

A.I.D. EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS
 2. USE LETTER QUALITY TYPE, NOT 'DOT MATRIX' TYPE

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: Mission or AID/W Office <u>USAID/Burkina</u> (ES# _____)		B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input checked="" type="checkbox"/> Slipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>89</u> <u>02</u>	C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>
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D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable list title and date of the evaluation report.)						
Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)	
686-0260	Family Planning Support Project, Interim Evaluation, November 11 - December 2, 1988	06/30/86	06/90	1,922	1,922	

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director		
Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
1. Social Action field agents of the Ministry of Health and Social Action (MOHSA) should participate in counseling and promotion activities at clinic sites on a part-time basis.	Directorate of Family Health (DFH) and Directorate of Family Promotion (DFP)	12/89
2. Further work should be done on the standardization of clinic reporting forms to assure that family planning statistics are reported in a consistent and regular fashion.	DFH	12/89
3. The recent reorganization of the MOHSA should be confirmed in all aspects with appropriate administrative guidelines and new position descriptions.	MOHSA	ASAP
4. The MOHSA should reprint family planning information, education, and communication (IEC) materials to allow their distribution in sufficient quantities to all levels of the health system.	DFP	12/89
continued on separate sheet		

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation:	(Month) <u>2</u>	(Day) <u>16</u>	(Year) <u>89</u>
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G. Approvals of Evaluation Summary And Action Decisions				
Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
	Richard S. Greene	Ambroise Nanéma	Issa Koussoubé	Herbert N. Miller
Signature	<i>Richard S. Greene</i>	<i>Ambroise Nanéma</i>	<i>Issa Koussoubé</i>	<i>Herbert N. Miller</i>
Date	<u>2/15/89</u>	<u>16-2-89</u>	<u>2/17/89</u>	<u>2/17/89</u>

E. (continued)

- | | | |
|--|-------|-------|
| 5. The current medical standards are deemed to be appropriate and should be issued in manual form. | DFH | 12/89 |
| 6. The DFH should verify that family planning themes are integrated into the medical school curriculum. | DFH | 06/90 |
| 7. The project should continue its collaboration with the A.I.D. centrally funded Family Planning Management Training Project. | USAID | 02/89 |

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The purpose of the project is to strengthen the institutional capacity of the Burkina Ministry of Health and Social Action (MOHSA) to develop and execute improved programs for family planning information and services. The project is implemented by the Directorates of Family Promotion and Family Health of the MOHSA in collaboration with Population Communication Services and the Program for International Training in Health (INTRAH). The interim evaluation (11/88) was conducted by a two member independent evaluation team fielded by Pragma Corporation. It was based on in-depth interviews with MOHSA staff, site visits to observe family planning information and services in 5 provinces, and a review of project documents. The purpose of the evaluation was to assess progress towards achieving project objectives and to set future priorities for activities. The major findings and conclusions are:

- This project has been exceptionally successful, with progress towards end of project targets either on or ahead of schedule.

- Family planning services are available at 50-60 clinics compared to the projected 40 and acceptors are increasing faster than the projected ten percent per annum.

- Management has been improved by development of well functioning record keeping, logistics, and supervisory systems.

The chief recommendations are:

- Information, education, and communication (IEC) field agents should participate in counseling activities at clinic sites.

- Further work should be done on the standardization of clinic reporting forms to assure that family planning statistics are reported in a consistent and regular fashion.

The evaluators noted the following important "lesson":

- The development of a core national training team to conduct in-country training yields positive results and self-sufficiency.

COSTS

1. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
George Coleman	Pragma Corporation	23	Total Pragma contract cost: \$39,790	Project
William Boynton	Pragma Corporation	22		

2. Mission/Office Professional Staff Person-Days (Estimate) 12

3. Borrower/Grantee Professional Staff Person-Days (Estimate) 18

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Purpose of evaluation and methodology used • Purpose of activity(ies) evaluated • Findings and conclusions (relate to questions) | <ul style="list-style-type: none"> • Principal recommendations • Lessons learned |
|--|--|

Mission or Office:

USAID/Burkina

Date This Summary Prepared:

02/08/89

Title And Date Of Full Evaluation Report:
 Interim Evaluation Family Planning Support
 Project (686-0260) - Burkina Faso

November 11 - December 2, 1988

Burkina is plagued by both high fertility (total fertility rate of 6.16 live births and high infant mortality (139/1000). The Family Planning Support (FPS) Project attempts to ameliorate these problems by strengthening the institutional capacity of the Burkina Faso Ministry of Health and Social Action (MOHSA) to develop and implement improved programs for family planning information and services. This project is a Phase I effort to assist the Government of Burkina (GOB) in developing a strong public sector foundation from which to expand nationwide an integrated maternal and child health/family planning information and service program.

This interim evaluation was conducted by a two member team fielded by Pragma Corporation. The primary objective of the evaluation was to assess the implementation and management of the project in order to assist USAID and the MOHSA to improve project activities and make programming decisions for the future. The evaluation was based on in-depth interviews with MOHSA staff, including the National Family Planning Training Team, clinical and Social Action staff in Ouagadougou and from a sample of rural locations in the country. In addition, the team was able to observe clinical and information, education, and communication (IEC) training in process. Finally, team members conducted site visits to observe family planning information and services in 5 provinces.

The major findings and conclusions of the evaluation team were as follows:

"The evaluation team concluded that the project has made excellent progress to date. The general objectives of the project are being met. The project design and log frame remain valid and the purpose and output level indicators can be expected to be realized by the project assistance completion date. The project is realistic in the scope and extent of assistance provided, and has been impressively implemented by the MOHSA, USAID and the cooperating agencies. There exists close and productive coordination among the MOHSA personnel, USAID and the cooperating agencies. The team found that the project has, in a brief time, developed skilled manpower, strong management, appropriate training resources and service delivery, and a movement toward self-sufficiency. Both the MOHSA and USAID should be commended for the spirit and manner in which the project has thus far been implemented.

The training team of ten health and eight Social Action members has trained 96 health personnel toward a goal of 165 and 83 Social Action personnel toward a goal of 120. Some trainers have done secondary family planning training for their staffs at provincial and departmental levels. Some 50 staff members have had family planning training out of country, funded by the project and by central and regional sources.

