Ex post evaluation – Burkina Faso

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Sector: Health policy and administrative management (CRS code: 1211000)
Project: Basket financing, Healthcare I and II, BMZ no. 2008 66 392* (A) and BMZ no. 2011 65 299 (B)
Implementing agency: Ministry of Health (Ministère de la Santé)

Ex post evaluation report: 2020

All figures in EUR million	Project A (Planned)	Project A (Actual)	Project B (Planned)	Project B (Actual)
Investment costs (total**)	6.00	29.27	6.00	6.00
Counterpart contribution	0.00	0.07	0.00	0.00
Co-financing	0.00	23.20	0.00	0.00
Funding	6.00	6.00	6.00	6.00
of which BMZ budget funds	6.00	6.00	6.00	6.00

*) Random sample 2018, **) Total volume of the non-earmarked funds, co-financing and counterpart contribution in the 2011–2015 basket for project A. No planning figures available for co-financing and counterpart contribution

Summary: The “Programme d'Appui au Développement Sanitaire (PADS)” was a financing tool that aimed to improve healthcare in Burkina Faso. The programme, which was co-financed by a number of donors, supported the implementation of the Burkinabe health strategy (“Plan National de Développement Sanitaire” PNDS, 2001–2010, and PNDS II, 2011–2020). Its focus was on the provision of healthcare services via a decentralised healthcare system (strengthening of regional and district level with regard to equipment, capacity and administration) in order to improve the population’s access to basic healthcare services. As two of seven priorities, HIV/AIDS prevention/treatment and reproductive health made up a large part of the approach. A further explicitly named subject of the financing wereNGOs – who were selected and contracted as part of a public competition – working primarily in the field of disease prevention. The non-earmarked (FC) financing of PADS expired in 2015.

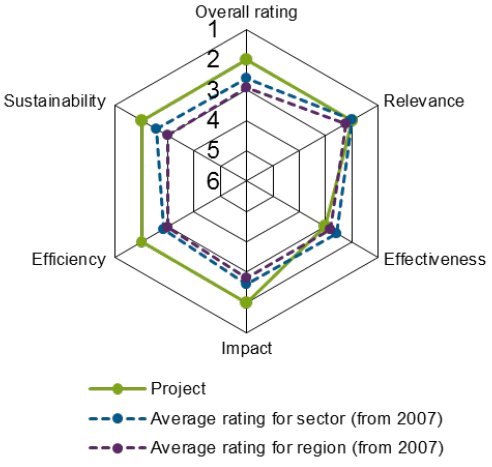
Development objectives: The impact-level objective was to contribute to a reduction in the population’s morbidity and mortality rates. The outcome-level objective was the use of improved access to and better quality of healthcare facilities and services through the financing of priority healthcare measures .

Target group: The target group were all users of public healthcare facilities; the aim was to cover 90 % of the population, 80 % of whom lived in rural areas with a focus on women (pregnant women, mothers) and socially disadvantaged population groups.

Overall rating: 2

Rationale: The goal of contributing to a reduction in the population’s morbidity and mortality rates was achieved in cooperation with other donors, particularly in the area of mother and child health. Strengthening the healthcare system through the PADS financing tool was and still is extremely important; following the phasing-out of non-earmarked funds, PADS continues to serve as a vehicle for earmarked donor financing, which benefits from the structures established.

Highlights: A positive aspect is that planning, implementation and monitoring procedures were developed during FC financing. These served to strengthen the coordination of the health care levels as a whole and are still in use today.



Rating according to DAC criteria

Overall rating: 2

The two FC commitments are based on one appraisal; there are no differences in the design of the projects, which is why they are evaluated and rated together.

