levels. There is still a lack of good communication, and for this reason, there is weak coordination and a lack of respect of allocations. In particular, at the district level, a long delay in the operationalisation process causes an insufficiency in sanitary coverage. In spite of these facts, the second wave of decentralisation has started. After the municipal elections of the 23rd of March 2006, healthcare services have progressively decentralised towards municipalities (SNV, n.d., p.1).

2.2 The structure of public healthcare

As well as the administrative system, the public healthcare structures have also been reorganised. The different hierarchic levels of the healthcare structure guarantee the following:

- Primary Healthcare Post (PSP)
- Healthcare and Social Promotion Centre (CSPS)
- Medical Centre (CM)
- Medical Centre with Chirurgical Branch (CMA)
- Regional Hospital (CHR)
- National Hospital (CHN)
- University Hospital (CHU)

The PSP and the CSPS are the two institutions that give primary medical treatment, but presently one of the two is barely active, the PSP. In 1984, the government of Burkina Faso created the programme 10,000 villages – 10,000 PSPs, which implied the establishment of one medical centre per village. Unfortunately, this goal was

never achieved, as only 6,495 PSPs were constructed between 1984 and 1987, and the majority never became operational. This can be explained by the model of the programme, based on voluntary work, unlike CSPSs. To this day, only a handful of PSPs are active, and can only treat infectious diseases and non-serious injuries (PSP – Poste de Santé Primaire, n.d.). Also, the accessibility to healthcare services in rural areas did not improve with this initiative. The CSPS are now the main healthcare-providing centres in rural areas. These centres are well equipped, and are also capable of treating serious diseases. The centres made up of a health centre section and a maternity ward, and the personnel is trained and paid for by the government. The cover of these centres is between 8,000 and 15,000 inhabitants, and the government's aim is to make sure that each inhabitant has access to a CSPS within a radius of 15 km. Currently, this goal is achieved in 18 of the 30 provinces (CSPS - Centre de Santé et de Promotion Sociale, n.d.).

The Medical Centres are the hospitals of large cities with a cover of 20,000 to 30,000 inhabitants. The composition of these centres like that of CSPSs, is a health centre and a maternity ward. Some of them also dispose of a surgery. Generally, these centres are the reference for sanitary training in the district, but certain sanitary districts are centred around Regional Hospitals (CHR). CHRs are the second level of healthcare infrastructure, found mainly in large cities. These hospitals provide specialised healthcare services.

The third level consists of the University Hospital, which provides specialised healthcare services and serves as a training centre for personnel and for research.

It is clear that the government is building new medical centres, but the cover remains insufficient. Buildings are present, but they are not operational. Also, the quality of available services is not the best. For this reason, there are a considerable number of medical evacuations towards other countries (Ministère de la Santé, 2000, p.14). Generally, the public structures are confronted with a lack of organisation of the reference and counter reference systems. This development is closely tied to the decentralisation of the administrative system, the level of sanitary districts and the delay in implementation.

Parallel to the public sector are the private healthcare sector and the traditional sector. Some of the private sector's establishments were created by NGOs. Thanks to them, the offer of services has increased. On the other hand, the structure of the departments in charge of support and control are not fully functional. This no doubt leads to an increase in offer, but the quality is not always adequate. The traditional healthcare sector is officially recognised (by law n° 23/94/ADP passed on 19/5/94). Since this sector has not adopted an official policy, there are insufficiencies in the managing of local medicinal plans, validation of products etc. Better cooperation between the different sectors could increase and improve the sanitary offer. For this reason, this objective was adopted by the PNDS.

3. The measures taken

The Burkinabé government has produced two documents/plans to help improve the access of the poor to healthcare services. These are the Poverty Reduction Strategy Paper (PRSP) and the National Sanitary Development Plan (PNDS). There is a theoretical link between the two, which is that the PNDS is based on the PRSP, but in reality, little communication is upheld between those in charge of both the plans, which leads to some confusion. In the following chapter, both plans will be described.

3.1 The Poverty Reduction Strategy Paper

In order to understand how the PRSP works, it is important to see how it is linked to the other development programmes.

The PRSP is, theoretically, the base document for all decisions taken by the government. All national plans must be formulated in accordance with the PRSP, and all decisions must be taken with the reduction of poverty in mind.

The PRSP consists of 4 main objectives, which determine the fields in which improvements are to be made. The four objectives can be described as follows:

1. Acceleration of growth founded on equity.
2. Improvement of access for the poor to basic social services and social protection.
3. Enlargement of employment and earning opportunities for the poor.
4. Promotion of good governance.

Every year, the PRSP is divided into Priority Action Programmes (PAP), on which the government has to focus. In this manner, every year, an implementation report is published in which progress made towards the ultimate goal is described.

The PAP divides the objectives of the PRSP and formulates specific objectives for each of these divisions.

This report focuses on the second objective, the improvement of access for the poor to basic social services and social protection, and research has focused on the access of the poor to healthcare services.

The sub-objectives for this objective are as follows (Ministère de l'Économie et du Développement, 2004c, p.21):

- i. Increase sanitary coverage through the development of sanitary infrastructure and equipment, render sanitary districts operational, develop community-based services and strengthen the collaboration between public, private and traditional healthcare sectors in the provision of healthcare.
- ii. Improvement in the quality and usage of healthcare services through the application of standards, improvement in the availability of essential medicines and the intensifying of activities.
- iii. Greater efforts in combating diseases through the promotion of healthcare to specific groups, the reduction of incidence and prevalence of diseases in

- public healthcare.
- iv. Reduction of the transmission of HIV through reinforcement of STD and HIV preventive measures and the improvement of the quality of medical and psychosocial assistance given to those living with HIV/AIDS.
 - v. Development of human resources in healthcare by defining national goals and satisfying the needs of the healthcare system.
 - vi. Improvement of financial accessibility for the population to healthcare services by increasing the effectiveness of these services and the promotion of risk-sharing mechanisms such as insurance.
 - vii. Increased finance for the healthcare sector, mainly through the improvement of cost recovery.
 - viii. Strengthening of the institutional capacities of the Ministry of Health through improvement in the organisational structure, reinforcement of the legal structure, increase in the administrative and management capabilities, improvement in the coordination of sectoral intervention and the strengthening of interdepartmental collaboration.

Not all of these points are directly connected to accessibility, but it is clear that the faults in the system have been well studied, and that it is now known which problems to tackle. All of the points mentioned above have been further developed in the PRSP documents in order to accomplish the objectives.

