TRANSITION TO PROGRAMME BUDGETING IN HEALTH IN BURKINA FASO:

STATUS OF THE REFORM AND PRELIMINARY LESSONS FOR HEALTH FINANCING

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World Health Organization

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EXECUTIVE SUMMARY

Budget formulation can play a critical role in optimizing health sector performance, though it is often overlooked. Public performance and expenditure in the health sector depends on an effective allocation and flow of resources within the health system. Near the end of the 1990s, Burkina Faso initiated profound reforms in the management of public finances, in line with regulations set by the West African Economic and Monetary Union (WAEMU). The pivotal measure was the introduction of budgetary programmes, which marked a shift away from purely input-based budgeting. Parliament approved the programme-based budget in 2017, 20 years after the reforms began. Burkina Faso became the first country in the WAEMU region to adopt a programme budget. The Ministry of Health (MoH) was one of the first ministries to institute the reforms. The MoH created a budget including three major budgetary programmes which were aligned with the priorities laid out in the national health plan, the *Plan National de Développement Sanitaire* (PNDS). Burkina Faso's shift to a programme-based budget in health offers interesting lessons for other countries engaged in similar reforms. The following lessons on the definition and implementation of budgetary programmes emerged:

- Defining the content of budgetary programmes is a central issue in the health sector. To harmonize content with sector priorities, key actors in the health and financial sectors must work together to define the programmes and review them periodically.
- Budgetary programmes can reduce the financial fragmentation that may be a remnant of input-based budgeting. By integrating specific disease-related interventions into broader budgetary programmes, programme-based budgeting may also further reduce financial duplication and fragmentation.
- Reforms should include a transition across different levels of governance. Along with reforms relating directly to public finance, legal and institutional elements should also be priorities. Legal aspects may include updating the regulatory framework. Institutional aspects may include strengthening budgetary planning capacities within each sector.
- Reforms must go beyond mere changes in budget formulation and should include improved management of expenditures. Reforms lay the foundation for more flexible spending that can adapt to changes within the sector and which allows for reallocations within budgetary programmes.
- When accompanied by a quality performance monitoring framework, programme-based budgets make it possible to monitor financial and operational performance within a single framework. Policy-makers can use performance information to guide future budgetary decisions.

While Burkina Faso is well advanced in the implementation of a programme-based budget, particularly in the health sector, some challenges remain. In 2018, the MoH launched a review of the content of two of the main budgetary programmes. The goal was to improve quality and align the programmes with the department's new strategic direction. Other aspects of the budget that require additional work include: strengthening the definition of the performance monitoring framework; building the programme budgeting capacity of programme directors

and their teams; tightening the links between budget reform and the health financing strategy, notably the creation of the health insurance scheme, the *Régime d'assurance maladie universelle* (RAMU); and improving monitoring to ensure coherence and coordination.

INTRODUCTION

Most countries have begun a transition to programme- or objective-based budgets, to better align with public policy priorities and to meet the need for accountability and transparency.1 In addition to changes in the presentation of budget documents, this reform triggers shifts in budgeting and expenditure management systems, which require closer collaboration between finance and line ministries. In the health sector, it is often a challenge to identify the outlines and content of budgetary programmes. This reform has the potential to improve the allocation of funds according to sector priorities. Health authorities must get involved during the preparation phase if the process is to deliver the expected benefits. Development partners, too, are frequently uninformed during such transitions and need to better understand the implications.

The World Health Organization (WHO) began a work programme in 2018 on health budget structure issues. The WHO Department of Health Systems Governance and Financing (HGF) wanted to examine the process and the effects of health budget reform and offer more support to countries undergoing such a transition. The HGF divided this work into three principal areas:

1. a global review of health budget structures
2. case studies on the transition to programme budgets in the health sector
3. training and support for health budget reform.

Burkina Faso was identified as one of the first countries to be studied in the WHO African Region. In 2017, it had crafted a budget for all ministries around major public policy objectives and priorities. It had completed a pilot phase and was the first WAEMU country to have institutionalized programme budgets. The WHO chose Burkina Faso to identify the lessons learned and to share these lessons with other countries in the subregion and beyond. The specific goals were:

- to analyse the structure of the health budget before and after the reform;
- to document the transition from a line budget to a programme budget, focusing on specific projects such as immunization;
- to analyse the initial effects of the reform from a sector perspective; and
- to recommend any possible changes.

The study began with a review of budgetary and legal documents, followed by data collection and interviews with key stakeholders in the health and finance sectors between January and March 2018. The results were shared with the MoH in May 2018 then reviewed and approved in July 2018.

The report begins with a contextual review of developments in the WAEMU regulatory framework and its conversion into national law with respect to the programme budget and public financial management. The report also surveys developments in health financing and their links to public finance. The second part focuses on the budget reform process, analysing the stages in the transition and roles of various players. The third part explores the structure and content of the MoH's three budgetary programmes.

At the request of the partners supporting and involved in the study, this includes an analysis of the inclusion in the budget formulation of specific interventions, such as those for HIV/AIDS, malaria, tuberculosis, as well as immunization. The last section analyses the initial impact of the reform on budget planning, flexibility in managing expenditures, and accountability. The report concludes with a summary of the progress and challenges and includes recommendations on adapting the reform to best address the needs of the sector in Burkina Faso.

1. CONTEXT OF THE REFORM

In 2009, the WAEMU agreed to a harmonized public finance framework applicable to all member states following discussions that had been held since the early 2000s. Some of the notable measures included introducing results-based management and a programme budget tool. Between 2013 and 2016, Burkina Faso amended the regulatory and legislative framework required by WAEMU into its own legislation. In 2017, it became the first WAEMU country to adopt a programme budget.[1] These discussions about public financial management reform prompted similar discussions about the implications for the health sector.

1.1 CHANGES TO THE SUBREGIONAL REGULATORY FRAMEWORK

In 2009, WAEMU countries adapted the Harmonized Public Financial Management Framework which had been drafted in the late 1990s to international standards and best practices in financial management. The WAEMU Council of Ministers framed their work around six directives (see Table 1).

The aim of this regulatory framework was to ensure better outcomes and more effective public policies. The new rules modernized budgetary management. They introduced budgetary discipline that facilitated sustainable policies and a more efficient use of public resources, set within a framework of major constraints. The approach was designed to strengthen the link between national development strategies, sector policies and the state budget. The framework established a results-based culture, giving operational staff responsibility for the results achieved and introducing greater clarity, transparency and accountability to the management of public affairs.

The transition to a programme budget is one of the key elements of the WAEMU Finance Law Directive (No. 06/2009). In Section III, Article 12, "content of the year's finance laws", the directive specifies that "within ministries, appropriations are broken down into **programmes[...]**" The article defines a programme as **"consolidating the appropriations set aside to implement an action or a coherent set of measures that represent a clearly defined medium-term public policy."** These programmes are combined with "specific goals, agreed on the basis of public interest and expected outcomes." These outcomes, "measured by performance indicators, are regularly evaluated and embodied in a [annual] performance report."

Adapting the directives to national law varies according to the directive and the state. The WAEMU member states had committed to adapting the directives to their national legislation in December 2011, with a deadline of January 2017 for full implementation of the programme budget. In April 2017, the

1 Burkina Faso officially adopted the term "programme budget", which will be used in the rest of this report.

Table 1: Summary of the WAEMU Harmonized Public Financial Management Framework

Directives of the WAEMU Harmonized Public Financial Management Framework	Main guidelines of the Directives
Directive No. 01/2009/CM/WAEMU of 27 March 2009 on the Code of transparency in public financial management in WAEMU	General umbrella directive for five others, which establishes the principles and obligations that the member states must respect on managing government and other government departments' funds in their legislation and practice.
Directive No. 06/2009/CM/WAEMU on Finance laws in WAEMU	Sets out the rules on the scope and classification of the Finance laws, their content, presentation, macroeconomic framework, preparation and votes, as well as the implementation and checks on the Finance laws and, finally, the transitional provisions.
Directive No. 07/2009/CM/WAEMU on the General regulations on public accounting in WAEMU	Sets out the rules governing the management of public accounts, securities or assets.
Directive No. 08/2009/CM/WAEMU on the government budget classification in WAEMU	Sets out the basic rules and principles for presenting budget operations.
Directive No. 09/2009/CM/WAEMU on the government chart of accounts in WAEMU	Lays down the basic rules for the accounting of financial and budget operations in the member states. It determines the aim of the general accounting, the standards, rules and procedures on keeping and producing the state's accounts and financial statements.
Directive No. 10/2009/CM/WAEMU on the government financial operations table in WAEMU	Specifies the general principles on the drafting and joint presentation of statistics on the state's financial operations that form the basis of multilateral monitoring.

Source: WAEMU, 2009

WAEMU Council of Ministers extended this deadline to 1 January 2019.[II]

In December 2012, Senegal became the first member state to conform with the Transparency Code. Burkina Faso followed. However, it was the last to conform with the Finance Law and the decrees pursuant to it. Other countries have amended their regulatory frameworks more swiftly although implementation has been uneven between states. By the end of 2016, only Burkina Faso had decided to adopt a programme budget for the 2017 fiscal year, in line with the initial deadline set by WAEMU. Other member states (Benin, Côte d'Ivoire, Mali and Senegal) had planned implementation in some ministries or future implementation in the state budget (2018 in Niger, 2019 in Togo).[4]

1.2 CHANGES TO BURKINA FASO'S LEGISLATIVE AND REGULATORY FRAMEWORK

Burkina Faso has made a considerable effort to update and strengthen its legislative and regulatory framework for public finance. All laws and decrees were incorporated between 2009 and 2016, streamlining a regulatory framework for WAEMU directives (see Table 2).

Burkina Faso instituted this process in the late 1990s. In 2001, the authorities introduced

II Press release of the Ordinary Session of the Council of Ministers of the Union, Dakar, 31 March 2017 "The Council examined the status of implementation of the Directives of the Harmonized Public Financial Management Framework on 31 December 2016 (...). With respect to the states' implementation of these reforms, the Council invited the Ministers of Finance to complete the implementation of the directives and in particular the implementation of the programme budget by 1 January 2019 at the latest." In December 2016, Senegal's National Assembly voted to postpone the date that the new finance laws would come into effect to 1 January 2020.