Ratings:

Relevance	2
Effectiveness	3
Efficiency	2
Impact	2
Sustainability	2

General conditions and classification of the project (for complex projects only)

The Health Development Support Programme (PADS[1]) was set up in 2002 by the Burkinabe Ministry of Health and international donors as a financing tool to facilitate, manage and coordinate the financing needed to implement the healthcare sector strategy (PNDS). PADS' strategy is managed in regular meetings of the steering committee, which is attended by representatives from the Ministries of Health and Finance as well as representatives from the NGOs and representatives from the donor organisations. With annual plans, the individual measures to be financed (particularly equipment) were coordinated with the various levels of the healthcare system. During the FC projects (2011–2015), the financing consisted of earmarked and non-earmarked funds in the total amount of EUR 101 million. The earmarked portion amounted to around EUR 35 million: FC financed 34 % of this amount, the Netherlands financed 54 %, the French Development Agency AFD 7 %, UNICEF 3 %, UNFPA 2 % and the Burkinabe government less than 1%. The evaluation refers exclusively to the earmarked financing.

Between 2006 and 2010, prior to the start of the FC project, 41 % of the total volume of around EUR 24 million were non-earmarked funds and 59 % were earmarked funds. Since 2016, PADS has been financed exclusively with earmarked funds: in 2019, the funds of around EUR 77 million were contributed by the GFTAM (62 %), the World Bank (27 %), GAVI (10 %), and UNFPA (1 %) while the Burkinabe state supports the programme through tax and customs exemptions.

An earlier phase of PADS (2008–2012) was evaluated by a Burkinabe office in 2014 on behalf of the Ministry of Health, which came to the conclusion that PADS was highly relevant, coherent with strategies and policies, and efficient in terms of target achievement.

Relevance

At the time, Burkina Faso was one of the least developed countries in the world (ranked 161st out of 169 (2010)) and remains so to this day (ranked 182nd out of 188 (2019)) in the Human Development Index. This was due, among other things, to poor health statistics, for example high maternal mortality rate and high infant mortality rate (see Impact). According to UNFPA (2009), the reasons for the high infant mortality rate were malnutrition, acute respiratory tract infections, diarrhoea, malaria, measles and the frequently poor level of care during birth. The percentage of attended births was just 54 % in 2006 (66 % in 2010, World Bank, 2018). In 2010, HIV prevalence was recorded at 1.2 %; in 2003, it was estimated to be 2.7–6.5 % (WHO 2005) and was thus in a concerning range with regard to spreading further.

On the whole, the population's health situation was assessed correctly. The selection of the target group, namely the entire population but in particular women and socially disadvantaged population groups, was consistent.

[1] Programme d'Appui au Développement Sanitaire, PADS

The project was in line with the PNDS healthcare strategy[2] (2011–2020), which aims to improve the health status of the entire population and to achieve the Millennium Development Goals and later the Sustainable Development Goals, and also the national poverty alleviation strategy (2011–2015)[3].

The design of the FC financing followed the "Paris Declaration" (2005) with the harmonisation of processes and strategies in a "basket", and was therefore up to date. The funds provided by the German Governmentwere not earmarked and could thus be used in accordance with the requirements of the Ministry of Health. They were used in accordance with the Burkinabe government's priorities and plans (PNDS), mainly for reproductive health and HIV control, as well as to reinforce the healthcare system, in particular through financing for the lower care levels (district and regional directorates). The results chain was plausible.

Parallel to this, a bilateral social marketing project was implemented in the area of reproductive health, which also fell within the PNDS framework and thus had a complementary effect to the PADS. By improving sexual education, particularly for young people and women, the supply and use of contraceptives could be increased.

From the current perspective, the approach of structurally strengthening the healthcare system at the various levels of care, reinforcing coordination between these levels, and following the partner government's priorities remains relevant.

Relevance rating: 2

Effectiveness

The project objective (outcome) was the use of the improved access and better quality of health care facilities and services through the financing of priority health care measures.Seven indicators were used in the ex post evaluation to verify the achievement of the objective: During the analysis, it must be taken into consideration that the FC financing only makes up a portion of the basket and a significant volume of earmarked funds from other donors were also implemented at the same time.