S U M M A R Y (Continued)

Management has been improved by development of record-keeping, logistics and supervisory systems. The Family Planning Management Training (FPMT) and the Family Planning International Assistance (FPIA) projects assisted the MOHSA in the training of program managers. All systems are functioning well for such an early stage of the program.

Family planning services are available in 15 provinces at 50-60 clinics compared to the projected 40. Family planning acceptors are increasing faster than the ten percent per annum projected under the project.

The projected model Maternal and Child Health (MCH) Center for child spacing has been established and seven others have been added to permit all trainees to receive IUD and other practical training. These centers are all functioning well.

The three reference centers planned for sexually transmitted diseases have been reduced to two for financial reasons. Commodity procurement has been initiated and these centers should be operational before the end of the project.

At the end of project, MOHSA will have demonstrated the capacity to manage a nationwide family planning service. It has already demonstrated its ability to successfully organize and manage the various necessary elements. The clinical staff training system, a logistic system and the IEC system are all in place and will be perfected by the end of the project. It remains only to extrapolate the present excellent systems in order to manage the family planning clinics needed for Burkina Faso.

The experience gained during four years of this project in the Social Action area will enable the MOHSA to serve as the in-country training resource for the projected extension of IEC and counseling activities to the entire national network of family planning services. The MOHSA will have developed and used during this time a comprehensive portfolio of IEC materials which will have been thoroughly tested through field use at all levels for their applicability and acceptance in the Burkinabe culture. Media activities, including radio, TV and theatrical productions will also have been audience-tested and perhaps modified based on these tests. They should therefore be even more effective than earlier prototypes.

In summary, the project has made remarkable progress and should meet its goals. At the end of the project there will be a solid institutional base for further expansion into a national program."

The chief recommendations are as follows:

1. Social Action field agents of the Ministry of Health and Social Action should participate in counseling and promotion activities at clinic sites on a part-time basis.
2. Further work should be done on the standardization of clinic reporting forms to assure that family planning statistics are reported in a consistent and regular fashion.
3. The recent reorganization of the MOHSA should be confirmed in all aspects with appropriate administrative guidelines and new position descriptions.

S U M M A R Y (Continued)

4. The MOHSA should reprint family planning IEC materials in sufficient quantities to allow their distribution to all levels of its health system .
5. The current medical standards are deemed to be appropriate and should be issued in manual form.
6. The DPH should verify that family planning themes are integrated into the medical school curriculum.
7. The project should continue its collaboration with the A.I.D. centrally funded Family Planning Management Training Project.

Finally the evaluation team noted the following important "lesson":

"The development of self-sufficiency in training through the planned development of a national training team to serve as the core of trainers for the remaining personnel of the system yields results that should continue in the years to come."

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Interim Evaluation: Family Planning Support Project,
Project No. 686-0260, Burkina Faso

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

Mission's comments: USAID/Burkina considers that the subject evaluation was well done and effectively met the demands of the scope of work. All of the specific questions posed in the scope of work or more were adequately addressed. Sufficient field work, site visits, and relevant interviews were conducted to assure a fully informed project assessment. USAID/Burkina concurs in the overall conclusions and findings cited by the evaluation team.

GOB's comments: The MOdSA fully endorses the findings and conclusions of the subject evaluation. The evaluation was found to be particularly useful in assisting MOdSA technical staff to formulate ideas for a projected follow-on project.

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INTERIM EVALUATION

FAMILY PLANNING SUPPORT PROJECT
Project No. 686-0260
Burkina Faso

November 11-December 2, 1988

Evaluation Team:

George Coleman, MPH
Dr. Willard Boynton, MD, MPH

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INTERIM EVALUATION
FAMILY PLANNING SUPPORT PROJECT
Project No. 686-0260
Burkina Faso

November 11-December 2, 1988

Evaluation Team:

George Coleman, MPH
Dr. Willard Boynton, MD, MPH

ACKNOWLEDGEMENTS

The evaluation team is extremely grateful for the splendid cooperation it received in Burkina Faso from members of the MOHSA management staff, the national family planning training team, family planning workers at provincial and departmental levels, representatives of INTRAH, FPIA, PCS and REDSO present during the evaluation, and particularly to the staff of the USAID. Throughout our stay there was a sense of participation and sharing in the knowledge and understanding of the project as well as a desire to make this evaluation a positive contribution to the future improvement of what clearly is an immensely productive and successful family planning project. Without this positive support from our colleagues, the team would not have had access to the insights and realities about family planning in Burkina Faso which are necessary to produce an evaluation that can be useful to those who have nurtured the project.

For a list of those who contributed to this effort, please see the list of individuals and agencies contacted, Annex D of this report.

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LIST OF ACRONYMS

ABBEF	Burkina Faso Association for Family Welfare
A.I.D.	Agency for International Development
CAFS	Francophone Africa Center for Health
CEDPA	Center for Development and Population Activities
CM	Medical Center
CSPS	District Center for Health and Social Promotion
CYP	Couple Years of Protection
DEP	Directorate of Studies and Planning
DFP	Directorate of Family Planning
DSF	Directorate of Family Health
FPIA	Family Planning International Assistance
FPMT	Family Planning Management Training of Management Science for Health
GOB	Government of Burkina Faso
IEC	Information, Education and Communication
INTRAH	University of North Carolina Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Project for International Education in Gynecology and Obstetrics
KAP	Knowledge, Attitudes and Practices Survey
MCH/FP	Maternal and Child Health and Family Planning
MOHSA	Ministry of Health and Social Action
NTT	National Family Planning Training Team
PACD	Project Assistance Completion Date

PCS Population Communication Services, Johns Hopkins
University

PHP Primary Health Care Posts

REDSO Regional Economic Development Support Office

STD Sexually Transmitted Diseases

UNFPA United Nations Fund for Population Activities

USAID Country Mission of the United States Agency for
International Development

Project Identification Sheet

1. Country: Burkina Faso
2. Project Title: Family Planning Support Project
3. Project Number: 686-0620
4. Critical Project Dates:
Grant Agreement: June 30, 1986
Grant Agreement Amendment 1: December 31, 1986
Grant Agreement Amendment 2: July 29, 1987
Final Obligation Date: To be Determined by USAID
Project Assistance Completion Date: June 30, 1990
5. Project Funding (\$ millions):
A.I.D. Bilateral Funds: 1.922
A.I.D. Regional Funds: (.600 estimated)
A.I.D. Central Funds: (.200 estimated)
Government of Burkina Faso (GOB) Counterpart Funds: .288
6. Mode of Implementation:
A.I.D. Bilateral: Grant
A.I.D. Regional: Sub-agreement between A.I.D. cooperating agencies and MOHSA
A.I.D. Central: Sub-agreement between A.I.D. cooperating agencies and MOHSA
7. Project Designers:
Leslie Curtin, former USAID/Burkina Health/Population Officer
Joyce Holfeld, Regional Population officer
Adeline Verly, Family Planning Consultant
Nancy Yinger, Demographic Consultant
8. Responsible Mission Officials:
Richard Greene, Health and Population Officer
Roxana de Sole, Project Manager
9. Previous Evaluations: None

I. EXECUTIVE SUMMARY

A. Overview

The purpose of the Family Planning Support Project is to strengthen the institutional capability of the Burkina Faso Ministry of Health and Social Action (MOHSA) to develop and implement improved programs for family planning information and services.