Table 2: Key aspects of budget reform agenda in Burkina Faso

Directives of the WAEMU Harmonized Public Financial Management Framework	Burkina Faso – National legislative and regulatory transposition
Directive No. 01/2009/CM/WAEMU on the Code of transparency in public financial management in WAEMU	Law No. 008-2013/AN of 23 April 2013 on the general code of transparency in public financial management in Burkina Faso
Directive No. 06/2009/CM/WAEMU on Finance laws in WAEMU	Institutional act No. 073-2015/CNT of 06 November 2015 on finance laws, which came into effect on 1 January 2016
Directive No. 07/2009/CM/WAEMU on the general public accounting regulations in WAEMU	Decree No. 2016-598/PRES/PM/MINEFID of 08 July 2016 on general public accounting regulations
Directive No. 08/2009/CM/WAEMU on the government budget classification in WAEMU	Decree No. 2016-600/PRES/PM/MINEFID of 08 July 2016 on the government budget classification
Directive No. 09/2009/CM/WAEMU on the government chart of accounts in WAEMU	Decree No. 2016-601/PRES/PM/MINEFID of 08 July 2016 on the conceptual framework for public sector accounting
Directive No. 10/2009/CM/WAEMU on the government financial operations table in WAEMU	Decree No. 2016-602/PRES/PM/MINEFID of 08 July 2016 on the government financial operations table

Source: WAEMU, 2009 and Burkina Faso, www.legiburkina.bf[5]

the Medium-Term Expenditure Framework (MTEF) to improve the planning of resources. The MTEF set out budget allocations, or envelopes, for each ministry based on inputs such as operations, personnel, goods and services, and transfers.[III] The MTEF is updated every year to follow macroeconomic forecasts as closely as possible. In July 2002, authorities drafted a plan of action to strengthen budget management then started to update budgetary systems based on **results-based management (RBM)**. They reflected this commitment with a strategy to strengthen public finance in April 2007 then again with the economic and financial sector policy for 2011–2020 (see Table 3). The guidelines for results-based management are laid down within these frameworks.

In addition to changes that affect budget planning, public finance reforms also have an impact on expenditure practices, namely by introducing the principle of "decentralizing authorization" (Article 70, Institutional Act on Finance Laws – LOLF). Previously, the Minister of Finance served as the sole primary authorizing officer in confirming appropriations. Decentralization allowed for the transfer of this prerogative to sector ministers including the Minister of Health. They became the chief authorizing officers for their ministries' appropriations. They assumed responsibility for expenditures and payments as they followed through with ministry commitments. They could also delegate their powers for appropriation commitments within their ministry (Article 67), specifically to programme managers.[IV] Further, the sector ministries became responsible for controls over

III The goals of the global MTEF are: (1) to define a coherent and realistic multi-year resource framework based on an accurate macroeconomic framework, (2) to identify medium-term sectoral financial budgets aligned with the Government's strategic priorities and budgetary constraints, and (3) to ensure a predictable financial framework for ministries to develop and implement strategies and achieve the expected results.

IV In the MoH, commitment is delegated to the Department of Financial Affairs (DAF) and may subsequently be transferred to programme managers; the *cellule d'ordonnancement* is responsible for authorizations (currently still within the Ministry of the Economy, Finance and Development thought it will be transferred to the sector ministry).

Table 3: Main items related to planning and implementation of reform plans and sector finance strategy

	Plan of action to strengthen budget management 2002–2006	Strategy to Strengthen Public Finance 2007–2015	Economic and financial sector policy 2011–2020
Budget planning	Strengthen the quality and transparency of the Finance Law (with an emphasis on frameworks for medium-term expenditure and results-based management (RBM))	- Transparent and efficient public expenditure management process - Plan expenditure according to the strategic allocation principle and results-based budgeting - Strengthen stakeholder accountability	- Results-Based Management and introduction of Programme Budget approach - Strengthen consistency of the macroeconomic framework, medium-term fiscal plans and budget allocations - Adjust tools to the Results-Based Management approach and the Programme Budget - Support in sector public policy-making - Bring the legislative and regulatory framework in line with WAEMU directives - Capacity building of budget management stakeholders according to the PB approach
Budget implementation	Strengthen the monitoring of budget implementation (system and data)	- Transparent and efficient public expenditure management process - Strengthen stakeholder accountability - Complete and reliable budget implementation data	- Develop statistical output - Adjust the I.T. system to the PB - Improve the spending flow by creating verification units in sector ministries along with the flow in terms of procedure and participants
Controls	Strengthen controls on the implementation of the budget	Efficient monitoring system aligned with international standards	Consideration/further development of the monitoring system in principle and adjusting it to PB requirements

Sources: Plan of action to strengthen budget management and Strategy to strengthen public finance from "Evaluation of Public Financial Management Reform in Burkina Faso, 2001–2010, DANIDA, Final Country Case Study Report, June 2012"[6]; Economic and financial sector policy: Ministry of the Economy and Finance, Economic and Financial Sector Policy 2011-2020, Economic and financial sector policy 2011-2020, April 2011[7]

different stages in the chain of expenditure. In 2012, government expenditure verification units[V] were set up in the ministries. This supported efforts toward the decentralization of authorizations, freed up central monitoring departments, and reduced the time taken to authorize expenditures.[VI]

Another principle governing public expenditure is that of asymmetric fungibility. Burkina Faso introduced this standard in the Institutional Act of 2015. This principle maintains that spending can vary upwards or downwards within each budgetary

V The units are responsible for verifying and validating the expenditure, from the administrative phase through to the payment; a verification unit is made up of a financial check cell, an authorizations cell and a payments cell, which are hierarchically and operationally linked to the parent organization, namely the Ministry of the Economy, Finance and Development's Office of public procurement and financial commitments, Office for scheduling and accounting, and Public accounting office and treasury, respectively.

VI In accordance with the WAEMU directive, the LOLF enshrines the increased powers of the Minister of Finance through regulatory powers, which enables them to maintain the budgetary and financial balance stipulated in the current Finance Act, cancel appropriations and make the authorizing officers' use of appropriations subject to the availability of cash (Art. 69).

programme. Wage expenditure remains under control. It can only fall, not rise, while capital expenditure can only rise, hence the asymmetry. This principle is supposed to apply to each budgetary programme, providing greater autonomy to the ministry. However, it contradicts a programme model that would enable full flexibility on all items of expenditure within the same programme.[VII]

1.3 CHANGES WITHIN THE HEALTH FINANCING SYSTEM AND ALIGNMENT WITH PUBLIC FINANCIAL MANAGEMENT REFORMS

Alongside these reforms to public financial management, Burkina Faso began a review in 2010 to change the health financing system. Between 2013 and 2017, the MoH developed a health financing strategy (2017–2030)8 then presented it to the Council of Ministers in June 2017.[VIII]

In 2015, public funds accounted for 33% of total current health expenditures. External funds accounted for 22%.9 Between 2015 and 2016, the share of direct payments decreased from 36% to 31% of total health expenditures, most likely attributable to the user fee removal policy. External funds financed almost half of public expenditures (on average 47% of public health expenditures between 2012 and 2015).

In absolute terms, budgetary allocations nearly quadrupled over 10 years, rising from around 34 billion CFA francs in 2005 to 132 billion in 2014 (and 180 billion in 2016). As a share of total public expenditures, health expenditures remained relatively stable between 2012 and 2015, averaging 12%. Historically, Burkina Faso is one of the countries in the African region that has given high priority to its public spending to the health sector.

In the past, the health financing system had been characterized by highly fragmented funding. Mapping conducted in 2014[10] indicated approximately 30 schemes, most of which were attributable to free programmes set up since 2006. Two funds covered a limited range of health services for employees in the formal private sector (National Social Security Fund – CNSS) and among civil servants (Civil Servants' Pension Fund – CARFO).[IX] A 2011 study suggested around 200 entities were engaged in community-based health insurance, of which 188 are in operation.[X] These *mutuelles* covered 140,000 beneficiaries, fewer than 1,000 beneficiaries per entity. They covered services that were generally part of the minimum and

VII Fungibility (LOLF, Art. 17, section 2): "... within the same programme, the authorizing officers may amend the type of current appropriations and use them, if they are free to do so, in the following cases: – staff appropriations to increase appropriations for goods and services, transfer or investment line items; – appropriations for goods and services and transfers to increase investment appropriations."

VIII The financing strategy (October 2017 version) is available but has not been formally adopted by the Government. Following a review by the Council of Ministers, the hope is to develop an operational plan based on this strategy, enabling progress to be made towards concrete implementation. In November 2018, the operational plan was finalized and submitted to the Cabinet for approval.

IX CNSS package includes maternal and child health services, HIV/AIDS treatment, and medical evacuation for treatment abroad. CARFO extended coverage in 2009 to provide medical and surgical assistance, and care and treatment in case of work accidents.

X According to a 2011 study, these include 131 community-based health insurance *mutuelles*, 38 professional *mutuelles*, 22 other cost-sharing schemes, nine other prepayment schemes, and five village solidarity funds (ASMADE. Inventory of mutual societies for universal health coverage in Burkina Faso, October 2011)[11]

Table 4: List of purchasers and payment methods used

	Overall budget allocation	Allocation by budget item	Payment by procedure	Payment on a case-by-case basis (flat rate)	Capitation	Payment by results
Ministry of Health – DAF		X	X			
Ministry of Health – Health development programme	X	X				X
Ministry of the Economy, Finance and Development/Ministry of Territorial Administration and Decentralization/Ministry of Health		X				
Generic medicines purchasing agency						X
National council for the fight against HIV/AIDS and sexually-transmitted infections		X				
NGO	X	X	X	X		
Mutual health insurance			X			
Private insurance			X			
Universal health insurance scheme				X	X	
TFPs (regulated)	X	X				

Source: WHO, 2017[12]

complementary health care package in first- and second-level health facilities.

The payment system for health services encompasses a range of methods, due to the fragmentation of schemes and to the use of multiple payment systems for the same scheme. A WHO study on payment for health services charts the various mechanisms.[12]

The overall goal of the new health financing strategy is to "remove barriers to access to health care." The strategy lists 17 measures to address the challenges. These include the implementation of a universal health insurance scheme, RAMU. This would be a mandatory pre-financing system, subsidized with public funds. Experts have identified coverage of the formal public and private sector as a priority. Community-based health insurance schemes would cover the informal sector, although the terms have yet to be defined. Authorities will also have to determine how to coordinate RAMU with existing funding systems, particularly those for free care programmes.

Many of the challenges identified in the health financing strategy relate to the improved management of public resources, with a clear link to reforms in the management of public finances. The strategy points to the implementation of results-based management and a programme budget as tools for improved "oversight/governance/monitoring of the sector's financing system" (see Table 5). This would produce a beneficial orientation between public finance and health financing reform.

Decentralization is linked to these public financial management reforms and directly

affects the health sector. The process, which began in 2004,[13] provides for the transfer of skills and resources from the state to the municipalities for level-1 facilities, health centres (*Centre de Santé et de Promotion Sociale*).[14] The regions were assigned jurisdiction over level-2 facilities, health centres with surgical units.[15] This involves a transfer of skills to build, staff, and manage these health facilities to deliver minimum (level-1) and complementary (level-2) care packages.

This reform has several implications for sector financing. The transition to the programme budget involves grouping two types of transfers for the municipalities under a single government "transfer of resources to local and regional authorities" programme and "transfer to the health sector" action. In principle, the MoH no longer manages the subsidies to operate and invest in level-1 health facilities.[XI] In practice, however, only skills, and therefore resources, are transferred to the municipalities without any transfer to the regions.

The human resources associated with the delivery of minimum and complementary care packages should also be transferred to lower levels, though this has not been implemented. Ministry staff are part of the civil service and have demonstrated some resistance. Discussions have been underway since 2017 to create a hospital public service that would be separate from the national civil service. All jobs in health facilities could be associated with this new body. Under the programme budget, staff costs are charged to MoH programmes (see section 4.2) but are still implemented for remuneration by the Ministry of the Economy, Finance and Development.