Indicator	Status PA (2010)	Target value* (for 2015)	Ex post evaluation (2019)**
(1) Average distance to the nearest health station	7.3 km	6.8 km	6.5 km
(2) Proportion of health stations (CSPS) that meet the minimum staffing requirements	83.1 %	90 %	91 %
(3) Proportion of health stations without any stock-outs for the most important medicines	90.8 %	> 95 %	13 % (2014 with donor financing still 81.3 %)
(4) Vaccination rate for children aged 12–23 months (measles)	92 %	95 %	88 %
(5) Proportion of attended births	76 %	85 %	84 %
(6) Rate at which young women (15–24) use modern family planning methods	15–19: 5.9 % 20–24: 17.3 % (***EDS 2010)	n.a.	15–19: 50 % 20–24: 55.6 % (****PRSR)

[2] Plan National de Développement Sanitaire, PNDS

[3] Stratégie de Croissance Accélérée et de Développement Durable; SCADD

(7) Proportion of women who received at least 4 pre-natal check-ups (CPN4)	22.3 %	40 %	38 %

*) Target data defined for the year 2015 as part of PNDS

**) Data from "Annuaire Statistique 2018" (some deviations from the information in the final inspection due to the use of different sources)

***) EDS: Enquête Démographique et de Santé

****) PRSR: Programme Régional de Santé Reproductive (OOAS)

The data is taken from different sources that do not always match up. Data is normally collected at five- or ten-year intervals and published in the nationwide "Enquêtes Demographique et de Santé". The new edition is currently being prepared (2020).

The indicators reflect the objectives in the Burkinabe programme. Indicator 1 has been exceeded. While indicator 2 is an output indicator, it depicts the efforts to improve healthcare services to a significant extent. Medical staff numbers were increased drastically – from nurses who are important in peripheral areas (2013: 3,500 to 2017: 5,400) to doctors (2013: 803 to 2017: 1,363), though there is no evidence for their distribution between urban and rural areas[4]. The increase in staff numbers led to improved employee motivation in the healthcare sector.

Indicator 3 (stock-out for certain "tracer" medications) reveals one of the central problems in the current Burkinabe healthcare system. Following the withdrawal of many donors in 2015, the availability of medicines fell dramatically: in 2014, the proportion of health stations with sufficient medicines was still 81.3 %; five years later and only 13 % of stations had a sufficient stock/supply. A lack of funds is one of the main causes, though it is also the result of the country's fragile security situation, which gives rise to very unique challenges, such as the migration of people towards secured zones. The vaccination rate for infants also fell – it is now below the 95 % required for herd immunity to prevent a measles epidemic.

Indicators 4 (vaccination rate), 5 (proportion of professionally supervised births) and 7 (proportion of pregnant women receiving 4 prenatal check-ups), which were almost achieved, require particular attention: they are directly linked to mother and child health and are therefore a priority set by the Ministry of Health and PADS. Despite the current situation, the broad achievement of objectives related to mother/child health can be attributed to factors such as intervention by several projects from various donors (UNICEF, GAVI, World Bank and others), which were earmarked and in part took place outside of PADS, as well as efforts by the Ministry of Health.

With regard to child health, the prevalence of underweight children under the age of 5 developed on a positive trajectory: while as many as 37 % of all children under 5 years of age were underweight in 2008, this figure was improved by 10 % (27 % in 2018), though it is sadly still far too high.[5] This figure was recorded in the HDI 2018, while the Ministry of Health (Annuaire statistique 2017/2018)[6] puts the number at 16 %, which is much better. This improvement can be traced back to factors such as awareness-raising measures implemented by NGOs involved in PADS at health centres and communities.

At present, target achievement is impaired by a lack of financing caused by the withdrawal of many donors, particularly bilateral ones, from the healthcare sector and also by the difficult security situation in recent years. The success achieved in the area of mother/child health and awareness-raising is remarkable given this state of affairs and was the result of interaction with other interventions. Overall, the result falls short of expectations due to external factors (fluctuating funds and volatile security situation), but the positive outcomes dominate.

Effectiveness rating: 3

[4] (Annuaire Statistique 2017/2018).

[5] Human Development Index 2018. According to the Annuaire Statistique 2017/18, 16.2% of under 5s are underweight.