The evaluation team concluded that the project has made excellent progress to date. The general objectives of the project are being met. The project design and log frame remain valid and the purpose and output level indicator can be expected to be realized by the Project Assistance Completion Date (PACD). The project is realistic in the scope and extent of assistance provided, and has been impressively implemented by the MOHSA, the Country Mission of the United States Agency for International Development (USAID) and the cooperating agencies. There exists close and productive coordination among the MOHSA personnel, USAID and the cooperating agencies. The team found that the project has, in a brief time, developed skilled manpower, strong management, appropriate training resources and service delivery, and a movement toward self-sufficiency.

Both the MOHSA and USAID should be commended for the spirit and manner in which the project has thus far been implemented. The remaining comments in this section then should be viewed within the foregoing positive context.

B. Conclusions and Recommendations

Organization and Management

- 1) The recent fusion of the health and social action ministries, which has consolidated family planning information and services into one ministry, should be confirmed with appropriate administrative guidelines and position descriptions.
- 2) The MOHSA and USAID should continue the kind of close coordination and attention to detail that has characterized the project to date. When centrally-funded resources from the Agency for International Development (A.I.D.) are available for long-term training, the project should take advantage of these opportunities. The project should continue its collaboration with the centrally-funded Family Planning Management Training Project (FPMT).

Training

- 1) The MOHSA has achieved an effective capability to provide clinical, management, and information, education and communication (IEC) training to its personnel. In addition, good progress has been made in completing the family planning modules for the professional schools for nursing, midwifery, and social work. Further action should be initiated to develop a family planning module for the new medical school.
- 2) With the technical assistance provided by cooperating agencies such as the University of North Carolina Program for International Training in Health (INTRAH), Population Communication Services (PCS), Family Planning International Assistance (FPIA) and FPMT, the MOHSA has developed a capacity to plan, implement, and evaluate its own family planning training programs. The MOHSA should continue to perfect its training capability through maintenance of the quality and professional composition of the national family planning training team.
- 3) The project has already trained a cadre of competent family planning clinical and IEC workers. The MOHSA should assure that all trained staff are allowed to continue in assignments related to their training.

Information, Education and Communication

- 1) The MOHSA should encourage close collaboration between social action staff doing IEC work and clinical personnel. Workers trained in IEC should participate in counseling and promotion activities at health clinics on a part-time basis.
- 2) The MOHSA should assure that the IEC materials which have been designed and pretested under the project are distributed in sufficient quantities to reach all levels of the MOHSA system.

Clinical Services

- 1) The 18 Burkina Faso training team members have been training more than 160 MOHSA staff with assistance from INTRAH and PCS. Several trainees have already taken the initiative of training their entire provincial staffs in family planning information and delivery services, with the exception of IUD insertions. This secondary training should be encouraged through additional provision of teaching

materials and equipment and through any technical assistance needed from the national training team. IUD training should be provided to all appropriate staff.

- 2) The current policy of selling contraceptives should be maintained. It has the positive effects of providing funds for essential clinic operations and of insuring accurate reporting of contraceptive use.
- 3) In 1983, an assessment team found less than 100 couples were protected by modern clinical family planning methods. Using the indicator of couple years of protection (CYP), it is estimated that the equivalent of about 6,000 couples in 1985, 9,000 in 1986, 13,000 in 1987 and 20,000 in 1988 were fully protected by modern family planning methods. These numbers are far in excess of the ten percent increase in clients per year projected under the project. The numbers are growing at virtually all clinics.

In order to continue to effectively monitor the program, the MOHSA should assure that all clinics submit their family planning contraceptive and utilization reports consistently and in a timely fashion. These reports should be analyzed for CYP and cross-checked against the financial reports. In the future a sample survey of contraceptive users should be conducted.

C. Projected USAID Follow-On Project

The MOHSA and USAID should proceed to develop a follow-on project. There should be close coordination with the MOHSA Studies and Planning Directorate (DEP), the United Nations Fund for Population Activities (UNFPA), the World Bank Health Project, and other donors. This will permit an extension of family planning services nationwide, parallel with the development of a capacity to deliver health services.

Recommendations for a future project component are as follows:

- Regular refresher training for trained family planning personnel
- Commodity procurement for new service sites based on a prior needs assessment
- Continued support for supervision activities
- Training and equipment for the six regional hospitals to prepare them for voluntary surgical sterilization and sterility services.

D. Summary Conclusion

The project has made remarkable progress and should meet its goals. At the end of the project there will be a solid institutional base for further expansion into a national program.

II. PURPOSE AND METHODOLOGY OF THE EVALUATION

The primary objective of this interim evaluation was to analyze the present status of implementation and management of the project in order to assist USAID and MOHSA to improve project activities and to make programming decisions for the future. The major emphasis of the evaluation was to identify those constraints and lessons learned during the first two years of the project. Specific issues examined included the effectiveness of the MOHSA organizational structure and the projected institutional capability of the MOHSA at the end of the project to manage family planning information and services. This evaluation includes guidance for future directions in the family planning sector.

The evaluation team reviewed available project files and documents, including the project paper and supplement, grant agreements and amendments, reports of cooperating agencies (including INTRAH, PCS, FPIA, Columbia University and FPMT) and other USAID documentation (See Annex C).