XI These funds are subject to two interministerial orders (Ministry of the Economy, Finance and Development, the Ministry of Territorial Administration, Decentralization and Social Cohesion, and the MoH) on the allocation of transferred financial resources and orders drafted by the MoH DAF (based on the Directorate General of Sector Studies and Statistics Proposals), prior to being sent to the Ministry of the Economy, Finance and Development's General Directorate for Regional Development (DGDT) for their operational implementation and transfers at the start of the year. One relates to funds earmarked for investments in buildings to standardize basic health facilities and the other, sums intended for recurring costs in basic health facilities.

Table 5: Health financing strategy: challenges and remedial action for public expenditure on health

Task	Challenges	Measures
Mobilizing resources	Capacity of the Ministry of Public Health to monitor the overall health budget	System for mobilizing and monitoring financial flows for the whole sector
	Ensure appropriate financing of the sector	Allocate 12% of the health budget
	Ensure financing of the various schemes, possibly subsidized (universal health insurance scheme and free schemes)	Universal health insurance scheme subsidy plan
Pooling resources/strategic purchasing	Implement decentralization	Municipal financing plan
	Optimize and align appropriations centrally	Delegated appropriation targeting plan
	Allocation of appropriations	Set up a strategic purchasing team
Oversight/governance/ monitoring	Alignment between planning and financing needs	Results-based management (programme budget)
	Actual availability of financial resources in health facilities and flexibility in managing funds	Review of provisions related to health facilities' use of resources

Source: Health Financing Strategy, Ministry of Health, 2017[10]

2. PROCESS OF TRANSITION TO THE PROGRAMME BUDGET

The transition in Burkina Faso lasted almost two decades. But, in 2017, Parliament institutionalized and adopted a programme budget. For the health sector, the years of preparation between 1998 and 2015 cultivated a favourable technical, legal and institutional environment. During that period, a programme budget was prepared for the MoH, to complement the input line budget. The objectives and programmes were aligned with the 2011–2020 National Health Development Plan. In 2018, under the leadership of a new minister, the MoH began to integrate budgetary programmes with a new vision for the sector that put prevention and universal access to services at the core. The MoH saw an opportunity to synchronize the sector's priorities with the budget and took ownership of the reform.

2.1 PROGRAMME BUDGET: FROM PREPARATION TO INSTITUTIONALIZATION FOR ALL MINISTRIES (1998–2015)

Burkina Faso introduced the concept of a programme budget in 1997.[16] In 1998, the government chose six pilot ministries, including the MoH, to implement the system. The approach was extended in 2000 to all ministries and institutions. They were required to prepare a programme budget in addition to their line budgets. Those preparing these documents did not have access to suitable reference systems or frameworks. As a result, there was little consistency in their work.

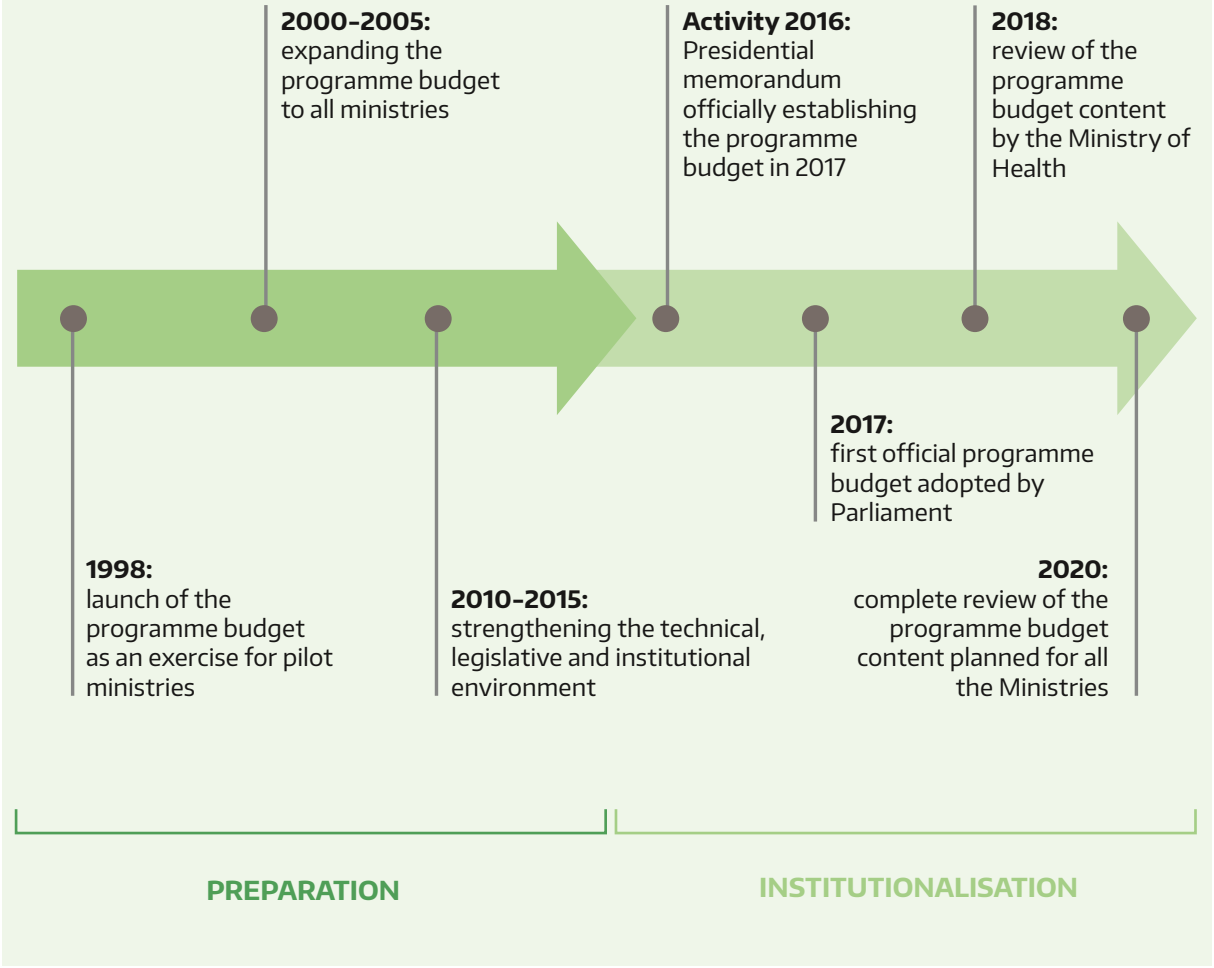
In 2005, the government started to frame and formalize the process, which was expedited in 2010. The Ministry of Finance (MoF) created governance entities with contacts in other ministries to implement closer oversight. The technical framework was developed to include benchmarks that offered guidance on preparing programme budgets, particularly for the six ministries that had taken part in the pilot project.

From 2010 to 2016, the country entered a pre-institutionalization phase with the aim of meeting the deadlines set by WAEMU for a planned transition in 2017. The legislative and regulatory framework was updated between 2013 and 2016, as mentioned above (see section 1). Regulations were changed to comply with international recommendations to include accurate information on the number and structure of budgetary programmes with a maximum of seven programmes, 10 actions per programme, and 40 activities per action in each ministry.[17] Support for ministries has been accelerated through training, along with adjustments to expenditure management and monitoring tools (See Box 1).

In 2016, a presidential circular ordered a shift in the 2017 budget law. **The programme budget became mandatory and would be the only budget presented by ministries**. Parliament approved the law which set out 127 programmes and allocations for the 39 ministerial departments and institutions.[XII]

XII The appropriations not allocated to programmes were divided into provisions, comprising a set of appropriations to cover expenditure that could not be directly linked to public policy objectives (Institutional Act, Art. 16).

Figure 1: History of the transition to the programme budget in Burkina Faso



Source : Authors

2.2 THE MINISTRY OF HEALTH'S TRANSITION TO A PROGRAMME BUDGET: ALIGNMENT WITH NATIONAL HEALTH STRATEGIES

The MoH budget was an input or line budget through the end of 2016. The budget was presented by type of expenditure, based on four main categories (headings) and then broken down by economic classification (article, section, paragraph) (see Table 6). The budget was detailed and was reported down to each item. For example, the heading "operating expenditures" included the article "purchase of goods and services" which was broken down to the section "supplies" then to the paragraph items "fuel, office supplies, maintenance products." This structure had several disadvantages for those within the sector.

Box 1: Key factors for programme budget institutionalization in Burkina Faso

Technical guidance: production and gradual revision of standards and tools (guidance document for the implementation of the 2010 programme budget), programme- budget implementation strategy (2011), methodology guides (2010 and 2011),[XIII] outline, work on dividing public policies into budgetary programmes (2010-2011), setting out annual performance plans (from 2011 onwards), guide for programme-budget execution (2017)

Governance: setting up governance of the reform involving finance and the sectors (budget planning reform committee (2008), steering committee for the implementation of the programme budget (from 2009)[XIV] with implementation teams in each ministry[XV] and the creation of ministerial technical units for the programme budget[XVI])

Adapting the management tools: adapting financial information systems to the new approach (review of the Integrated Expenditure System – CID)[XVII]

Capacity building: producing a capacity-building plan for stakeholders, including in the sectors (2013), with the exception of programme officers (from the Ministry of Health) appointed after the training. Capacity building activities targeted at the financial responsible officers, and not the operational arm of the reform (e.g., budgetary programme directors).

Legal framework: Suitable legal and regulatory framework, including the transposition of WAEMU directives (2013-2016) Adoption of a presidential circular in 2016 for official transition to the programme budget in all ministries.

XIII (1) Policy document for the implementation of a programme budget in Burkina Faso, June 2010 (adopted by the Council of Ministers in June 2010); (2) "Programme budget implementation strategy" (approved by the government programme budget in June 2011 and adopted by the Council of Ministers in February 2012) supported by an action plan; (3) two methodology guides (a) to prepare the programme budget and (b) to monitor/evaluate the process in the ministries (adopted by the Council of Ministers in 2010 and 2011 respectively); (3) design of several mock-ups/outline for the ministerial programme budget document.

XIV Order No. 2009-477/MEF/CAB of 29 December 2009 on the setting-up, roles, composition and running of the Steering Committee for the government programme budget and Order No. 2009-484/MEF/CAB of 29 December 2009 on the Unit to set up the government programme budget.

XV Their aims were to provide guidance, to stimulate and supervise the process and finally, to lead the work to be performed on incorporating the WAEMU directives into the finance laws. The Steering Committee for the government programme budget and the Technical secretariat of the Steering Committee for the government programme budget were established by decree in September 2010.

XVI Their roles were (i) to work with the MoF to contribute to the drafting or re-reading/transposition of the sector policy into a programme; (ii) to work with the MoF to lead the process of drafting and monitoring the implementation of their ministry or institution's programme budget and (iii) to participate in the implementation of any activity contributing to the drafting of the government's programme budget.