[6] No newer data is available from the Ministry of Health

Efficiency

The project's individual economic efficiency cannot be analysed due to the basket financing structure. The non-earmarked funds were used primarily for health centres at regional and district level. During the FC financing, EUR 2.2 million were used for construction and refurbishment measures at two healthcare facilities (Yagma and Pisys near Ouagadougou). The average construction costs of these construction measures were within the appropriate range at EUR 306 per square metre.

PADS was established to create a harmonised financing mechanism for implementing the national health strategy and to reduce direct financing in line with certain donors' preferences without justification in the national budget and without parliamentary control. The goal of achieving mostly **non**-earmarked financing for PADS was not achieved. Nevertheless, from an allocation point of view, the non-earmarked basket was able to efficiently fill the gaps in health sector promotion that were not taken into account by others. This is particularly important for strengthening the healthcare system in areas that are not covered by theme-specific programmes, e.g. for the provision of equipment at regional and district level (e.g. ambulances, office equipment), logistics (e.g. refrigeration units), coordination between districts, within districts and at health-centre level, for the professional development of healthcare professionals and for the monitoring of medicine stocks, for example.

Measures were coordinated and implemented in line with annual plans, which covered both earmarked and non-earmarked funds. The procedures and workflows applied for administering PADS, consisting of a steering committee and annual plans, were already well established before the FC financing started and proved to be successful. During the FC financing, a performance-based approach was introduced to PADS via the basket financing and is still applied to this day: specific indicators are formulated and the districts and healthcare facilities that achieve their targets receive more funding than others. According to PADS, this led to greater efficiency with regard to planning and implementation. While at first its work with around 250 non-governmental organisations (NGOs) appears complicated in terms of sub-contracting, it was needed in order to achieve wide-scale awareness-raising among the population for health issues related to family planning, nutrition, etc. Addressing the population outside of state institutions in a manner appropriate to the target group led to better education and also to a reduction in the workload on staff in the public centers..

According to the Ministry of Health and PADS, the implementation costs for PADS (staff, equipment and operating costs for the administration unit) are estimated to be a cost-effective 2 % of total costs, while the administration costs for a stand-alone project are 7 % on average (2019). At the time of the final inspection (2016), they were estimated to be as high as 9 %. Costs were reduced, for example, due to a consolidated approach to planning and monitoring processes, which could be developed and applied while the FC financing was still being implemented. For example, planning at the district level could be improved and adapted to the respective situation; until then, this level had not yet been firmly integrated

Overall efficiency is rated as good. The basket's harmonised approach, which followed a joint strategy (PNDS), allowed for good allocation efficiency. The established procedures are still evident today in low implementation costs of only 2%..

Efficiency rating: 2

Impact

The impact-level objective was to contribute to a reduction in the population's morbidity and mortality rates.

The following indicators are used for the evaluation to summarise the achievement of the impact-level objective. (The target values for these general indicators were not defined ex ante; the global SDG and political PNDS objective is provided as a reference):

Indicator	Status PA (2010)	Ex post evaluation (2019)	PNDS objective 2020	SDG objective for 2030
(1) Maternal mortality (per 100,000 live births) (source: Tableau de Bord Social 2017)	341	330 (2015)	242	70
(2) Infant mortality (per 1,000 live births)	65	43 (2015)	9.16	12
(3) Contraceptive prevalence among young women (aged 15–24)	16 % (all women aged between 15 and 49, traditional and modern methods) (source: World Bank)	32 % (all women aged between 15 and 49, traditional and modern methods) (source: World Bank 2019) 15–19: 50%; 20–24: 58.4% (modern methods) 2019, OOAS study	-	-
(4) HIV prevalence (P) in % and incidence (I) per 1,000 non-infected people (aged 15–49) (Source: P: WHO 2018; I: UNAIDS 2018)	P: 1.2 % I: 0.3/1,000 (2010)	P: 0.8 % (2018) I: 0.12/1,000 (2018)	-	0

The health indicators only improved slowly, particularly due to the poor healthcare in rural areas.