3.2 The National Sanitary Development Plan (PNDS)

As a consequence of the eleventh conference of partners in the development of healthcare in 1997, the Ministry of Health decided to revise the national healthcare policy and to develop a national sanitary development plan to cover a period of ten years (Ministère de la Santé, 2000, p.5).

This plan has eight objectives, which are exactly the same as those of the PRSP (Ministère de la Santé, 2000, p.5-7).

The PNDS was ratified in September 2000, the same year as the PRSP. It is not evident which programme preceded the other, but it is undeniable that the objectives are the same and that they should thus be amalgamated. Since the PRSP is, theoretically, the base document for development in Burkina Faso, it seems obvious that when the PNDS is revised, the PRSP would be too and vice versa, but this is not the case. Unfortunately, there is no coordination between the two; this leads to slow progress and bad information transfer. It is unclear whether the developments that are made in both programmes are taken credit for by both.

4. Financing

4.1 The role of financial backers in the development of healthcare

Financial backers play an important role in the improvement of the accessibility to healthcare services. Regarding the PRSP, of which objective 2 is partially devoted to this problem, we can see that its implementation and elaboration is supported by several bilateral and multilateral financial backers. Since the PRSP is the reference for all healthcare programmes, it is important to explain the role of financial backers in the realisation of PRSP objectives.

In the PRSP we can make a distinction between bilateral financial backers and multilateral ones;

4.1.1 Multilateral backers

The Bretton Woods institutions, the World Bank and International Monetary Foundation, played an active and continuous role in the elaboration process of the PRSP in Burkina Faso. The Burkinabé administration received technical support from the World Bank. It also received support for the formulation of the document, through finance for questionnaires, the results of which were used to define the determining factors of poverty in Burkina Faso (incidence, depth, etc).

Regarding support for the implementation and follow-up of the PRSP, the World Bank intervenes in the following ways (Agence Canadienne de Développement International, 2002, p.22):

- Provision of support credit to the poverty reduction strategy (CASRP): this 120 million dollar credit is paid according to a sliding triennial envelope; its objective is to support the Burkinabé government in the poverty reduction strategy through budget support.
- Finance for a national forum on the statistical information for monitoring poverty, organised by the INSD in December 2001. At the end of the forum, the Burkinabé authorities had to prepare a plan of action for the follow-up on poverty.
- Support for the INSD to prepare the national questionnaire on the consumption budget of households.

The Burkinabé authorities have indicated that this support from the World Bank remains insufficient as the national statistical apparatus will need to answer a lot of requests.

The other United Nations bodies, the United Nations Programme for Development (UNDP), strongly linked itself to the PRSP process, principally through the Support Project for the Strengthening of Economic Governance (PRGE). The 4 objectives of this project are closely linked to the PRSP process and aim to contribute to the strengthening of local capacities for political elaboration, poverty monitoring and aid coordination. This project financed the following: (i) The National Observatory of Poverty and Durable Human Development (ONAPAD) and (ii) The National Observatory of Employment and Professional Training (ONEF) (Agence Canadienne de Développement International, 2002, p.23).

4.1.2 Bilateral backers

Numerous bilateral partners provide aid for the implementation of the PRSP, the most significant being the Conjoint Budget Support Group to the Poverty Reduction Strategy Paper (SBC-PRSP). This group is composed of six financial backers - Belgium, Denmark, the Swiss Cooperation, The Netherlands and Sweden and the European Union. Its objective is to support the implementation of the PRSP through coordinated budget support. The support is provided as non-targeted budgetary support, or on condition that progress is made in the implementation of the PRSP. Payment involves a fixed part and a variable part, both of which depend on policy performance, measured with PRSP indicators. Progress is evaluated jointly, based on the reviews of the Facility for the Reduction of Poverty and Growth (FRPC) and of the PRSP (Agence Canadienne de Développement International, 2002, p.23).

This group has envisaged the establishment of an Institutional Support Fund to implement the PRSP. It would be a multi-backers fund that could finance studies, questionnaires and technical assistance for the strengthening of the administrations' capacities. This fund could also bring support to the decentralised monitoring of the PRSP. At the time of writing, there was no evidence to suggest this fund was functional yet, as the implementation modalities were not yet defined.

In Burkina Faso, the necessary conditions for an effective concentration and coordination of financial backers are not yet in place, and divergences subsist between certain partners in development. These concern:

- **The payment requirements:** regarding payout, certain backers demand that criteria be tested, while others do not.
- **The schedule of due dates:** certain technical and financial partners find that the schedule of due dates for the realisation of the PRSP are too constraining, in that there would be insufficient time for the reasonable production of results.
- **The nature and viability of macroeconomic data**
- **The indicators to consider:** There is general agreement on the importance of result indicators, but there is divergence between financial backers on the importance and emphasis to give to the process indicators.
- **The coherence and priorities of PRSP support measures:** for certain partners, the priority would be to decrease the state's public spending, whereas for others, this policy is incompatible with the objectives of the PRSP.

These divergences mean that the financial backers have trouble speaking with a single voice, and this leads to a certain incoherence in the messages sent to the Burkinabé authorities. This was seen during the evaluation of the first evaluation report of the PRSP, when some backers criticised the contents of the report, while others expressed their satisfaction to the Burkinabé authorities (Agence Canadienne de Développement International, 2002, p.24).

The existence of a functional coordination platform between an important sub-group of financial backers is in itself a good thing. It would be even better however if there were to be a committee involving all bilateral and multilateral financial backers. Such a committee would permit the clarification of the rules of play, and would create a natural pressure to harmonise the demands whilst leading to more effective

coordination between the Burkinabé authorities and the technical and financial partners (PTF).

It is therefore important that there should be coordination of financial backers, to ensure that the available funds are used in the most effective way. The introduction of the SBC (a joint budgetary support group) is an important development, but remains constrained since there are only 5 bilateral and 1 multilateral backers in this group. On top of this, there is more and more divergence between certain financial backers. These developments form an obstacle to the realisation of, amongst others, objective 2 of the PRSP.

4.2 The PRSPs budget

The PRSP programme, and the other plans it is linked to, are extremely expensive policies. It is certainly extremely difficult for the world's third poorest country to finance a complete reform of the healthcare system, and even more so in view of the previous situation!