XVII The Integrated Expenditure System (CID) has been adjusted to the programme approach. The budget planning module for the information system was therefore deployed to ensure the 2017 draft budget could be prepared, and that the system could include all the tables using the programme approach and in accordance with the LOLF.

1. Expenditures were broken down into categories unrelated to sectoral objectives and activities.
2. There was a lack of flexibility when reallocating between different items. [XVIII]
3. The reporting, although burdensome, was limited and did not provide information on the sector's actual performance.

The MoH had worked towards a programme budget since the pilot project in 1998. After more than a decade of trials, the line budget was converted to a programme budget in 2010. Those in charge of the Department of Studies and Planning (now the Directorate General of Sector Studies and Statistics) said the MoH saw the main advantage of the transition as being an "increased alignment between allocations and sector priorities."

The MoH's initial proposal in 2010 was built around five programmes and 24 actions, associated with the strategic focus of the national health plan 2011–2020 and its 24 focus areas. Following discussions with the MoF, a consensus emerged around a smaller group of three programmes: access to services, health service delivery, and oversight. Budget pilot projects through 2016 would be developed on this basis and would be formalized starting in 2017 with modifications to the number of programmes and the drafting of actions (26 in 2017, 21 in 2018) and activities.

The drafting of the 2011 programme budget demonstrated more consistency with the National Health Development Plan (PNDS), and a closer relationship between the sector's needs and expenditures. A review of the strategic objectives of the PNDS and budgetary programmes reveals the commonalities (see Figure 2). The same model was used to prepare the MoH budgetary programmes in the years following 2011. Officials reviewed the PNDS 2016–2020 (second phase) and decided to mirror the plan's new strategic objectives with the MoH's three budgetary programmes.

A new Minister of Health took up the post in February 2017. The budgetary programmes were redefined to correspond with his vision for the sector. The 2018 MoH organization chart aimed towards "a national health system that values prevention and makes the community-based approach to primary health care the foundation of Burkina Faso's move towards universal health coverage".[XIX] The proposed budgetary formulation changed to include:

- a national public health programme covering prevention, promotion and health security;
- a national programme of health care delivery and access to health products that targets curative care; and
- a national programme of governance of the health system.

The proposed formulation was not adopted for the 2018 budget. Moreover, a formal review is not expected to take place before 2020 when the MoF has scheduled a review of all budgetary programmes (see Table 7).

The MoH expected the official revision for the

XVIII The absence of flexibility belongs more to an expenditure management issue than a purely budget formulation and presentation challenge. However, since expenditure management is often aligned on budget formulation, budgets that are formulated by inputs are generally associated with lack of flexibility in the use of resources.

XIX Presentation by Prof. Nicolas Méda, Minister of Health: Vision, reorganization, priorities and response strategies, 2018

Table 6: Extract of the structure of the line budget, Ministry of Health (before 2017)

Heading	Chapter	Article, section, paragraph
Heading 3. Operating expenses		
	Cabinet/General Secretariat/Departments Regional health directorates Health districts*	Purchase of goods and services (article) – supplies (section) . fuel, office supplies, maintenance products, etc. (paragraph) . vaccines, specific supplies – expenditure on care/maintenance . building, vehicle, etc. – service provision . security costs, etc. . gas – others . meetings, travel, etc. . food, medicines, reagents, travel
Heading 4. Current transfer expenditure		
	Public establishments: university/regional hospitals National Centres Programmes/specific activities (diseases, free of charge/subsidies, national immunization days (NID), contributions to organizations, etc.) Interns/specialist doctors	Operating Grants – subsidies to public institutions . salary, equipment, materials, medical care (public establishments, university/regional hospitals) – grants to beneficiary categories . support for activities (programme, specific actions) Other current transfers . contribution to organizations . internal allowances/bursaries

Note: Health district: functioning of the district core team and provisions for medical centres with a surgical unit.
Source: Budget 2016.

project of finance law 2019 and proposed the following formulation:

1. Access/Purchase of health care
2. Provision of services/Public health
3. Governance/Stewardship

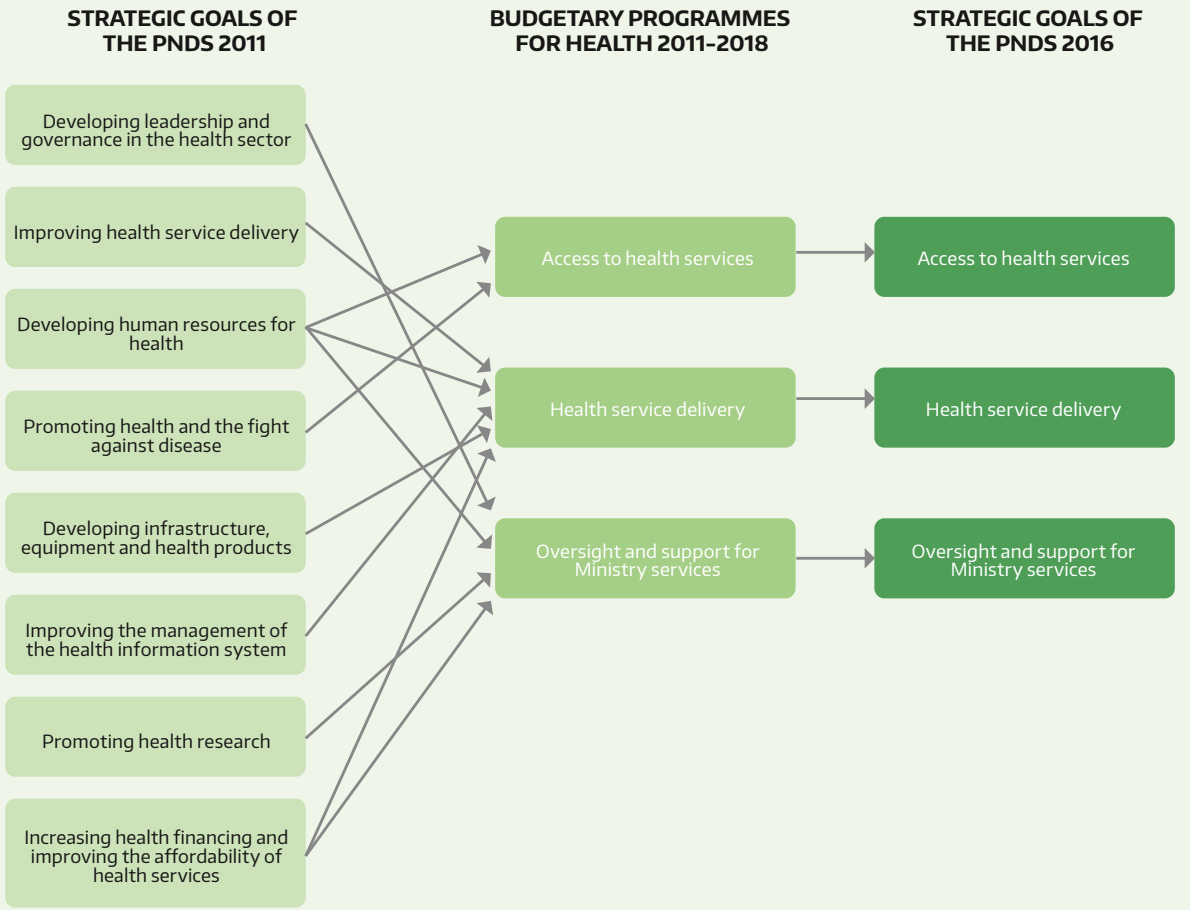
This transitional approach was chosen to preserve the delivery of the operational content, which was identical to the 2018 budget. However, this created some confusion between the naming of the programmes and the outputs. For example, under the programme "Provision of services/ Public health", most actions are a matter of provision, which was the former name of this programme. The MoH has committed to revisit the content of the programmes during the official revision in 2020–2021 and to propose a more coherent framework.

2.3 CHANGING ROLE OF STAKEHOLDERS IN THE REFORM

The MoF managed the reform process with support from the International Monetary Fund (IMF). The transition to a programme budget was part of a broader reform to modernize public finance, which mainly affected the finance sector. The pressure from WAEMU to meet the 2017 deadline to introduce programme budgets encouraged major investment. Consequently, heads of state across the subregion were determined to push the reforms through.

The MoF launched a dialogue with the six pilot ministries soon after they were chosen in 1998. For the MoH, the relationship between the budget and the national health plan was

Figure 2: Mapping of 2011 PNDS objectives, 2011-2018 Ministry of Health budgetary programmes and 2016 PNDS objectives



critical, especially for planning. MoH officials, mainly those in the Department of Studies and Planning, increased their engagement in 2010 with the development of the PNDS 2011–2020. They took part in a number of joint committees led by the MoF as part of the dialogue.

The Department of Studies and Planning was responsible for formulating the consolidated budget around three programmes. Its director was convinced of the necessity of budgetary reform and drove much of the progress. Many of those in the technical directorates and at the administrative levels in the sectors and districts did not share that commitment. The PNDS, the framework for formulating budgetary programmes, was meant to be developed in consultation with all stakeholders. However, much of that development did not come from the bottom up.

A change in June 2018 in the organization chart of the MoH created two general directorates to administer the first two

Table 7: Alignment between the new budgetary programmes and the Ministry of Health's reorganization (2018)

Formulation of budgetary programmes (until 2018)	New formulation of budgetary programmes (as formulated by Ministry of Health); post-2018	Allocation to new Directorates (from 2018 onwards)
Access to health services	Public health	Directorate General for Public Health
Delivery of health services	Supply and purchasing of health care	Directorate General for Health Care and Health Products
Oversight	Oversight and governance	Directorate General for Sector Studies and Statistics

Source: Authors

budgetary programmes (see Table 7). This structural change facilitated the transition.[XX] The Directorate General for Public Health would lead the public health budgetary programme, formerly "access to health services." The Directorate General for Health Care and Health Products would lead the national care supply programme, formerly "delivery of health services". The Directorate General for Sector Studies and Statistics (DGESS) would remain the lead for the programme on oversight and governance.

These departments will require capacity building and support. They will need the skills and the technical tools to review the outlines and the content of their programmes: planning, prioritization, coordination, and definition of the performance monitoring framework. They will also need to be trained in the operational and financial management of a budgetary programme including planning, spending, monitoring, and reporting on performance.

The MoH appointed programme managers in October 2017. They were expected to become increasingly involved in the formulation of programme budgets and in their implementation from 2021 onwards.[XXI] Article 67 in the Institutional Act on Finance states that the authorization ("engagement") may be delegated to the programme manager who "authorizes" the expenditure, with financial managers being part of each programme's management team. The programme manager will be answerable for achieving results. The role of the Finance and Administration Department (DAF) will be modified and limited to the monitoring and financial reporting of the department's expenditures. The DAF is expected to be replaced by financial officers integrated into each programme unit.

XX MoH's organization chart, May 2018

XXI Initially planned for 2019, the scale plan was rescheduled in June 2018 to 2021.