PADS and, as a result, the two FC projects, pursued two priorities: to improve reproductive health and reduce HIV infections. All four indicators express these priorities: increased contraceptive prevalence reduces HIV infections and unwanted pregnancies and contributes to a decrease in the number of births per woman. It can plausibly be assumed that this also has positive effects on lower maternal and infant mortality rates to a certain extent.

Contraceptive prevalence (indicator 3) doubled among all women of reproductive age using all methods of contraception, i.e. traditional and modern. A recent study by the West African Health Organisation (OOAS) shows the use of modern contraceptives (including condoms) by young women (aged 15–24). Half (50 %) of 15 to 19-year-olds used modern methods, with this figure rising to 58 % for young women aged between 20 and 24. The difference between urban (57 %) and rural (55 %) areas is as good as eliminated after large differences were still visible in 2010 (urban 31 %, rural 11 %, all women between 15 and 49; EDS 2010). This may be related to the extra awareness-raising measures in rural areas in particular, which were implemented by NGOs as part of the “basket” and social marketing campaigns addressing especially young people. The use of contraceptives serves as a proxy indicator for women’s self-determination over their fertility; the progress achieved in raising awareness reveals an impressively positive picture, particularly for young women aged between 20 and 24.

In line with the situation in West Africa, the HIV prevalence rate (indicator 4) has remained low (at around 1%) over the past ten years and has maintained about the same level, which is also due to the availability of antiretroviral medication. It was possible to reduce HIV incidence from 0.3/1,000 (2010) to 0.12/1,000 (2018) (UNAIDS).

The NGOs involved made a significant contribution to the development of the indicators for HIV prevention and sexual/reproductive health at community level. They were essential to communication with the target group in health centres and remote villages alike.

A positive side effect, which was not initially explicitly intended at the beginning, is that the Ministry of Health and all districts now have detailed plans for their activities and finances: thanks to the lessons from PADS, the Ministry of Health is now regarded as the champion planner among all ministries. PADS functions as a parallel unit linked to the government; it implements the priorities in the PNDS (around 20 % of PNDS' funds) according to established procedures. It has also been used as an example of how to plan for the healthcare sector in Burundi, Niger, Côte d'Ivoire and Mali.The financing of the "basket", i.e. the non-earmarked funds, had a structure-building effect, as it helped to strengthen the healthcare system, which could and still can rely on improved planning, communication, accounting, etc. The provision of non-earmarked funds further contributed to strengthening the ownership and thus the governance of the Burkinabe healthcare sector.

Overall, achievement of the objectives was made more difficult because too few donors provided non-earmarked funds and thus did not contribute directly to improving the health sector budget. In 2015, as much as 28 % of PADS was made up of non-earmarked funds; in 2019, it only received earmarked funds (GFATM, WB, GAVI, UNFPA). The total budget amounted to EUR 86 million in 2018 and is planned to be EUR 77 million for 2019. The plan to raise new non-earmarked funds failed. One major advantage of the non-earmarked FC project was that it could finance measures to strengthen the healthcare system, which is particularly important when the national budget is unable to provide sufficient funds. GAVI and the Global Fund (GFATM) have only recently accepted this necessity and have now incorporated components to strengthen the healthcare system into their projects. Furthermore, there is a "Strategic Plan for Reinforcing the Healthcare System (2018–2022)", which can be regarded as a lesson learnt from the non-earmarked financing.

The programme was based on the national health strategies (PNDS 2001–2010 and PNDS II 2011–2020), which were and still are integral parts of medium-term national financial planning.

The evaluation did not identify any serious negative impacts of the project.

The impact is rated as good since the structures formed by PADS had a beneficial effect on the public healthcare system, the established planning procedures provided a good example for other ministries as well as also other countries in the region. It can be plausibly assumed that PADS contributed to the achievement of the sectoral targets.