It is clear that the PRSP was adopted in order to make the country benefit from a debt reduction, as well reducing the incidence of poverty; the adoption of the plan also encouraged many other financial backers to provide financial and technical support. The state's budget is largely spent on this, and is increased by a strong flow of funds from partners and NGOs. Some backers support the PRSP in its entirety, others support only certain aspects of it, or only certain programmes (Ministère de la Santé, 2003, p.15). Some support more than one aspect or programme, but allot a different budget to each. According to the Dutch embassy in Ouagadougou, problems in the justification of state expenditure have recently led to certain financial backers preferring to pay for the projects directly rather than allowing the State to manage the funds. This is also a form of financial support, but cannot be included in this analysis as the details are too difficult to ascertain.

In objective 2 of the PRSP, there are numerous points requiring finance, but they are limited to certain PAPs. The spending is done, in matters of healthcare, on the following point (Ministère de l'Economie et du Développement, 2006a, p.15):

4. Promotion of the access of the poor to healthcare services and nutritional programmes

Each of the points is sub-divided, and each of these sub-division receives its own budget, varying from F CFA 28.5 million for creating water wells in the gold mines, to F CFA 20.5 billion for the common fund of the PDDEB.

The PRSP is a major point of action of the government's agenda as can be seen by the share of the national budget devoted to this programme. As is apparent from the table below, in 2004, almost two thirds of the state budget was allocated to the PRSP. It is also clear from the table below that more than 50% of the financing for this programme stems from budgetary aid.

Year	Total State budget ¹	Budgetary aid ¹	Budget PRSP ²	Healthcare expenditure ²
2004	666 129 346	215 974 441	411 107 000	47 148 500
2005	779 337 292	280 370 415	483 416 300	39 272 800
2006	892 097 099	331 483 242	500 074 900	40 852 200

Amounts are in thousands of F CFA

¹(Source : Ministère des finances et du budget, 2005)

²(Source : Ministère de l'Economie et du Développement, 2004c, p.99-124)

The healthcare figures above are taken from the 2004-2006 PAP document. This indicates that these were the planned figures, and not those achieved. From figure 4, we can see more clearly what was planned per year. During the AIDS summit in Abuja in April 2001, the heads of state decided to increase the healthcare budget to 15% of the total national budgets. Also, the WHO, which is less ambitious, or more realistic, fixed this at 10% (Centre Pour La Gouvernance Démocratique, 2005, p.19). It is clear by consulting figure 4 however, that Burkina Faso did not come near to attaining either of these percentages.

State budget and healthcare budget between 2003 and 2006

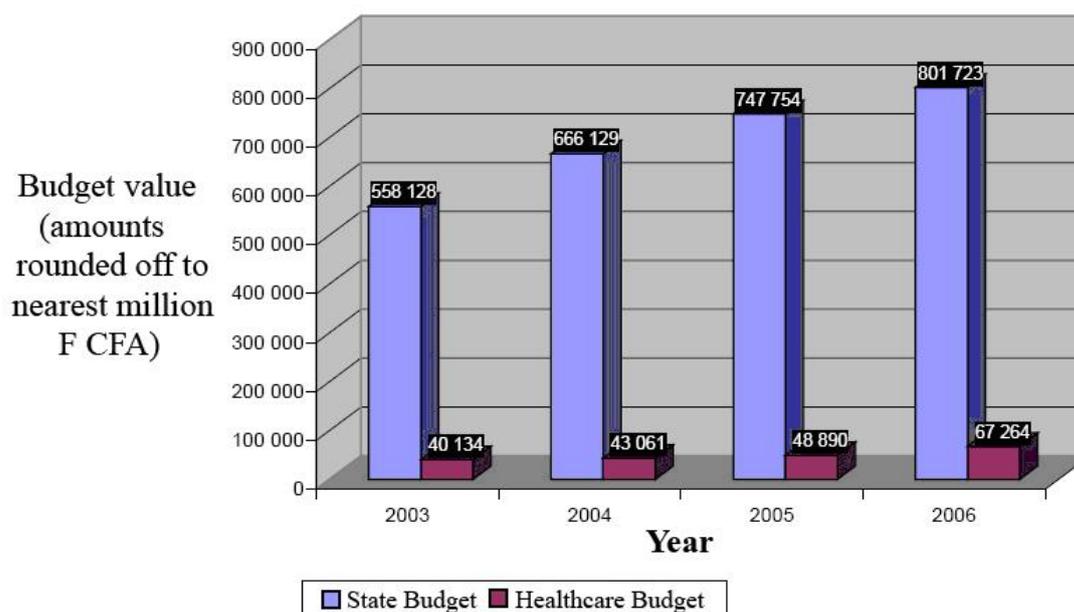


Figure 4 (Source: Centre Pour La Gouvernance Démocratique, 2005, p.20)

These figures clearly show that the PRSP could not be implemented without exterior financial backing. This makes it difficult to understand why the state was unable to justify certain discrepancies in the common fund. If the financial aid is so necessary, why jeopardise it?