3. STRUCTURE AND CONTENT OF THE MINISTRY OF HEALTH'S BUDGETARY PROGRAMMES

The structure of Burkina Faso's MoH programme budget is built on three major programmes. The budget complies with legal requirements and with the goals of the PNDS 2011–2020. However, a more in-depth analysis reveals a need to review the drafting and shaping of certain actions and activities, to improve their relevance to the programme's goals. While the programme budget has had an impact on the sector as a whole, it has specifically changed the management of specific interventions such as immunization and the fight against major epidemics, which are now part of broader budgetary programmes.

3.1 STRUCTURE OF THE MINISTRY OF HEALTH'S PROGRAMME BUDGET

The MoH's programme budget, adopted in 2017 and 2018, complies with legal requirements and follows a **programme/action/activity model**, conforming to international recommendations (see Fig. 3). The programme level includes a public policy, a sector priority to which a goal is attached (e.g. access to quality health services). The action is associated with a set of measures (e.g. strengthening the infrastructure) to achieve the programme's goal. In the MoH's programme budget, an activity relates to more specific projects that have clearly identified costs (e.g. setting up a fund, purchasing vaccines).

The number of programmes, actions and activities in the sector complies with legal requirements which set a maximum of seven programmes, 10 actions per programme, and 40 activities. In 2018, the MoH's first two programmes consisted of six actions each. The third programme – oversight – consisted of nine.

Each action is broken down into a variable number of activities (see Appendix 2). The first programme – access to health services – included 44 activities, excluding salaries. The second programme – delivery of health services – included 20 activities, excluding salaries. The third programme – oversight – included 39 activities.

Beginning in 2018, the MTEF for health has followed the same format as the annual budget. The MTEF is structured in line with the three budgetary programmes and adheres to the strategic orientation of the PNDS. This would make it easier to anticipate the annual budgets for each programme. However, the decision to adopt a three-year programme budget has lessened the usefulness of the MTEF (see Box 2).

Figure 3: Structure of the Ministry of Health's budgetary programmes in Burkina Faso

Source: 2016 Budget

3.2 ANALYSIS OF THE CONTENT OF THE MINISTRY OF HEALTH'S BUDGETARY PROGRAMMES

The MoH's first two programmes meet the sector's main objectives in the PNDS: (i) improving access to quality health services (access programme), and (ii) reducing morbidity and mortality through improved prevention, effective treatment and changes in behaviour (benefits programme). One formulation is directed towards output, the other towards outcomes. Yet the content in both relates to an **overall system logic**. By incorporating disease-specific work into broader programmes, this budget formulation enables a more coordinated approach in the system.

The service delivery programme also presents an advantage for the sector in facilitating the establishment of a strategic purchasing function. Different actions or activities relate to a purchasing function without links being explicitly established: action 2 relates to funds for districts, health facilities, and other dedicated funds; action 3 to the provision of care; action 5 to funds dedicated to health promotion. The payment systems for these services have yet to be integrated into health financing reform.

The division between the first two programmes suggests that the first programme covers prevention and the second covers curative care, seeming to be a division of functions. However, this distinction is not as clear with respect to actions. The first programme – access – mainly includes actions that pertain to strengthening the health care offer including design, staff training, equipment, and health products. The second programme – services – actually includes several preventive actions such as disaster health management, health promotion, and community participation. The next programme review should clarify the outlines for each programme and integrate their formulation with the content.

An analysis of each action also reveals certain weaknesses and suggests a need to review their definition and formulation, to improve their relevance. The programmes contain different types of actions. In the delivery of services programme, some actions refer to results (e.g. reduced endemic/epidemic disease morbidity and mortality). Others seem to refer more to activities (e.g. disaster health management).

In the access programme, actions refer more to the linchpins or inputs in a health system, such as personnel, infrastructure, and equipment (see Table 8). The activities level appears to cover a more diverse group of projects, which creates problems with the formulation or indicates they are disconnected from the action they relate to. Some activities are consistent with the action and the programme; others appear reductive

Box 2: Changes in the aggregate and sector MTEF structure in Burkina Faso

In 2001, the overall MTEF, the Medium-Term Budget Framework (MTBF), was introduced. It was structured by type of expenditure following the model used at the time in the annual budget.

The first MTEF for the health sector was elaborated in 2005, following the strategic orientations of the National Health Development Plan (2001-2010).

From 2011-2012, the health MTEF was formulated according to the PNDS 2011-2020's eight strategic objectives and based on three scenarios, on the basis of Marginal Budgeting for Bottlenecks (MBB) cost estimates. The same still applies to the MTEF 2017-2020.

It is considered an advocacy tool to mobilize more domestic but also external resources (external aid), by demonstrating the gap in funding between what is needed to achieve the strategic goals and the budgets allocated for the sector by the overall MTEF.

Since it was decided to adopt a three-year programmes budget, the MTEF has ceased to be useful. The predictability that made the tool valuable in the annual state and sector budgets has become less important. The budget is now prepared for three years and adjusted each year according to macroeconomic forecasts and priorities. However, the health sector appears to want to retain the health MTEF in the future viewing it as a useful tool for its advocacy to mobilize resources, particularly external ones.

From 2018 (MTEF 2018-2021), the structure of the health MTEF is expected to change and align with the structure of the Ministry of Health's three budgetary programmes, on top of a PNDS divided into strategic goals and type of expenditure (based on three different scenarios).

Table 8: Ministry of Health's programme budget's programmes and actions (2018)*
Programmes and actions
055 Access to health services
05501 Training of health personnel
05502 Constructing/rehabilitating health facilities
05503 Purchase and maintenance of sanitary equipment
05504 Improving the availability of quality health products
05505 Promoting systems to divide risks in the area of health[XXII]
05507 Promoting traditional medicine and pharmacopoeia
056 Health service delivery
05601 Community participation
05602 Reducing morbidity and mortality associated with endemic/epidemic diseases
05603 Quality mother and child health services
05604 Disaster health management
05605 Health promotion
05606 Health product quality assurance
057 Oversight and support of Ministry of Health services
05701 Oversight, coordination and intersector collaboration of Ministry of Health actions
05702 Increase in health sector financing
05703 Management of financial and material resources
05704 Management of human resources
05705 Planning, monitoring and evaluation
05706 Building/rehabilitating and equipping administrative and educational infrastructure
05708 Health information
05709 Promoting health research
05710 Communication

Source: Budget – expenditure, Ministry of Health, 2018 (CID).
* *Note:* for the project of the finance law 2019, the proposed formulation is: 055 access to services/public health; 056 provision of health services/purchase; 057 oversight and support of services of the Ministry of Health/governance of health system

or misaligned with the programme's goal. With respect to promoting health, the main action in 2017 is to "ensure the central and other authorities are working." This does not appear to be focused on achieving the expected result ("improve hygiene, sanitation and behaviours conducive to good health"). Another example relates to the oversight programme; the "increased funding" action is linked to the programme budget formulation activity, which is certainly insufficient to increase funding, even though it can contribute to advocacy for more resources for the sector.

XXII Some actions have been canceled between 2017 and 2018, like the action 05506. The action 05705, not present in 2017, has been reintroduced in 2018.

3.3 IMPLICATIONS OF THE REFORM FOR SPECIFIC HEALTH PROJECTS (IMMUNIZATION, HIV/AIDS, MALARIA, TUBERCULOSIS)

Budgetary reform affected national and international partners including the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and Gavi, the Vaccine Alliance. The transition modified the budget item to which expenditure on disease-specific projects was charged. That changed where their work was reflected in the budget. Such interventions are listed under activities. The rationale is consistent with the PNDS. The budgetary change does not appear to have altered the level of funding for diseases or projects. Still, these partners will be monitoring developments.

Prior to reform, budgetary allocations for immunization fell primarily under two main headings: purchasing vaccines and consumables, and support for national immunization days (NIDs). Now, these expenditures are divided between the first two budgetary programmes, access and delivery. Both operations can be found under activities. The purchase of vaccines is now charged as an activity in the access programme, under the action "improving the availability of quality health products". The contribution to the financing of NIDs is included in the health services delivery programme, under the action "quality services for mother and child health" (see Table 9). The funding for each of the three major epidemics – HIV/AIDS, tuberculosis, and malaria – is treated differently.

The MoH plans some allocations for **HIV/AIDS**-related projects. However, the National Multisector Programme to Combat HIV/AIDS and Sexually-Transmitted Infections, a programme of the National Council to Combat HIV/AIDS and STDs placed under the auspices of the Presidency, provides most of the funding. Before 2017, spending on national resources was divided in the Presidency section into operating expenditure, a grant for the AIDS Solidarity Fund, and an entry under "project to support the implementation of the Strategic Framework for the fight against AIDS". Afterwards, the allocations were grouped under a "Fight against HIV, AIDS and STDs" programme divided into three actions: 1. Preventing the transmission of HIV/AIDS and STDs; 2. Care, treatment, support and protection of those who are affected; and 3. Governance, funding of the response and strategic information management" (see Table 9).

The MoH is responsible for a number of activities that respond to the aforementioned three actions, either on its own (e.g. promoting sexual and reproductive health) or alongside other ministries (e.g. promoting safer behaviour). Nevertheless, the budgetary allocation remains with the Presidency.

Partners in the sector provide most of the financing, partly off-budget, in the fight against **tuberculosis**. For the state budget allocations through the MoH, the shift to a programme budget required funding dedicated to the prevention and fight against this disease, under the benefits programme. Previously, the allocations were essentially a contribution to the National and Regional Tuberculosis Control Centre and to the National Reference Laboratory for Tuberculosis, as well as a non-itemized allocation to run the National Tuberculosis Control Programme (under a Department of Health operating subsidy). After the transition, this earmarked funding has been charged to the benefits programme

Table 9: Allocation of pre-reform and post-reform immunization expenditure

Pre-reform (before 2017)	Post-reform (2017 & 2018)		
Heading	**Programme**	**Action**	**Activity**
Heading 3. Operating expenses Chap. 65137. Department of prevention through immunization 621 62. Medical immunization products 621 69. Other specific supplies	055. Access to health services	05504. Improved availability of quality health products	0550401. Purchase vaccines and consumables
Heading 4. Current transfers Chap. 61141. National Immunization Days	056. Health service delivery	05603. Quality health services for mother and child health	0560303. Organize national immunization days

Source: Budgets 2016, 2017, 2018 (CID)[18]

under the action "reducing endemic/epidemic morbidity and mortality" and the activity "support for the national tuberculosis control centre". Other unrestricted funding covers actions and activities related to the fight against tuberculosis including staffing, the running of diagnostic and treatment centres, the monitoring and dispensing of treatment was passed on to the health and welfare centres, as well as the payment of stipends to the community-based health workers who perform screening activities and provide support for treatment compliance.

With regard to **malaria**, domestic funding is historically associated with two main activities: 1. an allocation to run the National Malaria Research and Training Centre – which is now part of the "steering and support for services" programme under the action "promotion of health research"; and 2. funding for preventive or curative activities related to a free health care programme (see Table 11).

This free programme covers much of the funding for malaria-related activities and involves both preventive and curative activities. It covers children under 5 and pregnant women (preventive and curative activities) as well as postpartum women (curative activities) and is now included in the access programme. Since 2017, the activity "ensuring the implementation of the free health care strategy" was included in the action "promotion of mechanisms for sharing health risks" in the access programme. A second activity in the same programme that refers to the action "improving the availability of quality health products" was maintained to cover the purchase of malaria drugs, among other activities. These two budget items cover the authorities' contribution to subsidizing free treatment in the fight against malaria.