The team also gained valuable information through direct interviews with MOHSA personnel, including the National Family Planning Training Team, clinical and Social Action staff in Ouagadougou and from a sample of rural locations in the country. The insights of these colleagues and their avid participation in the evaluation process contributed a degree of reality to our findings that would not have been possible otherwise. Also, the team was able to observe clinical and IEC participants as they underwent training in theoretical and clinical settings and participated in evaluation sessions in which trainees gave feedback to trainers concerning the quality and appropriateness of their training. Other cooperating agencies such as UNFPA and the Burkinabe Association for Family Welfare (ABBEF), an affiliate of the International Planned Parenthood Federation (IPPF), were included in these interviews. (See Annex D for agencies and personnel contacted and interviewed.)

Finally, the team members spent a week in the field to observe the process and flow of service delivery in clinical and social agencies at the national, provincial, departmental and village levels. They reviewed the capability for organizing, managing, reporting and delivering family planning service and IEC activities at all levels.

Valuable resources for the evaluation were the USAID and cooperating agency personnel whose presence in Burkina Faso was arranged by the USAID mission to coincide with the performance of this evaluation: Joyce Holfield, Population Officer, A.I.D. Regional Economic Development Support Office (REDSO); Pape Gaye, INTRAH representative from Abidjan; Philippe Langlois, of the PCS, Johns Hopkins University, Baltimore; and Ismael Buka, FPIA

representative based in Nairobi. Essential insights were provided by USAID personnel, particularly Richard Greene, Chief of Health and Population, Roxana de Sole, Project Manager, and Perle Combar, Assistant Health and Population Officer.

The evaluation team consisted of Dr. Willard H. Boynton, MP/MPH, Population and Public Health Consultant; and George M. Coleman, MPH Consultant, Team Leader, Specialist in Management and IEC.

III. OVERVIEW OF FAMILY PLANNING IN BURKINA FASO

The GOB established a favorable climate for the development of family planning information and service delivery during the several years preceding the initiation of the Family Planning Support Project. Active interest in population problems was formalized in 1983, when the government signed a decree establishing a National Population Council under the Minister of Planning, with an interministerial representation. This council was formed to develop a plan to incorporate population issues into national development policy in Burkina Faso.

A private organization (ABBEF) already existed to promote the idea of family planning but it had not provided any family planning services. ABBEF developed an educational program to promote awareness of family planning among special target groups such as leaders and students. It referred prospective clients to private physicians and the number of acceptors remained low.

In response to government interest in assistance for its nascent family planning activities, USAID requested an in-depth needs assessment in October, 1983. Support for this effort came from the government, especially the planning and health ministries and the organization of midwives and nurses. In 1985, USAID designed a modest project to support family planning services and IEC activities, with initial funding of \$1.25 million. This was amended later with additional funding of \$672,000. The initial project was based on a wisely-designed strategy which USAID developed with the GOB to emphasize institutional building to provide the basis for a future nationwide program. The government did and still does give priority to the promotion of maternal and child health, including child spacing as a means of improving the health of mothers and families of Burkina Faso. Therefore, the current project strategy is acceptable to these interests and objectives and likely to lead to a successful expansion of family planning in the future.

This strategy has been translated into a project that has developed trained personnel into a cadre working as part of a nationwide training effort in clinical and IEC activities. USAID has been skillful in drawing on existing central and regional resources and for operational research, policy development, contraceptive supplies, participant training, and management

assistance. This has allowed for a concentration of resources from the present project for the development of skilled manpower, strong management, training resources and service delivery currently concentrated in nine provinces. (Note: UNFPA has been allocated nine provinces and the World Bank six provinces. Thus, all of Burkina Faso's 30 provinces are covered by donor support.)

The project is closely coordinated with donor organizations functioning in the remaining provinces. Therefore, the government and private Burkinabe organizations eventually will be able to operate a national family planning program.

There is no major opposition to family planning in Burkina Faso. There is, of course, a prohibition against abortion as a family planning method. All other methods are available, including sterilization. Certain Catholic organizations have an interest in promoting natural family planning methods. But despite their opposition to offering other family planning methods, some religious members have referred clients to other sources which provide the other methods. The climate for establishing a responsive, coherent family planning program was ripe; the responses of the government and USAID have been appropriate. Field observations demonstrated no serious organized resistance to family planning in Christian, Muslim, Animist or other cultural areas.

IV. ENVIRONMENT AND VALIDITY OF THE PROJECT DESIGN

It was clear from the events preceding the initiation of this project that the environment within Burkina Faso for successful support for family planning programs was positive. For example:

- The GOB had already pronounced its interest in linking family planning to maternal and child health and family welfare.
- There had already been an initiative in-country to develop awareness and acceptance of family planning for health reasons, through the family planning association ABBEF.
- There was no significant religious opposition to the GOB maintaining a program in family planning.
- The major professional associations had expressed interest and support for family planning, including the associations of midwives and professional nurses.
- Private initiatives already existed, on a very limited scale, which provided a minimum service to women in search of contraception.

- GOB policies regarding contraceptive methods and the relationship between health and child spacing were in accord with USAID policy.
- The nurses and midwives had noted numerous requests from multiparous women to limit the size of their families, and these professionals were embarrassed by lack of family planning, training and supplies.

There were virtually no personnel within government who had training and were skilled in either IEC activities or clinical procedures for establishing a family planning program. Nor had the major professional schools of medicine, nursing, social educators, etc. incorporated any meaningful didactic content into their curricula. A few health and social action workers had been exposed to ideas of family planning through their training in schools outside the country.

Given the scarcity of knowledge and skills in this field, and the overall lack of experience in managing family planning service and IEC programs, the thrust of the current project was correct and timely. Additional demographic and population policy efforts were not required before beginning a direct approach of providing skilled manpower in several areas, including the following:

- Clinical service delivery
- IEC activities through a variety of media interventions appropriate in content and language to the culture of the country
- Development of management and planning capabilities within the Health and Social Action ministries (now combined into the MOHSA).

Inherent in the foregoing was the need for training plans, didactic materials and curriculum development, to be facilitated through external technical assistance.

In this way the project has evolved, a fairly direct matching of activities to the current needs of the GOB. The project was designed to initiate activities in approximately 40 sites in 15 provinces. This was a realistic goal. The basic structure is being built through the current project. This will permit an expansion within a few years to provide family planning to the entire country. The base of clinical and IEC skills being developed by this project will provide the cadre of trained personnel who will be able to train greater numbers of Burkinabe workers.