Comparison of Budget Support and Government Revenue

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004		Cumul 1994-2004
											Estimates	Actual	
Loans	42,812.0	36,332.0	9,379.9	10,596.3	23,699.0	26,483.3	5,179.0	48,728.0	56,065.0	14,840.0	45,700.0	42,862.0	317,179.5
IMF	13,865.0	13,263.0	4,930.9	10,596.3	10,401.0	10,423.3	5,179.0	15,657.0	10,114.0	2,756.0	5,300.0	2,731.0	99,936.5
World Bank	28,947.0	21,611.0	4,439.0	-	13,298.0	16,060.0	-	33,071.0	24,498.0	-	32,200.0	32,452.0	174,366.0
AfDB	-	1,658.0	-	-	-	-	-	-	21,456.0	12,084.0	8,200.0	7,679.0	42,877.0
Sub-total (excl. IMF)	28,947.0	23,269.0	4,439.0	-	13,298.0	16,060.0	-	33,071.0	45,954.0	12,084.0	40,400.0	40,131.0	217,243.0
Grants	39,957.0	36,815.0	27,266.3	16,778.3	19,781.9	23,658.0	22,908.0	27,185.0	29,937.0	71,555.6	48,142.0	47,062.0	362,904.1
European Union	15,038.0	14,926.0	11,397.0	12,689.0	13,373.0	12,463.0	20,321.0	9,900.0	16,005.0	24,795.1	28,206.0	24,649.0	175,556.1
World Bank	-	-	-	-	-	-	-	-	-	29,145.0	-	-	29,145.0
France	14,000.0	13,980.0	5,000.0	-	-	-	-	-	-	1,968.0	5,248.0	3,444.0	38,392.0
Denmark	-	-	4,402.0	-	1,700.0	1,778.0	-	-	-	-	-	-	7,880.0
Netherlands	-	6,157.0	6,467.3	1,930.2	2,008.9	6,986.0	-	11,907.0	8,374.0	6,130.4	8,424.0	12,687.0	62,647.8
Belgium	1,659.0	-	-	-	-	-	-	-	-	3,252.1	-	-	4,911.1
Switzerland	3,057.0	1,050.0	-	2,159.1	2,700.0	2,431.0	2,587.0	2,649.0	2,679.0	3,356.0	3,384.0	3,379.0	26,047.1
Sweden	6,203.0	702.0	-	-	-	-	-	2,729.0	2,879.0	2,909.0	2,880.0	2,903.0	18,325.0
GRAND TOTAL	82,769.0	73,347.0	36,646.2	27,374.6	43,480.9	50,141.3	28,087.0	75,913.0	86,005.0	86,395.6	93,842.0	89,924.0	680,083.6
<i>Annual change</i>		-11.4%	-50.0%	-25.3%	58.8%	15.2%	-44.0%	170.3%	13.2%	0.5%	-	4.1%	-
Total excl. IMF	68,904.0	60,084.0	31,695.3	16,778.3	33,079.9	39,718.0	22,908.0	60,256.0	75,891.0	83,639.6	88,542.0	87,193.0	590,147.1
Estimates	119,464.0	75,450.0	41,244.0	24,380.0	43,060.0	45,650.0	40,000.0	88,200.0	92,000.0	114,050.0	93,842.0	93,842.0	777,340.0
CURRENT REVENUES	114,230.3	137,183.1	160,892.4	182,132.9	199,367.2	213,801.2	219,348.3	227,965.8	259,442.6	300,971.3	345,412.5	344,827.2	2,360,182.3
<i>Annual change</i>		20.1%	17.3%	12.2%	9.5%	7.2%	2.6%	3.9%	13.8%	16.0%	14.6%	14.6%	11.8%
of which: fiscal revenue	104,417.1	127,973.1	150,220.9	168,137.8	183,315.0	197,822.6	202,936.4	213,220.4	240,876.5	270,081.3	318,884.5	318,554.0	2,177,555.1
<i>Annual change</i>		22.6%	17.4%	11.9%	9.0%	7.8%	2.6%	5.1%	13.0%	12.1%	17.8%	17.8%	17.8%
Parliamentary receipts	-	-	700.3	6,466.3	3,736.5	3,028.0	14,640.0	3,028.0	872.3	1,000.0	11,500.0	7,311.4	37,754.8
Project aid	62,509.5	97,530.5	125,166.7	135,026.4	150,973.7	191,614.8	179,363.8	114,069.7	111,942.7	179,363.8	174,800.0	150,493.0	1,498,094.6
TOTAL RESOURCES	259,308.8	308,060.6	322,705.3	345,254.2	400,288.1	459,293.8	441,459.1	420,976.5	458,262.6	567,750.7	625,554.5	592,555.6	4,576,115.3
of which: domestic resources	114,230.3	137,183.1	160,892.4	182,853.2	205,833.5	217,337.7	233,988.3	230,993.8	260,314.9	301,971.3	356,912.5	352,138.6	2,397,937.1
Share Budget Support	31.9%	23.8%	11.4%	7.9%	10.9%	10.9%	6.4%	18.0%	18.8%	15.2%	15.0%	15.2%	14.9%
Share project aid	24.1%	31.7%	38.8%	39.1%	37.7%	41.7%	40.6%	27.1%	24.4%	31.6%	27.9%	25.4%	32.7%
Share domestic revenue	44.0%	44.5%	40.9%	53.0%	51.4%	47.4%	53.0%	54.9%	56.8%	53.2%	57.1%	59.4%	52.4%

Source: SP-PPF, MFB, Ouagadougou (June 2005).

Figure 5 (Source: Lanser, P., Dom, C., Orivel, F. & Ouédraogo, J. P., 2006, p.188)

In figure 5, budgetary aid and public revenue are compared for the period of 1994 to 2004.

Not only can one see that the numbers representing the annual public revenue are different from the ones mentioned elsewhere in this chapter, but one can also notice that, since 1994, the state of Burkina Faso's share in annual public expenditure has never been greater than 59.4%. On the other hand, it is clear that the state's share is increasing every year. And of course, the absolute value of the public share is certainly in constant increase.

It is clear that a considerable part of the budget is used to fight poverty, and that budgetary support is indispensable to enable Burkina Faso to accomplish the planned objectives within the specified timeline. The state seems to be very good at attracting funding, but does not seem to manage to account for all its spending. If the objectives of the PRSP really represent what the state wishes to improve in its country, it is essential to show external backers that the funds are properly used.

5. The results

In the preceding chapters, the developments planned by the government in healthcare were discussed. Now we will examine what has actually been done in healthcare, particularly in the area of accessibility.

As was explained earlier, the healthcare development policy is the PNDS, which has eight main objectives (Ministère de l'Économie et du Développement, 2004c, p.26):

- (i) Increase national healthcare coverage;
- (ii) Improve the quality and usage of healthcare services;
- (iii) Strengthen the fight against disease;
- (iv) Reduce the infection rate of HIV/AIDS;
- (v) Develop human healthcare resources;
- (vi) Improve financial accessibility to healthcare services;
- (vii) Increase financing of the healthcare sector;
- (viii) Strengthen the institutional capacities of the ministry of health

As this research is on accessibility, only the achievement rates of points (i), (v) and (vi) will be examined.

The total amount set aside by the 2005 PAP for objective 2 of the PRSP is F CFA 128.8 billion. Of this, approximately 100.2 billion was mobilised, and F CFA 68.1 billion spent, giving a financial achievement rate of 68%.

Compared to the 2004 PAP, there is an improvement in the achievement rate of more than two percent. A detailed analysis of the programmes shows that much effort has been made to improve the access of the poor to basic social services and social protection. The most-improved sub-programme is the promotion of the access of the poor to healthcare services and nutritional programmes, which has an achievement rate of 88.9%.

There have been significant results in the domain of healthcare, with the indicators up, particularly for CSPSPs, which function according to personnel regulations, the number of assisted childbirths and the increase in vaccination cover (Ministère de l'Économie et du Développement, 2006b, p.13).