Table 10: Actions and activities posted under the Presidency's "Fight against HIV, AIDS and STDs" budget plan

Actions	Activities
Action 1: Preventing the transmission of HIV/AIDS and STDs	Promoting safer behaviour through Information Education Communication/ Behaviour Change Communication and Sexual and Reproductive Health; promoting male and female condom use; promoting sexual and reproductive health and screening advice; eliminating mother-to-child transmission of HIV (+ projects financed externally)
Action 2: Care, treatment, support and protection of infected and affected individuals	Strengthen biological, medical-technical and clinical services; strengthen the drug supply system, including ARVs, reagents, consumables and equipment; increase the involvement of associations and communities in the continuum of care for people infected and affected by HIV; improve the financial support for PLHIV, people who are affected and specific groups in all sectors
Action 3: Governance, financing the response and strategic information management	Ensure the leadership is coordinated and maintained; strengthen the organizational and institutional capacities of facilities; ensure internal and external resources are mobilized; conduct epidemiological, sector behaviour and impact studies; improve the organization of the national monitoring and evaluation system; document and disseminate best practice in the fight against HIV and STDs

Source: Budget – expenditure, Faso Presidency, 2018 (CID).

Table 11: Budget allocation of malaria prevention and management expenditure in the programme budget (post-reform)

Programmes	Actions	Activity
Steering	Promoting Health Research	Ensuring the functioning of the National malaria research and training centre
Access	Promoting risk-sharing mechanisms	Ensuring the implementation of the free health care strategy
	Improving the availability of health products	Purchasing malaria drugs

Source: 2017 & 2018 Budget

4. FIRST EFFECTS OF THE REFORM (2017–2018): PROGRESS AND CHALLENGES

The health sector's transition to the programme budget in 2017 and 2018 brought a certain degree of flexibility to expenditures. Instances of this appeared in adjustments and reallocations during 2017 and 2018, between and within budgetary programmes. Expenditure practices also became more responsive to the sector's changing needs. The programme budget performance monitoring framework offers more promise ahead. The tool provides users with information on the programmatic and financial performance of the sector which could inform future allocation decisions.

4.1 MOVING TOWARDS AN END TO ANNUAL DEFERRED BUDGETARY PROGRAMMES?

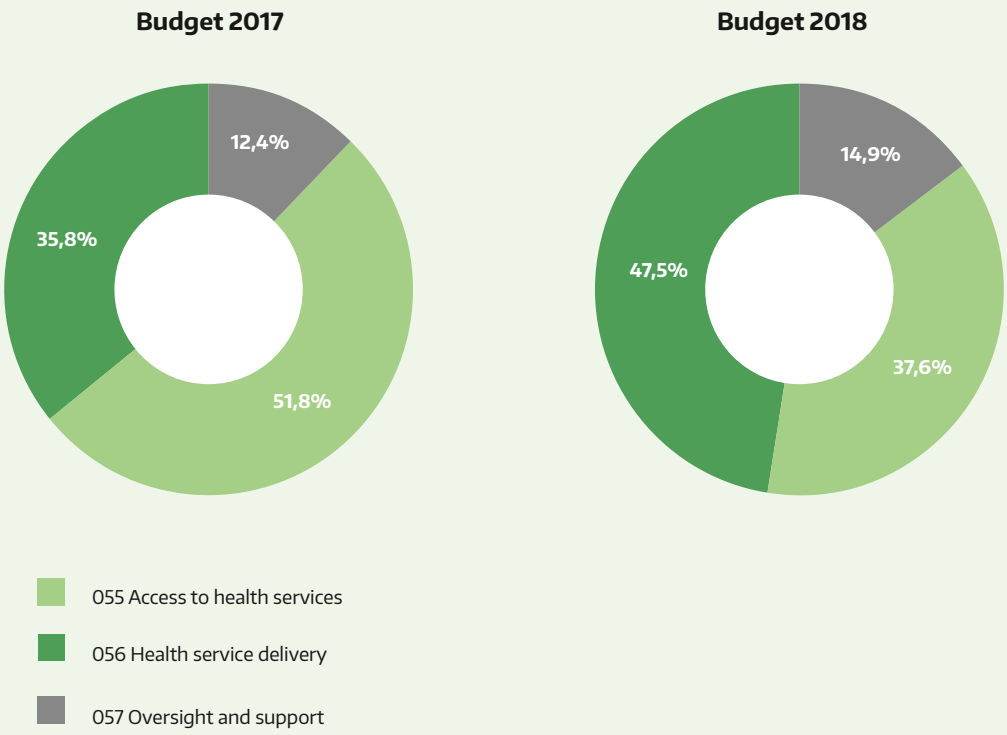
The formulation of budgetary programmes evolved between 2017 and 2018. The adjustment of actions and activities made the programmes more coherent. For example, in 2017, the "functioning of central and regional directorates" activity was charged to the "health promotion" action in the "delivery of services" programme. In 2018, that activity was charged to the "oversight" programme. The "functioning of health districts and university/regional hospitals" activity was transferred from the "health promotion" action to the "reducing endemic/epidemic morbidity and mortality" action in the delivery of services programme.

In the past, the budgeting process carried forward the same level of allocation for the same activities from one year to the next. Now, new activities can be included. Support for districts, regional health facilities and tertiary entities (university/regional hospitals) was added to the "reducing endemic/ epidemic morbidity and mortality" action. In 2017, no activity had been recorded under the action "community participation." The "community-based health worker management" activity was added the following year. The 2017 budget for the management programme only provided for more targeted support for two local research facilities. Two activities were added in 2018, "payments to the health research support fund" and "ensuring that the National Institute of Public Health (INSP) is operational".

Authorities reviewed the formulation and the allocations every year. In 2017, the greatest share of allocations, 52% of the MoH budget, went to the access programme. In 2018, the greatest share, 47%, went to the benefits programme. The share for the oversight programme increased from 12% to 14% (see Fig. 4).

The MoH global budget increased by 2% from 2017 to 2018. However, there were major variations between and within programmes and actions. The differences were mainly due to a transfer of staff costs from the access programme (-76%) to the benefits programme (+83%). Allocations for certain activities also deviated. Those for health promotion, quality services for mother and child health, and health product quality assurance varied by more than ±70% (see Appendix 3).

Figure 4: Distribution of budget appropriations by programme in 2017 and 2018, Ministry of Health



Source : Ministère de la Santé, 2017 et 2018

4.2 TOWARDS MORE FLEXIBILITY IN SPENDING?

Those who plan budgets now have more flexibility with the relaxing of some *ex ante* controls to authorize expenditures. In the past, they made commitments for their programmes and had to justify them down to the paragraph. Now, they are only required to justify down to the section level. Input-based logic is still present in the authorization process.

This flexibility is reflected in varying levels of implementation between and within programmes. In 2017, the access program achieved an implementation rate of 115%. The services programme achieved a rate of 66%. The implementation level for all three programmes reached 93% (see Table 12). Aside from personnel, fungibility provides the flexibility for expenditure items within the same programme to vary up or down with no preset limit.

The level of implementation of the actions within programmes varies, from 33% to 175%. Variations in the implementation of activities could be due to the inconsistency of carrying out those activities. However, such variation could also reflect an increased flexibility in financial management and an approach that is more responsive to the sector's needs.

A common pitfall in budgeting is to manage health personnel costs outside of programmes

Table 12: Implementation of the health budgetary programmes (2017)

	Initial provision (thousands CFA francs)	Revised provision (thousands CFA francs)	Settlement (thousands CFA francs)	Implementation (%)
Access to health services	121,287,749	101,457,294	117,515,245	115.8%
Provision of health services	71,585,283	70,051,757	46,313,277	66.1%
Steering and support	23,193,257	24,210,695	19,069,684	78.8%
Total	216,066,289	195,719,746	182,898,206	93.4%

Source: CID, 2017

within a specific staff line or lines. However, such costs in the MoH are charged to each budgetary programme.[XXIII] The budget includes three blocks for remuneration (called the balance) which are connected to the first action in each programme, with no specific relation to the content of the action. This could provide the advantage of including a major cost driver – 58% of expenditures within the benefits programme in 2018, for example – as part of a true model of programme efficiency.

The allocations for staff costs in 2017 differ significantly from the implementation. This implies estimates were unreliable. Implementation in the access programme is much higher than stated in the initial budget, at 190% of the revised allocations. Implementation in the services programme was 25% of allocations. In 2018, the MoH doubled allocations in a mass transfer to the "delivery" programme, covering 70% of salaries. Allocations for the "access" programme were reduced to 30%.

The Ministry of the Economy, Finance and Development maintains responsibility for salaries. So dividing staff costs across the MoH's three programmes appears to be an artificial exercise. The entries are not, in fact, linked to the action they have been logged under. Salaries in the access programme appear under "training health staff". Salaries in the second programme appear under "community participation". These lines are **retroactive entries** in the monitoring of expenditures. The MoH has little flexibility in adjusting payroll if it is to meet the goals of each programme (see section 1.2). Until it can manage remuneration more effectively, it will be limited in its ability to move towards more strategic purchasing of services and more efficient spending.

4.3 TOWARDS FINANCIAL ACCOUNTABILITY THAT IS OF BENEFIT TO THE SECTOR?

A programme budget works in concert with a performance monitoring framework (PMF)[21] that makes it possible to link allocated resources with changes in a sector's performance, a method of appraisal that had

XXIII Personnel expenditure at tertiary level (university/regional hospital) is accounted for in transfers to these bodies and is therefore not included in the remuneration expenditure.

Table 13: Extract from the Ministry of Health programme budget's Performance Monitoring (2018-2020)

Strategic objectives	Indicators	Reference			Targets			Responsible directorate
		Unit	Year	Value	2018	2019	2020	
Programme 056 Health service delivery								
Reduce morbidity and mortality for better prevention, effective treatment and a change in behaviour	Maternal mortality rate	RATIO	2016	341	243	243	243	DGESS
	Mortality rate for children under five	RATIO	2016	ND	62,75	62,75	62,75	DGESS
Action 05601 Community participation								
Promote community-based action in the area of health	Number of NGOs who have a performance contract with the Ministry of Health	NO.	2016	252	252	252	252	DGS
	Number of villages covered by the OBC-E	NO.	2016	8000	8000	8000	8000	DGS
Action 05602 Reducing morbidity and mortality related to endemic/epidemic diseases								
Promote community-based action in health[1]	New contacts per inhabitant and year in the primary health care facilities (CM and CSPS)	NO.	2016	1,02	1,3	1,4	1,5	DGESS
	Bed occupancy rate in the hospitals	%	2016	50,5	60	65	70	DGS
Action 05603 Quality service offer for mother and child								
Improve mother and child health	Rate of assisted deliveries	%	2016	80,9	>=87	>=90	>=90	DGESS
	Rate of caesarean sections among assisted births	%	2016	>=3.5	>=3.8	>=3.9	>=4	DGESS
	Immunisation rate of pentavalent vaccine among children	%	2016	103	100	100	100	DGESS
Action 05604 Disaster health management								
Improve disaster health management	Coverage rate for disaster victims	%	2016	NA	80	80	80	DGS
	Proportion of hospitals with a response plan <plan blanc>	%	2016	100	100	100	100	DGS

[1] The repetition of actions between 05602 and 05601 is provided in the original document.
DGESS: Directorate general of sector studies and statistics
DGS: Directorate general of health
Source: Budget 2018[19]

not previously existed.[XXIV] A PMF is defined according to the programme, not by inputs. The MoH framework provides information on achieving the goals of each of its first two budgetary programmes, namely "improving access to quality health services" and "reducing morbidity and mortality through better prevention, effective care and changes in behaviour" (see section 3.2).