A brief description of major project components indicates the scope and content of the current project. These will include, at

the end of the project, strengthened management units within the MOHSA for family planning activities and the IEC program. A cadre of trained personnel will be developed through formation of a national training team of 18 program planners and trainers, and some 165 workers trained in clinical services, including physicians, nurses and midwives. Approximately 120 social agents will receive training in counseling and communication skills directed toward family planning. Curricula will be designed and incorporated into the teaching offered at the national schools for nurses, midwives, health auxiliaries, social agents and educators. Development of a curriculum for family planning also is planned for the medical school. A network of clinical services and information activities is expected to be available in at least 41 facilities at all government levels and contraceptive users will increase at ten percent per year. Originally one but now eight, model maternal and child health (MCH) centers will be developed under the MOHSA as reference sites for training of health and social agents and to pre-test and evaluate IEC materials. Included in the project were three centers (now reduced to two) for treatment and diagnosis of sexually transmitted diseases (STD), which represent an ongoing threat to Burkina Faso. Finally, an IEC production unit planned for the MOHSA will have the capacity to develop, produce and distribute IEC materials and audio-visual productions.

V. OVERALL ASSESSMENT OF SUCCESS OF PROJECT TO DATE

The success of this project to date has been exceptionally good, with progress toward end of project targets either on or ahead of schedule in virtually all areas.

The training team of ten health and eight Social Action members has trained 96 health personnel toward a goal of 165 and 83 Social Action personnel toward a goal of 120. Some trainers have done secondary family planning training for their staff at provincial and departmental levels. Some 50 staff members have had family planning training out of country, funded by the project and by central and regional sources.

Management has been improved by development of a record keeping, logistics and supervisory systems. The FPMT and FPIA Projects assisted the MOHSA in the training of program managers. All systems are functioning well for such an early stage of the program.

Family planning services are available in 15 provinces at 50-60 clinics compared to the projected 40. Family planning acceptors are increasing faster than the ten percent per annum projected under the project.

The projected model MCH center for child spacing has been established and seven others have been added to permit all trainees to receive IUD and other practical training. These centers are all functioning well.

The three reference centers planned for STDs have been reduced to two for financial reasons. Commodity procurement has been initiated and these centers should be operational before the end of the project.

GOB contributions, according to the second amendment to the Project Grant Agreement, dated July 29, 1987, are projected to be not less than 144 million CFA (approximately U.S. \$288,000). This amount, mostly "in kind," includes provision of the GOB Project Director, National Training Team, medical personnel for the model centers and STD clinics and personnel for the delivery of family planning clinical and IEC services at approximately 41 sites at national and provincial levels. In most respects the GOB contributions are being met on a timely basis.

VI. SPECIFIC ISSUES AND PROJECT AREAS EXAMINED

A. Effectiveness of Organizational Structure of MOHSA for Support of Family Planning Information and Services

Findings: The recent fusion of the health and social action ministries has affected the national structure for delivering family planning and IEC activities by concentrating family planning program activities in one ministry. The process is almost complete, therefore previous uncertainties of relationships between staff of the former separate ministries have diminished.

Conclusions: The MOHSA is now staffed with experienced professionals, including the national family planning training team, which represents an appropriate balance of the disciplines required for effective family planning service delivery, including clinical, IEC and management support activities. There are still a few personnel appointments to be confirmed and then a structure will exist which brings together in the same ministry the functions of family planning service delivery and IEC. What is apparent from interviews the team held with key MOHSA people is the need to issue administrative guidelines based on the new organizational structure and to issue new position descriptions that will reflect any changes in duties brought about by the restructuring of the family planning components of MOHSA.

Recommendation: The reorganization should be confirmed in all aspects with appropriate administrative guidelines and new position descriptions. These essential actions will

provide all parties a clear understanding of their roles and functions in family planning services. It is essential that these actions be accomplished without delay.

B. Project Management

Findings: The team was impressed by the degree of understanding of the objectives of the project, its ability to organize an ambitious training program, and its capability to implement a well-conceived service delivery system.

On a national basis, the tasks of planning, coordinating, supervising, evaluating and training are carried out by a core staff within the Directorate of Family Health (DSF). A national plan for the management of a nationwide network of family planning has been issued. It is based on the action plan issued by the Ministerial Council in 1985. The guidelines are clear to the core staff, which has been instrumental in translating these plans into specific technical specifications for delivery of family planning services, assuring content in training programs, developing a supervision plan (to be activated in January, 1989) and in designing a contraceptive logistic system.

A manual for the management of contraceptive stocks has already been issued and a ten-day seminar developed that gives information on how to manage contraceptive logistics, accomplish reporting requirements, and arrange for procurement.

Financial management is apparently under control, although there is some concern that the present accountant may become overloaded as additional projects are activated with other donors.

Conclusions: The financial, logistic and management systems developed under the project are functioning well.

Relations between MOHSA project management staff and USAID project management staff appear to be very productive. MOHSA views USAID staff as responsive to its needs for action, although some delays are experienced in procurement, resulting from U.S. regulations, shipping times and MOHSA procurement review requirements.

Recommendation: While no change in the management style is recommended, the team urges the MOHSA and USAID to continue the kind of close coordination and attention to detail that have characterized the project to date. When USAID centrally-funded opportunities for long-term management training are available, the team recommends that the project

take advantage of these opportunities. Continued collaboration with the FPMT Project, which has had obvious beneficial effects, should also be pursued.

Recommendation: MOHSA should carefully monitor workload of present accounting personnel and add a trained accountant to the DSF as needed.

1) Directorate of Family Health (DSF)

The DSF is one of several directorates reporting directly to the Secretary-General of MOHSA. It is responsible for all maternal and child health/family planning (MCH/FP) and nutrition. Family planning services are delivered at MCH and other clinics and hospitals as a priority component of maternal and child health. Within the DSF there are separate offices for MCH and FP. The DSF staff are technically responsible for family planning down to the village level even though province medical chiefs are responsible for administration.

The DSF has its own building with an adequate meeting room and storage space for contraceptives and equipment. Needed additional office space is under construction, funded by UNFPA.

The staff of about a dozen people is somewhat overworked because of the recent addition of family planning duties. Accountability for funds received in payment for contraceptives has increased the workload as has administrative support of the family planning training courses.

DSF has developed a good record-keeping system including individual client cards, chronological registers, contraceptive sales records, monthly activities reports, and records for ordering and controlling contraceptives. FPIA and FPMT have assisted in the development of the logistic and record systems.