5.1 Increase national healthcare coverage

The following is a list (Ministère de l'Économie et du Développement, 2004c, p.23) of the objectives of the 2004-2006 PAP for the first objective (i) of the PNDS.

- Standardise the incomplete infrastructure: transform 97 isolated health centres into CSPSPs; build 51 Essential Generic Medicine (MEG) depots, 3 Medical Centres with Chirurgical Branch (CMA), 100 lodgings and 90 wells; improve 7 Regional Hospitals (CHR) and the 2 university hospitals;
- Build new infrastructure: 126 new Healthcare and Social Promotion Centres (CSPSP), 15 offices for the District Management Team (ECD) and 6 for the Regional Healthcare Management (DRS), the National Centre for Blood Transfusion;

- Rehabilitate existing infrastructure: rebuild the Kaya and Banfora CHRs; rehabilitate 48 CSPSPs, 9 CMAs, the Nutritional Department and the Burkinabé National Centre for Orthopaedic Equipment (CNAOB);

Comparing this list to the following extracts, one can make a conclusion on what has been achieved. The 2004 implementation report (Ministère de l’Economie et du Développement, 2005, p.52) tells us that:

“With the problem in mind of rendering sanitary structures more accessible in the most outback regions, 324 new infrastructures were completed in 2004.

- 28 health centres and 46 maternity wards have been transformed into CSPSPs; 27 MEG depots, 71 lodgings and 51 well have been created;
- 1 CMA (Boussé) has been built and 2 CMAs (sectors 15 and 22 of Bobo-Dioulasso) are in the course of being completed;
- 21 complete CSPSPs have also been built;
- The National Centre for Blood Transfusion in Ouagadougou and the Regional Centre for Blood Transfusion in Bobo-Dioulasso have been built.

In addition to this, many infrastructures have been rehabilitated:

- the 2 Universty Hospitals and 4 CHRs (Gaoua, Dori, Koudougou and Dédougou) have been strengthened;
- the Kaya and Banfora CHRs are in the process of being built;
- 12 CSPSPs and 6 CMAs have been rehabilitated;
- The construction of 6 offices for the ECD and 2 for the DRS (Kaya and Fada) is in progress.”

According to the 2005 Implementation Report (Ministère de l’Economie et du Développement, 2006b, p.59), the following achievements have been made:

“The government, with the support of its partners, has pursued its sanitary cover reinforcement actions by developing sanitary infrastructure and equipment. In this manner, 8 complete CSPSPs have been built, 22 health centres and 39 maternities have been transformed into CSPSPs, 20 MEG depots, 67 lodgings, 128 latrines/showers, 18 incinerators, 41 wells and 67 kitchens have been built, 4 youth centres have been built, the Kaya CHR has been inaugurated and the one in Banfora is still in construction, the 2 University Hospitals and 4 CHRs (Gaoua, Dori, Koudougou and Dédougou) have been strengthened, 6 health centres and 6 maternities have been rehabilitated.”

Infrastructure	Plans of the 2004-2006 PAP	Achieved according to the 2004 Implementation Report	Achieved according to the 2005 Implementation Report	Total achievement for 2004 - 2005	Percentage of the PAP realised in 2 years
New CSPSP	126	21	8	29	23%
Transformed CSPSP	97	74	61	135	76%
Rehabilitated CSPSP	48	12	12	24	50%

New CMA	3	1 (2)	0	1	33%
Rehabilitated CMA	9	6	0	6	66%
Reconstructed CHR	2	(2)	1 (1)	1	50%
Reinforced CHR	7	4	0	4	57%
CHN Reinforced	2	2	0	2	100%
New MEG depot	51	27	20	47	92%
Lodgings	100	71	67	138	138%
Wells	90	51	41	92	102%

Figure 6

From figure 6, one can see that, according to the implementation reports, there is already a reasonably high achievement rate of the PAP objectives. On the other hand, attentive readers will have noticed that in both the 2004 and 2005 implementation reports, the ministry of economy and development indicated that the strengthening of the Gaoua, Dori, Koudougou and Dédougou CHRs was complete. This of course casts some doubt over the validity of the other claims.

In Figure 7, the development of sanitary infrastructure is apparent, from the Ministry of Health figures. One can compare this table to the previous one to see if the CSPSs that have been counted as running by the Implementation Reports, have been named

Evolution of Healthcare Infrastructure

Year	CHR/CHN	CMA	CM	CSPS	Health centre	Maternity	TOTAL
1990	11		70	577	123	16	797
1991	11		68	588	107	10	784
1992	11		68	602	111	11	803
1993	11		67	612	119	14	823
1994	11	17	57	626	131	15	857
1995	11	17	61	677	116	16	898
1996	11	18	68	721	130	27	975
1997	11	25	44	740	128	18	966
1998	11	30	42	769	130	17	999
1999	11	30	42	774	145	17	1019
2000	11	31	41	798	145	46	1072
2001	12	33	36	835	145	46	1107
2002	12	36	28	1051	87	39	1253
2003	12	38	33	1147	93	28	1361
2004	12	41	42	1148	87	16	1326
2005	12	41	35	1172	88	29	1349

Figure 7 (Source: Ministère de la santé, 2006, p.7)

as such by the Ministry of Health. Here, we can thus see that in 2004, there were 1172-1148 = 24 new CSPSs. According to figure 6 though, 21 new CSPSs were constructed. The disparities between these figures can be linked to a difference in administrative years, as well as a different manner of counting. On the other hand, the

CMA that was built according to the implementation reports is not mentioned in the Ministry of Health's table. Maybe it is not yet functional, and this could be the reason that, according to the Ministry of Health, the number of CMAs has not increased.

5.2 Develop human healthcare resources

The personnel situation is as follows. According to the PAP document, the following list (Ministère de l'Economie et du Développement, 2004c, p.23) elaborates the objectives for 2004-2006.

- Training 30 doctors in district management and 15 in essential surgery annually
- Training COGES (Management Committee) members in healthcare training activities management, including those with a communal base
- Training traditional practitioners in the improvement of the quality of their services
- Periodically review the national list of essential medicines
- Training COGES members in the management procedures of MEG depots.

The 2004 Implementation report described the following list (Ministère de l'Economie et du Développement, 2005, p.53) of accomplishments:

- In 2004, 17 doctors were trained in management and 14 in essential surgery. The training of doctors in the management of districts in 2004 took place in one session instead of the two that were planned; which made it impossible to train 30 doctors.
- Community-based activities to increase sanitary coverage were not neglected: the training of COGES members to manage sanitary training activities including those of communal base was accomplished by the ECD, and can be checked in the sanitary districts action plans.
- The cooperation with traditional practitioners to improve the quality of their services was increased.