Impact rating: 2

Sustainability

PADS is a tool for implementing health policy, which was and still is one of the government's priorities. Over the past ten years, around 12 % of the national budget has been allocated to the Ministry of Health, which was able to spend 94 % of the funds (2016/2017). The total budget amounted to around 190,000 million CFA francs (roughly EUR 290 million) in 2017, around 2,300 million CFA francs of which (roughly EUR 3.5 million) came from the government budget (Annuaire Statistique 2017/2018, Ministère de la Santé). About 20 % of total health expenditure has been channelled through PADS in recent; whereby GFATM is currently the biggest financier at 62 %, followed by the World Bank (27 %). PADS (2011–2020) is currently still being implemented; a new PADS (2021–2030) is in preparation. PADS is therefore a government tool used to channel funds into the healthcare sector in line with the various government plans. Today, according to UNFPA, PADS (planned for 2021-2030) is still based on a performance-based approach, which was developed within the framework of the "basket".

Since 2015 – the end of the two FC projects – PADS has only been financed by earmarked funds, as donors who contributed non-earmarked funds to PADS readjusted their political alignments –not only Ger-

man, but also Dutch and French development cooperation ended its contributions to the Burkinabe healthcare sector in order to address other issues.

The non-earmarked financing of PADS was in fact designed as a precursor to sectoral budget financing in the spirit of the Paris Declaration (2005) (including the harmonisation of procedures and adjustment of strategies). Today it is clear that at that time not all donors were ready for this new step and therefore did not contribute to PADS (e.g. World Bank); the new requirements did not comply with internal procedures, e.g. tendering procedures. The German contribution (EUR 12 million), which followed the Dutch contribution in terms of volume (EUR 19 million), was logical and correct according to the Paris Declaration but was not supported by many other donors.

The health centres in Yagma and Pissy were the basket's only construction projects during the FC financing. They are still being used well by the population, even though there are sometimes - in accordance with the location in the country - not enough medicines available. There is good demand for prenatal care in particular and vaccination programmes are in regular supply and demand. However, not enough funds are allocated for maintenance and repair, so that, for example, damage to the roofs has occured which has still not been repaired even after four years (recorded at the time of the final inspection in 2016).

In the early stages, the implementation of PADS was delayed because procedures had not yet been established. Today, there is only one plan, one procedure and one monitoring process, not a range of different approaches - each following the needs of the various projects and their implementing agencies. The structure created has made a decisive contribution to effectiveness, efficiency and sustainability.

The structural effects on the healthcare system (established planning, implementation and monitoring procedures, and strengthening of the lower levels of care) have a positive influence on sustainability and on the continued financing of the Burkinabe government via PADS. The fragile security situation impairs the sustainability of healthcare services because, for example, not enough medication is currently available at decentralised level. By contrast, the discontinuation of non-earmarked financing with the withdrawal of bilateral donors must be regarded as negative. Disregarding the fragile security situation, it can generally be assumed that the impact will remain positive.

Sustainability rating: 2

Notes on the methods used to evaluate project success (project rating)

Projects (and programmes) are evaluated on a six-point scale, the criteria being **relevance, effectiveness, efficiency** and **overarching developmental impact**. The ratings are also used to arrive at a **final assessment** of a project's overall developmental efficacy. The scale is as follows:

Level 1	Very good result that clearly exceeds expectations
Level 2	Good result, fully in line with expectations and without any significant shortcomings
Level 3	Satisfactory result – project falls short of expectations but the positive results dominate
Level 4	Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results
Level 5	Clearly inadequate result – despite some positive partial results, the negative results clearly dominate
Level 6	The project has no impact or the situation has actually deteriorated

Rating levels 1-3 denote a positive assessment or successful project while rating levels 4-6 denote a negative assessment.

Sustainability is evaluated according to the following four-point scale:

Sustainability level 1 (very good sustainability): The developmental efficacy of the project (positive to date) is very likely to continue undiminished or even increase.

Sustainability level 2 (good sustainability): The developmental efficacy of the project (positive to date) is very likely to decline only minimally but remain positive overall. (This is what can normally be expected).

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.

Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

The **overall rating** on the six-point scale is compiled from a weighting of all five individual criteria as appropriate to the project in question. Rating levels 1-3 of the overall rating denote a "successful" project while rating levels 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally "successful" only if the achievement of the project objective ("effectiveness"), the impact on the overall objective ("overarching developmental impact") and the sustainability are rated at least "satisfactory" (level 3).