The DSF gives technical supervision and guidance to the family planning program at all levels. The project has provided a vehicle, fuel and per diem to DSF evaluators/supervisors to support field visits such as those in which the USAID evaluation team participated.

The DSF has proven its competency to manage a family planning program.

2) Social Action

The team held discussions with the Chief of Service of Family Education, who is well informed about the project status and eager to get on with the coordination and implementation of the social action component. Social Action only recently had its location within the new MOHSA structure confirmed. Despite the frustration which resulted from that uncertainty, the activities of the staff on the Social Action side have continued to meet their schedule. Training has continued, the production of IEC materials has been maintained and the Social Action component has continued to deliver the quality of services for IEC activities needed for success of the project. The staffing of the new Family Education Office includes at least four professionals previously trained under the project. This will allow the project momentum developed to date to continue.

The specific production of materials and discussions of training are described later in this report. It appears that because of the method in which the Social Action field reports are received in the ministry, there is some potential delay in the ability of the family planning project, including Social Action, to take remedial action if problems are reported. The information system would be enhanced if reports were sent directly to the family education office for action.

3) USAID

USAID has the benefit of three project officers whose skills are complementary to one another: A trained public health administrator serving as the USAID Health and Population Officer, who provides policy guidance, technical advice and overall guidance for the planning and implementation of the project; an experienced USAID Project Manager, trained as an MBA, who provides professional skills in planning, monitoring and documenting all project activities, including the budget, coordination with MOHSA and other donor agencies, liaison with the cooperating agencies and monitoring of the availability of contraceptive commodities and equipment; and a Program Specialist who has a doctorate in sociology and is skilled in project monitoring, computer operation, commodity planning and tracking, participant scheduling and processing, and who manages many of the complementary centrally and

regionally-funded population projects. These three have developed an effective project operation which is respected by their Burkinabe counterparts.

The pros and cons of locating the Project Manager within the GOB counterpart space was discussed. It is felt that the frequency of coordination meetings enables the Project Manager to monitor fully the MOHSA aspects of the project, whereas access to the USAID administrative systems facilitates her taking more rapid action located as she is within USAID mission space. It is suggested by the team that things are going well as is under present physical arrangements and that there seems to be no advantage to a move.

The Project Officer does an impressive job of coordination and providing technical and policy guidance to a comprehensive portfolio of population and related health projects. The dedicated work of his excellent staff permits an effective implementation of population activities. Together they form an excellent management team. The office appears to be one of the better managed USAID family planning operations, judging by the knowledgeable approach to management of this project staff.

4) Cooperating Agencies

It was possible to have the presence in-country of representatives from two of the cooperating agencies which contribute to the implementation of this project: INTRAH of the University of North Carolina and PCS of Johns Hopkins University. Both representatives assisted the evaluation team with their attendance at MOHSA meetings and several field visits to service delivery points in Ouagadougou and provincial sites. It is clear that these representatives are professionally prepared to make significant contributions to the project. Both are fluent in French and know the theory and techniques of family planning services. INTRAH provides the training for both clinical and IEC materials (which are described elsewhere in this report) and PCS provides training of IEC personnel. These cooperating agencies have developed effective rapport with their Burkinabe counterparts and are praised by their counterparts for being knowledgeable, pertinent, and responsive. They have provided practical application of theory and practice to resolving project constraints and have avoided bureaucratic over-involvement in the daily implementation of the project. Both seem to have a breadth of knowledge of family planning approaches in

other countries in Africa and how the experiences of one country or another may be shared with the needs of Burkina Faso.

VII. PROJECT PERFORMANCE TO DATE AND POTENTIAL BY END OF PROJECT

A. Strengthening Management Units for Family Planning

1) Record Keeping

Findings: The DSF has developed a good record system with assistance from FPIA and FPMT and workshops have been held to train concerned staff to use the system. Field visit inspection of records demonstrated that most of the records were complete and kept in good order, although there were some exceptions. The individual patient records varied slightly at the ABBEF and midwives clinics from those of the DSF but contained essentially the same information so that comparable monthly reports could be made.

Records include:

- Individual record cards which are stored in a wooden file provided under the project. They have complete information on gynecological history and examination as well as all necessary data on contraceptive experience.
- A chronological record book of patient visits with data on age, sex, religion, contraceptives used and reactions.
- A notebook of contraceptive sales which can be used to check against contraceptive usage reports. Since clinics must forward funds to the province consistent with contraceptive use reports, exaggeration of reports is not likely.
- A monthly report summarizing family planning activities, which is forwarded directly to the province and then to the central level. This monthly report will be changed to a quarterly report which will be adequate for management and less onerous for the clinic staff.
- A series of forms designed to control and track contraceptives, supplies and equipment through the logistic system.

Conclusion: The record keeping system is already satisfactory but can be improved by further standardization of forms and more supervision to ensure that reports are complete and submitted regularly.

Recommendation: Further work should be done on the standardization of record-keeping forms and supervision of the record-keeping process.

2) Supervision

Findings: There is an adequate plan for supervision at all levels which only needs to be carried out. This is not always possible at the provincial level because of overworked staff, inoperative vehicles or lack of funds for fuel. In principle, the province supervisor visits the medical centers (CM) and district centers (CSPS) monthly and the CM or CSPS staff supervise the village staff of the primary health care posts (PSP), also monthly. Record forms for supervision have been developed and training courses have a supervision component.

Conclusion: MOHSA should put even more stress on supervision because the large number of auxiliaries needed to fulfill the national health plan requires more supervision than fully trained professionals.

Recommendation: The project should assure that the supervision activities take place as scheduled.

3) Participant Training

Findings: With the assistance of FPMT, the MOHSA developed a plan for the training in management, supervision and IEC of family planning managers from the central and provincial levels. This plan provided for 41 short-term training courses over a four-year period.

To date the project has funded 18 participants to attend two to four weeks of out-of-country training courses at Santa Cruz, the Francophone Africa Center for Health (CAFS), Columbia University and the Center for Development and Population Activities (CEDPA). In addition, the project has supported a two-week study tour in Senegal for nine members of the national training team, and 23 additional participants attended IEC, management and clinical courses sponsored by the Johns Hopkins Project for International Education in Gynecology and Obstetrics (JHPIEGO), FPMT, INTRAH and Pathfinder. Finally, INTRAH and FPMT invited six

participants to attend the INTRAH Technical Advisory Committee and the FPMT Francophone Regional Advisory Committee, and six participants attended various conferences in Africa. In summary 53 MOHSA staff members received management and technical training.