The PMF has the advantage of being managed at the levels of **programme and action**. The programme manager is expected to report to action level and not to a lower level (activities). That gives them some autonomy in the implementation of activities. They will not be judged on whether or not an activity is complete, but on whether a particular result has been achieved, depending on the resources that have been allocated (see Table 13).

The volume of performance data reported in Burkina Faso is moderate in comparison to international standards.[XXV] Still, the performance framework would need some adjustments if it is to properly measure the achievement of the expected results. The indicators comply with the PNDS but do not follow a logical framework between results and inputs.

If the MoH adjusted the framework, it would have a useful tool to evaluate the operational and financial performance of the sector and inform decisions on allocations. Annual performance monitoring would enhance these benefits and the programme budget would make a more significant contribution to the sector.

XXIV Performance monitoring under the PNDS does not link the achievement of the goals directly to the expenditure to achieve these same goals.

XXV One sole outcome indicator is provided, and a maximum of three outcome indicators per action are suggested.

SUMMARY OF PROGRESS, CHALLENGES AND RECOMMENDATIONS

Summary of progress and challenges in the implementation of the health programme budget in Burkina Faso		
	Progress	**Challenges**
Budget planning	Aligning budget formulation with PNDS (2011–2020) priorities	Need to update the outlines and content of budgetary programmes in light of new policy directions for the sector
	Year-to-year adjustments between and within programmes	Usefulness of the MTEF given that the budget is defined for three years
	Harmonizing departmental organization and budgetary programmes to facilitate implementation and accountability	Delay in appointing managers following the reorganization of the MoH, which impeded budget planning before 2019 "Responsibility chain" was redefined
Implementing expenditure	Financial management tools adjusted to programme budgeting	Ineffective transferring of expenditure authorizing to programme managers
	Effective implementation of the principle of decentralized authorizing at the benefit of the minister	Artificially including staff remuneration with programme formulation
	Effective implementation of the fungibility principle at programme level	Fungibility justified on the basis of inputs
Performance monitoring and accountability	Annual performance monitoring at programme and action level	Relevance and consistency of performance framework to be improved
Technical capacity and ownership	Understanding, ownership and leadership in the design of programme budget by MoH	Lack of ownership by newly appointed programme managers
	Strong DAF teams formed	Operational teams not complete and not trained to effectively manage budgetary programmes

RECOMMENDATIONS

The following roadmap was defined and reviewed by participants in the MoH/WHO seminar on the programme budget in health in Ouagadougou on 11–12 July 2018.

Formulation of budgetary programmes in health:

- Reformulate the name, content, and outline of budgetary programmes according to the new orientations of the sector
- Use the results of the annual reports on performance to inform the budgetary allocations for the following year
- Ensure the coherence of the performance monitoring framework with the new budgetary programmes
- Clarify the purpose of the sectoral MTEF (information and advocacy) and the three-year budget as the primary tools for budgetary programming

Implementation and monitoring of the budgetary reform in health:

- Take part and use the results reform review to integrate lessons for a rapid implementation of the reform in 2020-2021
- Formulate and improve communication and coordination mechanisms between and within the budgetary programme teams, at the financial and operational levels
- Prepare for the effective transition of the financial management of programmes including the integration of those in charge of finances within the programmes
- Coordinate the implementation of the budget reform with the reform of health financing, specifically related to the universal health insurance scheme and other measures concurring with the more strategic purchase of health services
- Ensure coherence between the institutionalization of budget reform and the implementation of decentralization (in particular pending transfers of skills to the regions)
- Make progress with the MoF and the civil service on allocating the remuneration of health personnel at the programme level

Implementation of teams and capacity building:

- Finalize the assignment, organization and operation of the different entities and the new directorates according to the 2018 MoH organization chart
- Strengthen programme managers' capacities to prepare and manage budgetary programmes through training
- Make the teams of programme managers operational by including trained financial managers in each programme.

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APPENDIXES

APPENDIX 1: BUDGET-PLANNING PROCESS SINCE THE ADOPTION OF THE PROGRAMME BUDGET

The process and various parties involved in the ministerial budget planning are as follows:

- Presidential circular launching the budget-planning process setting out the assumptions and budget framework, as well as the general and sector-specific priorities and the strategic budgetary choices adopted by the authorities (outline of the BP attached).
- Send the ministries' and institutions' reference allocations to the departments, by type of expenditure, to implement the programmes they are responsible for, as specified in the Multiyear budget and economic planning document drawn up by the Directorate general for the budget of the Ministry of Finance (general MTEF).
- Minister of Health sets up the Budget planning committee and subcommittees, according to the type of expenditure.
- This committee sends the various entities in the Ministry (Directorates, regional/district health directorates, university/regional hospitals, establishments, etc.): (1) the provisions granted to each of them according to the intrasector distribution and total amounts allocated to operating and/or transfer appropriations; (2) a request framework to ascertain the financial needs/cost of "activities" for each, according to the economic classification of the expenditure.
- The committee selects and consolidates the various requests sent by the entities and incorporates them in the actions and programmes; specific work on staff costs and investment according to the information requested by the Directorate general for the budget; validation by the ministerial authorities.
- DAF planning department includes all the information and tables needed to prepare the Ministry of Health draft programme budget in the CID (programming module), including the programmes' performance framework; finalize the sector "Programme budget" document.
- Discussion of the ministerial budget proposal (summary table and "Programme budget" document) at a Budget Committee with the Ministry of the Economy, Finance and Development before inclusion in the draft budget/government Finance Law, which will be presented and validated in the Council of Ministers before being submitted to the National Assembly (Draft Finance bill and all the documents prescribed by the LOLF including the ministerial "Programme budget" documents).

APPENDIX 2: LIST OF THE MINISTRY OF HEALTH'S PROGRAMME BUDGET'S ACTIONS AND ACTIVITIES

Programmes, actions and activities
055 Access to health services
05501 Training of health personnel
Ensure support for students at the end of their studies, interns, doctors undergoing specialized training; ensure the continuing training of staff; ensure the National School of Public Health continues to provide training
+ 2018 Ensure a single examination is organized
05502 Construction/rehabilitation of health infrastructure and 05503 Purchase and maintenance of health equipment
Various investment projects
05504 Improving the availability of quality health products
Purchase vaccines and consumables; purchase drugs; purchase therapeutic foods/micronutrients (consolidation of social safety net); purchase health products (reagents, malaria drugs, medical and blood consumables – social safety net); support dialysis unit and running of the blood transfusion centre
05505 Promoting health risk-sharing schemes
Ensure the implementation of the free health care strategy
05507 Promoting traditional medicine and pharmacopoeia
Organize the African Traditional Medicine Days
056 Health service delivery
05601 Community participation
2017: (no activity)
2018: Care for community-based health workers (CBHW)
05602 Reducing morbidity and mortality associated with endemic/epidemic diseases
2017: Specific funds (fight against neglected tropical diseases, response to epidemics, national disease control funds, funds to support the vulnerable persons programme, etc.); Specialist centres (tuberculosis, blindness)
2018: Specific funds (fight against neglected tropical diseases, response to epidemics, national disease control funds, support funds for the vulnerable persons programme, etc.); districts (monitor the running of the health districts); university, regional and district hospitals (monitor the running* of university and regional hospitals); specialist centres (tuberculosis, blindness); HIV/AIDS sectoral programme
05603 Quality mother and child health services
Purchase contraceptive products; Organize National Immunization Days;
+ 2017: HIV/AIDS sector programme
05604 Disaster health management
Supply the national fund for the fight against epidemics
05605 Health promotion
2017: Monitor the running of central administrations, regional health directorates (monitor the running of decentralized bodies); Districts (monitor the running of decentralized bodies); university, regional and district hospitals (monitor the running* of public health establishments); management of CHBW; health promotion in the towns (ensure commitments to the global fund to tackle certain diseases)
2018: Health promotion in towns (support health promotion activities in towns);

APPENDIX 2: continued

Programmes, actions et activités
057 Department of health services' oversight and support
05701 Ministry of Health oversight, coordination and intersector collaboration
Contribution to international organizations
2018: Functioning of central administrations; regional health directorates (functioning of regional health directorates); Contribution to international organizations
05702 Increase in health sector financing
Drafting the Ministry of Health programme budget
05703 Management of financial and material resources
Cover the expenses of medical evacuation (transport and hospitalization expenses); cover the project's expenses, water/electricity, telephone, etc.
05704 Management of human resources
Support the functioning of the professional bodies;
+ 2017, Ensure the organization of single screening
05705 Planning, monitoring and evaluation
2017: Action not selected
2018: Develop planning guidelines, hold National Plan for Economic and Social Development sector dialogue framework sessions, update health card,
05706 Building/rehabilitating and equipping administrative and educational infrastructure
Various activities: office furniture equipment, computer equipment, building district management team offices, etc.
05708 Health information
Support the running of the drug information and documentation centre
+ 2018: Develop national health accounts
05709 Health Research Promotion
Support operations at the National malaria research and training centre, the Muraz centre, the Nouna health research centre
+ 2018: Supply the fund to support health research; Ensure the operation of the National institute of public health (INSP)
05710 Communication
Support Ministry of Health communication

APPENDIX 3: VARIATION IN ALLOCATIONS BY PROGRAMME AND ACTION BETWEEN 2017 AND 2018

By programme and action	2017	2018	74.566.207
055 Access to health services	**Revised provisions 2017**	**Initial provisions 2018**	**Variation 2018/2017 (%)**
05501 Training of health personnel	33.798.558	12.232.982	-64%
per month	28.343.084	6.686.644	-76%
05502 Construction/rehabilitation of health facilities	20.010.259	17.800.429	-11%
05503 Purchase and maintenance of health facilities	20.089.074	18.195.826	-9%
05504 Improving the availability of quality health products	11.329.863	10.748.334	-5%
05505 Promoting health risk sharing schemes	16.219.240	16.125.742	-1%
05507 Promoting traditional medicine and pharmacopoeia	10.300	20.000	94%
Total Programme 055	**101.457.294**	**75.123.313**	**-26%**
056 Health service delivery			
05601 Community participation	28.372.483	55.191.939	95%
per month	28.331.267	51.813.779	83%
05602 Reducing morbidity and mortality related to endemic/epidemic diseases	3.770.526	34.269.202	
05603 Provision of quality maternal and child health services	648.617	1.550.000	139%
05604 Disaster health management	51.627	50.000	-3%
05605 Health promotion	36.598.090	2.359.529	-94%
05606 Health product quality assurance	610.414	1.566.894	157%
Total Programme 056	**70.051.757**	**94.987.564**	**36%**
057 Department of health services' oversight and support			
05701 Ministry of Health oversight, coordination and intersector collaboration	13.571.042	17.623.612	30%
per month	13.435.423	16.065.784	20%
05702 Increase in health sector financing	20.033	25.000	25%
05703 Management of financial and material resources	7.207.967	6.703.608	-7%
05704 Management of human resources	461.453	1.530.476	232%
05705 Planning, monitoring and evaluation	–	43.000	0%
05706 Building/rehabilitating and equipping administrative and educational infrastructure	1.942.534	2.550.389	31%
05708 Health information	10.033	15.000	50%
05709 Health Research Promotion	879.246	1.162.702	32%
05710 Communication	118.387	30.000	-75%
Total Programme 057	**24.210.695**	**29.683.787**	**23%**
GENERAL TOTAL	**195.719.746**	**199.794.664**	**2,1%**

Source : CID ; pour l'année 2017, état de situation tiré à partir du CID au niveau de la DAF/MS (service de l'execution budgétaire)

Notes : 1. Dotations révisées : elles tiennent comptepour 2017, des deux Lois de finances rectificatives, des régulations/blocages instaurés par le MINEFID intégrés dans le CID, des modifications des crédits budgétaires au sein des programmes (dans le cadre de la fongibilité des crédits).