For 2005, the following extract (Ministère de l'Economie et du Développement, 2006b, p.59) describes the accomplishments:

“As for training, 17 doctors were trained in the management of sanitary districts, and 16 in essential surgery. The COGES members in the management of sanitary training activities (including those that are community based) and in the procedures of MEG depot management by the ECD were trained. Traditional practitioners have been trained in the improvement of the quality of their services. The national list of essential medicines has also been revised. Two hundred communal intermediaries and one hundred mothers per district have been trained on the handling of simple malaria in 55 sanitary districts. The legislative texts on the decentralisation of healthcare services have been adopted and handed out by the CADSS.”

Even though the evaluation of a real rate of achievement is difficult for this data due to the absence of figures, some can be calculated. It can thus be seen that the first PAP objective was achieved at 57%, as only 17 doctors were trained in management, and

for the second objective, training doctors in essential surgery, the achievement rate is 93% and 107% for the years 2004 and 2005 respectively. It can therefore be said that activities have been undertaken for all points mentioned by the PAP, which shows real progress in the development of healthcare.

Specifically for point (v) of the PNDS, it is more difficult to measure the progress as the improvements are not quantitative. As written in the PAP (Ministère de l'Economie et du Développement, 2004c, p.24), the objectives are to:

- Elaborate a policy document and a development plan for human healthcare resources;
- Periodically update the personnel situation through the implementation of a computerised human resource management system;
- Continue the decentralisation of the management of human resources by taking into account the needs of the regions for the recruitment and allocation of personnel in priority rural areas.

Although the 2005 implementation report does not mention the developments in this objective, in that of 2004, the following achievements (Ministère de l'Economie et du Développement, 2005, p.60) were reported:

- The state budget and PPTTE resources have permitted the recruitment of 864 agents in 2004 in all categories against 877 and 806 respectively in 2003 and 2002. In order to permit peripheral sanitary structures to respect personnel norms, around 90% of recruited agents were destined to first level sanitary
- In addition to this, in light of motivating personnel and maintaining the same level of quality, 253 agents of all categories were admitted to the professional competition by following classes at the healthcare school in 2004. The same number of pupils was also admitted in 2003.
- Also, in the year 2004, 38 doctors did specialisation internships against 22 in 2003 and 36 in 2002 structures.
- To help the problem in human resource management, a policy document has been made and is in the process of being adopted. The human resources development plan is being written. A programme for the computerised management of human resources has been procured, the putting in place of the Human Resources Department has started; a census of the personnel is planned to feed the databank. A plan of action for the motivation of human resources has been developed.

Though the objectives of this point of the PAP/PNDS would seem to be in the course of realisation, this may well not be the case, for it is impossible to measure the progress, and also, on the terrain, one notices that things are different.

To better understand the effectiveness of the PNDS initiatives, a CSPS was visited and its director interviewed.

From this visit it came out that even though the focus is on rural problems, there are still many problems in the urban areas. The first of these is cover. Even though the norm is 10,000 inhabitants per CSPS, the one visited had to supply healthcare for 13,840 people and was thus burdened. Also, since this CSPS is well run, the population that is meant to go to the CSPS in the sector next door uses the one visited.

The result is that this CSPS takes charge of 1500 sick per month, although it only has 3 observation beds. The problem is aggravated of course by a lack of staff. Whereas two years ago, the personnel requirements were fulfilled, since the implementation of the decentralisation process, some of the personnel have been transferred to rural CSPSs, with the result that the visited CSPS lacked 6 qualified employees.

Subsequently, some questions were asked about financial accessibility, and the measures of the government based on the reduction of costs for the population. The answers indicated that even though this measure has been communicated, in reality it is not feasible. The only cost that the government takes to its charge is the salary of public servants, and for the rest, the CSPS is self-sufficient. This means that materials, the salary of other employees, electricity, water etc must be paid for by the CSPS. The director said that it would be possible to lower prices, but that would lead to a reduction in quality, which would not be a good choice.

Finally, the director said that the PNDS is an administrative document, and that in practice few people know of its existence.

5.3 Improve financial accessibility to healthcare services

In the last point of the PNDS to be treated, it is equally difficult to measure the achievement rate. Nevertheless, for point (vi) of the PNDS, the objectives of the 2004-2006 PAP are (Ministère de l'Economie et du Développement, 2004c, p.24):

- Render systematic the use of diagnostic and treatment guides and supervise prescribers.
- Adopt a price structure which includes a reduction of beneficiary margins on pharmaceutical specialities.
- Implement a registry system of medicines based on the assessment of tax-free retail prices.
- Pass on price reductions operated by the CAMEG and other provisioning structures to the local health centres.
- Introduce a differential pricing of healthcare services to the sanitary structures.
- Define and implement the mechanisms for dealing with the poor at each sanitary structure.

Once again, the 2005 implementation report did not speak of the objectives achieved in that year, but for 2004, they were the following (Ministère de l'Economie et du Développement, 2005, p.61):

- Measures aiming at increasing the efficiency of healthcare services and promoting risk-sharing mechanisms have been taken in order to improve the financial accessibility of the population to healthcare services. More specifically :
 - The making available to sanitary structures of Therapeutical Diagnostic Guides (GDT) in view of the rationalisation of prescriptions;
 - The automatic repercussion at the peripheral level of the reduction of prices charged by the CAMEG and other provisioning structures.
 - The gratuity of certain preventive healthcare services, such as prenatal care and vaccination;
 - Taking care of urgent treatment with no prepayment;

- Regular control and supervision seem necessary to ensure that all sanitary structures implement these measures. The last joint outing established that not all personnel are trained in the use of the updated GDT and not all preventive services (chloroquine, iron and folic acid for pregnant women) are supplied free of charge.
- As for the taking in of first aid with no prepayment, the application of this measure, beyond organisational difficulties, encounters certain problems of which, are the disparities in the modalities of the financial aspects, which range from 100% reimbursement of the fees at the Yalgado Ouédraogo University Hospital (CHUYO) to a fixed rate in other hospitals whatever the quantity and costs of used medicines. Whatever modality is used, the recover of costs is difficult since taking care of first aid with no up-front payment is often associated to gratuity by the users of hospital services. Local initiatives and experiences such as the development of healthcare insurance and other risk-sharing mechanisms to improve the financial access of the population to healthcare services are also an option.