On the support side, the nomination process for participants at the MCHSA level has been simplified. In most cases USAID has handled all logistical arrangements. Participants have reported that courses were of high quality and appropriate. The most appreciated courses were those provided by JHPIEGO, CAFS, Santa Cruz, FPMT and Columbia University.

B. Cadre of Trained Personnel for Family Planning

1) National Training Team

At the heart of the institutional base which this project has built is the national family planning team, comprised of 18 members representing a variety of the key professions within the medical and social action components of family planning.

The eight team members for the DSF have received special training from the Social Action side of the project in IEC methods, family planning, supervision and evaluation. Three of the National Training Teams visited Dakar to observe the Senegalese family planning project. In addition, a number of the team were trained in-country in marketing, evaluation, supervision and communication through the FPMT sub-agreement. This team forms the basis of the national capability to achieve self-sufficiency in training. The members have benefited from the technical assistance received from INTRAH, JHPIEGO, and PCS in curriculum development. They have developed the training plan and curriculum for the ensuing courses that have trained over 165 workers thus far in various aspects of family planning service and IEC. They are working now with FPMT to perfect a supervision system that will strengthen monitoring, supervision, and reporting of activities throughout the 15 provinces.

As part of the effort to maintain their capability and continue the impetus developed in training within the project, the national training team continues to receive in-service assistance from the cooperating agencies and from exposure to new ideas in training. For example, nine of the members of the team will be sent to the Family Planning Training Center in Morocco to review the methods and techniques developed there

for application to the needs of Burkina Faso. All in all, the national training team brings formidable strength to the training component of this project.

2) Service Delivery Personnel

Findings: The MOHSA policy is to utilize existing personnel to deliver family planning services as a component of family health services, particularly MCH services. This is working well to date even though some field staff feel overworked. Training in family planning has progressed on schedule so that trained staff are available at enough clinics to meet project goals for acceptors of family planning services. This should continue until the end of the project.

All of the health personnel trained in family planning whom team members met on field trips were providing family planning services well. Either they had initiated family planning services or had notably expanded existing services. Many had given secondary training in family planning to their staffs, including auxiliaries, to further expand the availability of family planning services. Unfortunately, several trainees were found to have been reassigned since their training.

Conclusion: The functioning service delivery system is jeopardized by the MOHSA reassignment system.

Recommendation: DSF should monitor trainees to try to ensure that MOHSA reassigns family planning trainees only to positions where they can still use their family planning training.

3) Social Action Agents

It was possible for the team to interview the Social Action workers at the national, provincial and departmental levels within the MOHSA network. At the national level, as stated elsewhere, there is a trained core of trainers for the Social Action activities of the project. This group, part of the national family planning training team, consists of eight professionals who have received third country training under the project in IEC, family planning management, supervision, evaluation and operations research. They also have participated in study tours of other countries' programs. There is presently one MOHSA professional who is on a long-term training program at a U.S. public health school. The team was able to discuss the national program for Social Action with the

National Training Team. Members are knowledgeable, competent and devoted to the challenge of creating a national family planning program.

The National Training Team has in turn trained 83 Social Action workers within the 15 provinces of this project in techniques of IEC, counseling, contraceptive methods, and information reporting. This is an impressive number, more than two thirds of the 120 scheduled to be trained by the end of the project. Some of those visited by the evaluation team were from the trainee groups. As described elsewhere in this report, the trainees benefited very much from the training received and are prepared to use the new skills acquired. But they lack certain information materials that are being developed and need additional logistic support, including transportation. There is no doubt, however, that with continued supervision and support, these agents will form a competent body of workers to deliver IEC and counseling services for the family planning project. Moreover, with sufficient motivation and materials support, they could become the nucleus for training other social agents in other provinces in new approaches to IEC for family planning.

4) Pre-Service Curriculum for Health

Findings: Before the advent of this program there was very little population/family planning content in the curricula for health personnel. For example, the three-year nursing curriculum had ten hours devoted to family planning. The DSF, with assistance from INTRAH, has succeeded in integrating 100 hours of family planning studies into the curriculum for nurses and midwives. Work is currently proceeding on development of similar materials for integration into the curriculum for the two-year courses for assistant nurses and midwives. This year the new medical school graduated its first class and expects to have about 25 graduates annually.

Conclusion: It is important that family planning studies be integrated into the new medical school curriculum. Its graduates will be the future medical directors of the provinces and districts. If health leaders are knowledgeable about family planning and skilled in its clinical aspects, they will more enthusiastically support the program and be more willing to let their MCH personnel devote time to family planning.

Recommendation: DSF and INTRAH should make a serious effort to integrate a family planning content into the medical school curriculum.

5) Pre-Service Curriculum for Social Action

A family planning module which will be integrated into the curriculum of the social educators trained at the National School of Social Work has been designed with assistance from a consultant. The overall design has been accepted by the MOHSA and a strategy for its application is being developed.

The strategy adopted involves preparation of the individual lessons contained within the training modules and acquisition of the related reference books, texts, didactic materials and the family planning kit for each teacher and student. The kits will be used first as a teaching tool and later by the graduates as a promotional instrument. This will be followed by a workshop for the trainers at the National School of Social Work. Finally, a system for monitoring and evaluating the results of training and lessons learned from subsequent experience will be developed to insure that future training efforts include revisions based on this earlier phase.

The module includes information on the national policy on family planning, national demographic data, contraceptive methods, the organizational structure for delivering family planning services, information on STD, and an understanding of sterility. Finally, the module has a section on the management and reporting involved in family planning activities.

6) Development of Medical Standards

Most family planning programs start with higher medical standards for family planning than those generally prevailing in the medical practice of the country. For example, there have been countries with one doctor for 25,000 people where only a specialist in gynecology was considered fit to insert an IUD. The highest medical standards available should be used in family planning, but they should not prevent availability of services. The health advantages of family planning greatly outweigh the risks of frequent pregnancies, births insufficiently spaced, or births from mothers either too young or too old.