2. Investissement : crédits de paiement

APPENDIX 4: MINISTRY OF HEALTH'S BUDGETARY PROGRAMMES PERFORMANCE FRAMEWORK 2018-2020

Objectifs stratégique/ opérationnel	Indicateurs d'impact /d'effet	Référence			Cibles			Responsable
		Unité	Année	Valeur	2018	2019	2020	
Programme 055 Accès aux sevices de santé								
Améliorer l'accès des populations aux services de santé de qualité	Rayon moyen d'action théorique	KM	2015	6,8	6,1	5,9		DGESS
	Pourcentage de la population vivant à moins de 5 km d'une formation sanitaire (FS)	KM	2015	58,1	60	62,5		DGESS
Action 05501 Formation du personnel de santé								
Produire des ressources humaines suffissantes et de qualité pour la santé	Ration population / médecins	RATIO	2016	15836	14000	13000		DRH
	Ratio population / IDE	RATIO	2016	4108	<4000	<4000	<4000	DRH
	Ratio population / SFE			7778	INF7000	INF7000	INF7000	DRH
Action 05502 Construction/Rehabilitation d'infrastructures sanitaires								
Développer les infrastructures sanitaires	Pourcentage des formtions sanitaires répondant aux normes en infrastru	RATIO	2016	NA	85	90	95	DGESS
Action 05503 Acquisition et maintenance des équipements sanitaires								
Développer les équipements sanitaires et leur maintenance	Pourcentage des formations sanitaires fonctionnelles selon les normes en équipements sanitaires	%	2016	ND	65	70	75	DGESS
Action 05504 Amélioration de la disponibilité des produits de santé de qualité								
Renforcer le circuit d'approvision-nement et de distribution des Produits de santé tie qualité	Pourcentage des DMEG n'ayant pas connu de rupture des 20 molécules traceurs	%	2016	28				DGESS
	Taux de rupture des MEG au niveau des DRD pour les 45 médicaments traceurseu	%	2016	12,7	1,0	<1	<1	DGESS
Action 05505 Promotion des mécanismes de partage des risques en matière de santé								
Améliorer l'accessibilité financière des populations aux services de sauté	Proportion de la population couverte par un mécanisme de partage de risque maladie	%	2016	12	25	30	35	DGESS
	Nombre de nouveaux contacts par habitant et par an	NBRE	2016	1,02	1,3	1,4	1,5	DGESS

APPENDIX 4: continued

Objectifs stratégique/ opérationnel	Indicateurs d'impact /d'effet	Référence			Cibles			Responsable
		Unité	Année	Valeur	2018	2019	2020	
Action 05507 Promotion de la médecine et de la pharmacopée traditionnelles								
Renforcer la contribution de la médecine et de la pharmacopée traditionnelle a l'offre de soins de qualité	Nombre de médicaments traditionnels enregistrés a la nomenclature nationale	NBRE	2016	41	65	70	90	DGPML
	Nombre de tradipraticiens de santé autorisés a exercer	NBRE	2016	29	200	250	300	DGPML
Programme 056 Prestation des services de santé								
Réduire la morbidité , la mortalité pour une meilleure prevent°, des soins éfficaces et un changement des comportements	Taux de mortalité maternelle	RATIO	2016	341	243	243	243	DGESS
	Taux de mortalité des enfants de moins de 5 ans	RATIO	2016	62,75	62,75	62,75	62,75	DGESS
Action 05601 Participation communautaire								
Promouvoir les interventions intégrées à base communautaire en matière de santé	Nbre d'ONG sous contrat de prestation avec le Ministère de la Santé	NBRE	2016	252	252	252	252	DGS
	Nombre de villages couverts par les OBC-E	NBRE	2016	8000	8000	8000	8000	DGS
Action 05602 Réduction de lamobilitéet de la mortalité endémo-épidémies								
Promouvoir les interventions intégrées à base communautaire en matière de santé	Nbre de nouveaux contacts par habitant et par an dans les structures de soins de ler échelon (CM et CSPS)	NBRE	2016	1,02	1,3	1,4	1,5	DGESS
	Taux d'occupation des lits au niveau des hopitaux	%	2016	50,5	60	65	70	DGS
Action 05603 Offre de services de qualité en faveur de la santé de la mère et de l'enfant								
Améliorer la santé de la mère et de l'enfant	Taux d' accoucheinents assistés	%	2016	80,9	>=87	>=90	>=90	DGESS
	Taux de réalisation des césariennes parmis les naissances attendues	%	2016	>=3,5	>=3,8	>=3,9	>=4	DGESS
	Taux de couverture vaccinale des enfants en penta3	%	2016	103	100	100	100	DGESS
Action 05604 Gestion sanitaire des catastrophes								
Renforcer la gestion sanitaire des catastrophes	Taux de prise en charge des victimes des catastrophes	%	2016	NA	80	80	80	DGS
	Proportion des hopitaux disposant d'un plan de riposte <plan blanc>	%	2016	100	100	100	100	DGS

APPENDIX 4: continued

Objectifs stratégique/ opérationnel	Indicateurs d'impact /d'effet	Référence			Cibles			Responsable
		Unité	Année	Valeur	2018	2019	2020	
Action 05605 Promotion de la santé								
Améliorer l'hygiène, l'assainissement et les comportements favorables á la santé	Pourcentage de comités régionaux d'hygiène fonctionnels	%	2016	ND	100	100	100	DGS
	Taux de réalisation physique du plan de communication en faveur de l'hygiène et de l'assainissement	%	2016	>=85	>=85	>=85		DGS
Action 05606 Assurance qualité des produits de santé								
Renforcer le système d'assurance qualité des produits de santé	Taux de conformité des produits pharmaceutiques controlés	%	2016	>=95	>=95	>=95		DGPML
	Nombre de produits controlés en post marketing	NBRE	2016	339	360	370	380	DGPML
Programme 057 Pilotage et soutien des services du Ministère de la Santé								
Renforcer les Capacités institutionnelles, organisationnelles, la gouvernance et le leadership dans le secteur de la santé	Proportion des structures disposants de tous les outils de pilotage et de bonne et goouvernance	%	2016	ND	100	100	100	Cab. Min.
Action 05701 Pilotage, coordination des actions du Ministère de la Santé et collaboration intersectorielle								
Améliorer le pilotage stratégique des actions du Ministère de la santé et la collaboration intersectorielle	Taux de réalisation des revues du secteur de la santé	%	2016	100	100	100	100	Cab. Min.
	Nombre de CASEM santé tenus	NBRE	2016	2	2	2	2	DGESS
Action 05702 Accroissement des financements du secteur de la santé								
Mobiliser les financements au profit du secteur de la santé	Taux de mobilisation des ressources additionnelles	%	2016	ND	>=90	>=90	>=90	DAF
	Taux d'absorption des ressources financières allouées	%	2016	94,22	>=87	>87	>=88	DAF
	Proportion du budget de l'Etat allouée au Ministère de in Santé	%	2016	12,4	13,5	14	14,5	DAF
Action 05703 Gestion des ressources financières et matérielles								
Améliorer la gestion des ressources financières et matérielles mobilisées	Pourcentage des structures ayant fait l'objet d'audits financiers	%	2016	ND	100	100	100	SG
	Nombre d'inventaires de matériels realisés	NBRE	2016	ND	2	2	2	DAF

APPENDIX 4: continued

Objectifs stratégique/ opérationnel	Indicateurs d'impact /d'effet	Référence			Cibles			Responsable
		Unité	Année	Valeur	2018	2019	2020	
Action 05704 Gestion des ressources humaines								
Rationnaliser la gestion des ressources humaines pour la santé	Pourcentage de CSPS remplissant les normes minima en personnel	%	2016	93,2	>=95	>=95,3	>=96	DGESS
Action 05705 Planification, suivi et évaluation								
Améliorer le processus de planification de suivi et d'évaluation au sein du secteur de la santé	Proportion de structures disposant d'un plan d'action annuel	%	2016	100	1000	100	100	DGESS
	Taux d'exécution physique des plans d'action	%	2016	ND	>=85	>=85	>=85	DGESS
Action05706 Construction/réhabilitation et équipement d'infrastructures administratives et éducatives								
Développer les infrastructures administratives et éducatives, et leurs équipements	Pourcentages des ECD fonctionnelles selon les normes en infrastructures	%	2016	ND	100	100	100	DGESS
	Pourcentage des infrastructures éducatives publiques conformes aux normes	%	2016	ND	90	90	90	DGESS
Action 05708 Information sanitaire								
Développer l'information sanitaire	Taux de promptitude des rapports d'activités des Formations Sanitaires publiques de soins	%	2016	ND	>=85	>=85	>=85	DGESS
	Taux complétude des rapports d'activités des Formations Sanitaires publiques de soins	%	2016	97,1	100	100	100	DGESS
Action 05709 Promotion de la recherche pour la santé								
Développer la recherche pour la santé	Proportion de protocoles d'études et de recherches validés par un comité d'éthique ayant fait l'objet d'un rapport	%	2016	ND	100	100	100	DGESS
	Proportion des résultats de recherches utilisés dans le processus de prise de décision	%	2016	ND	60	65	70	DGESS
Action 05710 Communication								
Améliorer la communication pour le changement de comportement des population	Taux de réalisation physique annuel du plan de communication en faveur de l'hygiène et de l'assainissement	%	2016	ND	>85	>85	>85	DGS

Source: Budget – expenditure, Ministry of Health.
Note: an error has crept into the strategic objective for action 05602: Reducing endemic/epidemic morbidity and mortality should in fact be "Improve the supply of quality health services".

World Health Organization

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