As explained above and in the recapitulation of the interview, all measures aimed at increasing the financial accessibility of healthcare services bring problems for the service. The measures are taken, and this leads to a certain development, but the best way of increasing the accessibility remains insurance, and the best way of encouraging it in the population would be to make it compulsory, even if it has to be subsidised.

Also, the accessibility of the poor to healthcare services is linked to the accessibility of interested parties to become qualified healthcare personnel. Although there are quite a few educational infrastructures dedicated to the healthcare industry, Burkina Faso had a total of 359 doctors nationwide in 2004 (Ministère de la santé, 2006, p.8), which means that the task of diagnosing cases has to be taken over by nurses. Whereas this does make the care accessible, the question remains of whether one can call this access to proper healthcare.

Finally, in terms of physical accessibility, figure 8 shows that the yearly progression is positive, and that at this day, the average action range of a CSPTS is 8.2 km. This means that on average, no one need travel more than 8.2 km to visit such an establishment.

Year	Average action range of a CSPTS (Km)
1991	
1992	10,50
1993	10,70
1994	10,09
1995	10,40
1996	9,98
1997	9,69
1998	9,66
1999	9,55
2000	9,37
2001	9,18
2002	9,07
2003	8,68
2004	8,34
2005	8,2

Figure 8 (Source: *Ministère de la santé, 2006, p.8*)

6. Conclusion and recommendations

In order to answer the question of what the impact of the measures taken by the burkinabé government to improve the access of the poor to healthcare services is, a conclusion now follows, along with some recommendations.

After reading the previous chapters, one might conclude that the healthcare services offer has a high theoretical achievement rate. But in reality, the PNDS does not really let itself be noticed by those not directly dealing with it. Also, there seem to be disparities in the achievement rates published in different government reports. As for spending in the name of the PNDS, it is difficult to find consistent figures. The disparities between the different sets of statistics lead to a lack of trust in those in charge of the programme. The role played by the decentralisation of the healthcare system is very important here. In fact, the higher levels of decentralisation of the healthcare system are not yet functioning as had been expected. One can see a spreading of responsibilities, but at the financial level, decentralisation has hardly begun. As mentioned before, the greatest problem in the healthcare system is the lack of financial means. There is currently a reduction in the transfer of public resources to local authorities, which leads to a lack of means to implement local developments. So, there is a basic contradiction between the importance that the state gives to decentralisation on paper, and its real financial commitment in the field.

It can therefore be said that the impact of these measures is not yet noticeable by the poor. Whereas the programmes have made a difference, a lack of communication means that people are not aware of the improvements made. The decentralisation process seems to be the current focus, but this is an administrative measure, and with a lack of communication between the different levels, this process doesn't bring on increased accessibility to anyone. The construction of new healthcare infrastructure has yielded results, with the average action range of these becoming more acceptable each year, but the question remains of whether this is applicable outside of urban areas, and whether the healthcare offered in these buildings is of the standard and quality needed.

The question that remains is: what are the solutions for resolving these problems, and for making better use of the financial resources available? With the attempt at administrative decentralisation, there are too many financial mechanisms, and they are incoherently managed. The government could put in place a financing mechanism in which the financial backers could also participate. Financial resources would be used more effectively as those funding the programmes would also have a say in what to do next. Also, an improvement could be made in the financial transfer from the central level to the local level by implementing a viable system in this domain. With these two measures, there would be more resources available to villages, and so restructuring could be better implemented. Last but not least, the issue of social security should be more severely tackled. Even though there are changes in progress regarding the improvement of social cover, there are too few insured people in Burkina Faso. If the government really wants to improve the accessibility to healthcare services for the poor, the government should make insurance compulsory, even if it has to be subsidised. With social security, financial accessibility to healthcare services is much more certain.

Concretely, what I think needs to be done to improve the access of the poor to healthcare services and that isn't already being done, is:

- 1.** Set up a different mechanism to decide where the resources are spent and how. This mechanism should include the technical and financial partners, so that the resources are not all spent where the government thinks it is necessary, but also where it is truly needed.
- 2.** Make sure local communities receive their share of financial resources, by installing a viable feedback system.
- 3.** Make health insurance compulsory, and subsidise it heavily. A population that gets healthcare when it needs it, is a healthy workforce.

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Annex

- Transcript of interview with the director of a CSPA on 11-01-07

Partie 1: L'offre

1.1 Répondez-vous aux normes minimales de personnel?

Non, il manque un infirmier diplômé d'état, 1 sage femme, 2 infirmiers brevetés, 1 accoucheuse ainsi qu'une fille de salle. Avant ce n'était pas un problème, mais ceux-ci sont partis et n'ont pas été remplacés.

1.2 Pour bien fonctionner, avez vous besoin de plus d'équipement ? La norme minimale, est elle suffisante, ou devrait elle être changée ?

Par rapport à la population, nous avons 1500 malades par moi. Le nombre de malades a doublé ces dernières années, et donc il y a une très grande insuffisance de matériel. Par exemple, nous n'avons que 3 lits d'observation. Nous ne répondons pas aux normes, et nous l'avons signalé à la direction, mais eux aussi attendent toujours l'équipement. Si l'on répondait aux normes, ça serait suffisant pour bien pouvoir fonctionner.

1.3 Un CSPS par 10,000 personnes est la norme nationale, pensez vous que ce CSPS a cette couverture?

La couverture de ce CSPS est de 13,840 habitants. En plus de cela, beaucoup de patients viennent d'autres districts parce que c'est mieux ici.

1.4 Nous avons lu que l'accès aux services médicaux est de 38,1%, le besoin de ce service 10,9% et l'utilisation 6,9%. En général, la satisfaction sur les services médicaux est de 77,2%. Quelle est la raison de ce faible taux d'utilisation des services de santé comparé à la haute satisfaction?

Ici, l'utilisation est de plus de 100%, donc je ne peux pas répondre à cette question.

1.5 Un des objectifs du PNDS et d'accroître l'offre par une collaboration entre le secteur sanitaire public et le secteur sanitaire traditionnel. Y a-t-il une collaboration entre le secteur sanitaire traditionnelle et le privé ?

Ca a été essayé. Il y a trois cabinets privés autour de nous. Nous collaborons avec 2 d'entre eux, et un d'entre eux refuse de collaborer. Les collaborations se font généralement en matière de communauté comme avec les programmes de vaccination.

En ce qui concerne la collaboration entre le public et le Traditionnel, l'initiative n'a pas été suivie par le gouvernement. L'initiative est prise dans ce CSPS, des échantillons sont testés, mais une fois que le gouvernement l'apprend, il dit qu'il faut une autorisation spécifique, et il fait en sorte que l'on arrête. Par contre, avec le secteur traditionnel, il faut connaître les limites de ce que l'on peut faire. Il y a des médecins traditionnels qui pensent qu'ils peuvent tout guérir, mais c'en est loin d'être le cas.

1.6 Pourquoi y a-t-il un manque de ressources humaines ?

Dans le temps, le nombre nécessaire était complet. La raison pourquoi c'est le cas maintenant, je ne le sais pas. Peut être que c'est dû à une mauvaise répartition ? Nous nous sommes complétés le manque de personnel avec des stagiaires. C'est nécessaire pour pouvoir

fonctionner correctement, mais on doit les payer nous même, quand l'état est celui qui paye le personnel normal.

1.7 Pensez-vous que ce CSPS est capable de donner l'aide primaire à la population ?

Oui, mais quand ce CSPS fut construit, l'on n'a pas pris en compte la réalité. Regardez dehors, il y a plein de place... alors pourquoi construire ce bâtiment si petit, avec des colonnes et des beautés, quand on a que trois lits, ce qui n'est pas assez !!

Partie 2: Les coûts

2.1 Vous pensez que le tarif moyen des actes et des MEG (Initiative Bamako) au niveau du CSPS est trop élevé pour la population ?

Le gouvernement a dernièrement fait réduire le prix des actes médicaux, mais nous on pensait qu'il nous compenserait, ce qui n'est pas le cas. Nous travaillons ici sous un principe d'autogestion. Il est donc nécessaire d'avoir assez d'argent qui rentre pour pouvoir continuer à fonctionner. Dernièrement, les coûts d'opération ont augmenté, parce que beaucoup de produits sont maintenant nécessaire dans les soins qui ne l'étaient pas auparavant. Pour cette raison, nous ne pouvons pas respecter la baisse de prix, sinon il y aurait une perte de qualité dans nos services rendus.

2.2 Apparemment, il existe une baisse progressive de l'utilisation des services par la population, pensez-vous que l'Initiative Bamako est, entre autre, la cause de ceci ?

Ceci n'est pas le cas ici

2.3 Nous avons compris que les collectivités locales paient la majorité des salaires, savez vous qui sont ces collectivités locales ?

L'état paye nos salaires. Puisque le CSPS est en auto gestation, la caissière et le gardien et la caissière sont payés avec les recettes. Puisque les recettes proviennent des malades, qui sont locaux, on peut dire que ce sont eux les collectivités locales.

2.4 Dans le cas de la prise en charge de la santé de groupes spécifiques, avez vous notifié les différentes mesures pour par exemple les femmes et les enfants?

Une aide est reçue. L'état prend en charge le frais des soins préventifs pour les enfants, et les femmes reçoivent une dotation aussi.

Partie 3 : Contrôle

3.1 Combien d'inspections recevez-vous annuellement?

Trimestriellement nous recevons une inspection. Donc quatre fois par an.

3.2 L'IGESS (Inspection Générale des Etablissements et services) est responsable pour les inspections, quel est le rôle de l'ECD dans ce cas ?

C'est eux qui passent pour la supervision. L'IGESS est là pour le contrôle. Les besoins du CSPS sont envoyés au district (ECD). Ca peut prendre 6 mois avant d'avoir une réponse.

3.3 Y a-t-il des conférences entre les CSPS, l'ECD et le Conseil Santé de District a propos des besoins sanitaires?

Il y a une réunion de service entre tous ces partis tout les 2 mois. Cela est suffisant. Nous, nous avons une réunion tout les mois.

3.4 Est-ce que la communauté est impliquée dans l'évaluation et la formulation des besoins de la santé ?

Un petit peu. La communauté est impliquée dans le suivi de certains programmes comme la lutte contre le paludisme.

3.5 Ecrivez vous chaque année un bilan / rapport sur les besoins et les prestations ?

Oui

3.6 Qui est responsable pour l'évaluation de ce rapport ?

En faite, c'est une auto évaluation/monitorage. Mais le rapport écrit est aussi envoyé au district, mais ce qu'ils en font n'est pas connu

3.7 Y a-t-il un cadre de référence ?

Oui

3.8 Qui est responsable pour la livraison de matériels ?

La gérante du dépôt

3.9 L'IEC développe l'informatique dans le domaine de la santé, mais nous avons lu que l'absence d'orientation claire ainsi que l'insuffisance de personnel qualifié en informatique est un grand problème. Avez-vous remarqué dans ce CSPS que ce développement informatique a amélioré la communication du système administrative de la santé ?

Cette question n'a pas été posée, il n'y avait pas d'ordinateurs.

3.10 Pensez vous qu'il y a une non concordance entre le découpage administratif et le découpage sanitaire, qui crée des difficultés réelles d'organisation et de fonctionnement des structures ?

On ne prend pas en compte le découpage administratif dans la santé. Le dispensaire du secteur 12 ne marche pas donc les gens viennent ici. La fréquentation est faite ou les gens se sentent à l'aise.

Partie 4 : Autres

4.1 Le Plan Stratégique de lutte contre le Paludisme a fini en 2005. A-t-il réalisé ses objectifs ? Pensez vous qu'il soit nécessaire de renouveler le plan, ou y a-t-il déjà des plans pour cela ?

Le pourcentage de cas qui sont traités ici qui sont le paludisme est de 33%.
Nous avons rien remarqué/entendu de ce plan stratégique.

Partie 5 : Recommandations

5.1 Avez vous remarqué des différences dans le domaine de l'offre des services médicaux depuis l'introduction de PNDS ?

Nous ne sommes pas au courant du PNDS. C'est une chose administrative. Je n'ai aussi jamais vu un document qui parle de ça. Il n'y a pas eu d'amélioration à ce que je sache, On fait notre travail et on se débrouille.

5.2 Avez-vous des recommandations pour accroître l'offre de services médicaux aux pauvres ?

Les personnes les plus pauvres devraient être prises en charge sans devoir payer.

5.3 Quelle est votre opinion sur le cadre de référence ? Pensez-vous que ce cadre peut améliorer la qualité, est de cette manière accroître l'offre de santé ?

C'est un bon début, mais il manque beaucoup de choses.