In this program the requirement of testing for blood lipids before starting oral contraceptives was an example of unnecessarily high medical standards. Fortunately, this requirement was deleted after a study demonstrated its inutility. The prescription of injectable progesterones was originally restricted to doctors, but a policy change is being considered which should allow midwives and registered nurses to prescribe this method. Oral contraceptives can be given by trained midwives and nurses or by their assistant midwives and nurses who have had secondary training in family planning. A gynecological history and examination are a prerequisite. Clients are started with one cycle of orals but may have three cycles on resupply. IUDs are inserted only by doctors, nurses, or midwives who have taken the six-week family planning course and have inserted 15 IUDs under supervision. This would seem to be a wise precaution in a new program. Condoms and spermicides can be sold by all clinic staff. Only small numbers of voluntary surgical sterilizations have been done at the two national hospitals.

Conclusion: The training course materials for clinical family planning services are very useful. Materials will be translated into a manual of medical standards for the family planning program and will be printed and sent to all family planning clinics.

Recommendation: The current medical standards are appropriate for a developing family planning program and should be issued in manual form for use for the project duration. This should not preclude further liberalization of standards as more experience is gained and the program expands nationwide.

C. Family Planning Service Available

The national family planning training team has trained 81 doctors, nurses and midwives to deliver family planning services. This is in addition to the ten medical trainers and the staff of eight model clinics. The target of 165 by the PACD will be reached or exceeded. On their own initiative, several provincial and departmental health staff have trained members of their staff to provide all methods of family planning except IUD insertions and voluntary sterilization. Auxiliary health staff have been trained to resupply oral contraceptives and to sell condoms and spermicides. Thus there will be adequate trained staff in the 15 project provinces to provide family planning services. Delivery of family planning services is made at eight well-established MCH/FP clinics in Ouagadougou and

some 50 medical centers and clinics distributed throughout 14 other USAID assigned provinces. Thus the goal of 41 clinic sites has already been exceeded.

Voluntary surgical sterilization is available only at the two national hospitals and has little impact. Injectable progesterone has been supplied by UNFPA but can only be given on a doctor's prescription.

Oral contraceptives are supplied by USAID through FPIA. Regular dose pills (0.05 mg. estrogen) and low dose pills (0.030 mg. estrogen) are generally available now, but only low dose pills will be available from USAID in the future. When breakthrough intermenstrual bleeding occurs due to inadequate estrogen, as may occur in low dose orals or injections of progesterone, other sources of regular dose orals, such as pharmacies, will have to be used or the symptoms ignored. Oral contraceptives are the most popular contraceptives in Burkina Faso and were found to be in good supply at all clinics.

After being trained in family planning, doctors, nurses, midwives and some auxiliary nurses and midwives are permitted to perform the gynecological examination required before starting oral contraceptives. Clients who use oral contraceptives for one to three months without serious problems may receive a three-month supply. IUDs are inserted only by those who pass the theoretical and practical training, including the insertion of 15 IUDs under supervision. Condoms and spermicides are freely available without restrictions. Information on natural family planning methods is also provided.

Contraceptives are relatively well received by the Burkinabe. Oral contraceptives are the most popular by a factor of three or four to one over IUDs.

The logistics for family planning are functioning so well that lack of contraceptives has never been a significant problem.

D. Model MCH Center for Child Spacing

1) Samandin Clinic

The Samandin clinic currently offers family planning services three times a week as a component of its MCH services. In spite of a lack of adequate space, three trainees are undergoing practical training there and the number of family planning clients are increasing. In October, 1988 there were 75 new and 188 old clients. In September the clinic inserted 23 IUDs and delivered

398 cycles of orals, 1,418 condoms, 1,300 vaginal suppositories, and 18 containers of spermicidal foam.

The project is supporting the construction of a model family planning clinic adjoining the present clinic. It is almost completed. There will be space for a large waiting room for group discussions, two office/examining rooms for a doctor and a midwife, a storeroom for contraceptive supplies and a workroom. This new clinic should fill a need for a national model as well as provide practical experience for trainees.

2) Training Clinics (8) in Ouagadougou

In addition to the planned model clinic at Samandin, seven other clinics have been developed where trainees can receive practical experience after their two weeks of theoretical work. The need for such practical training was necessitated by the medical standard that each trainee must insert 15 IUDs under supervision before being allowed to perform such insertions alone. At first it was difficult to locate enough training situations where trainees could perform their 15 supervised IUD insertions. But with the eight clinics and the increasing numbers of clients, most students can now meet the goal of 15. If not, they finish their practical training under guidance at their provincial or district levels.

3) Columbia University Operations Research Project

The MOHSA policy of providing family planning services at MCH facilities using only existing MCH staff raises the question of their ability to do both maternal and child health and family planning activities efficiently. Columbia University will do an operations research study to gather specific data at representative clinics on staffing patterns, staff duties and time spent on the various components of MCH, such as pre-natal service, well baby clinics, immunizations, health education and family planning. The analysis of these data will enable the MOHSA to make informed judgments on the adequacy of the staffing patterns and the availability of family planning services. Currently, not all clinics provide family planning services daily and this should be a program objective.

E. Sexually Transmitted Diseases (STD) Component

STDs are common and interfere with contraception, especially the use of IUDs. These concerns have been addressed by a

\$35,000 mission buy-in to the centrally funded JHPIEGO. Fifteen doctors, nurses and midwives will be trained in clinical aspects of STDs and six others will be trained in laboratory diagnostic techniques for two to four weeks. The necessary laboratory equipment is expected to arrive in time to start the course in February 1989. Educational materials will also be provided and a public information campaign is underway. Condoms are one of the more effective means of preventing STDs and they are being distributed through the program. When the staff is trained, reference diagnostic centers will be established at Ouagadougou and Bobo Dioulasso. The projected third center has been canceled due to limitations on USAID's funding resources.

F. IEC Program

1) IEC Capability

A centralized IEC unit has been established by the project to give MOHSA the capability to produce IEC materials and to prepare radio and TV programs for transmission via national facilities. The concept is sound, i.e. to provide a central resource, including reference materials on family planning, which may be used by all units within the family planning network to enrich their IEC activities. Presently, the MOHSA is capable of designing posters and leaflets and other print materials. Printing, other than stenciled materials, will be accomplished through purchasing of services from local printing establishments in Ouagadougou. Much sound technical assistance has been invested by PCS and others to launch this necessary coordinating unit for all IEC materials production and distribution.

The team noted that only in a few local centers was there the type of close collaboration between the IEC and clinical personnel that would lead to more rapid growth in the acceptance of family planning at village levels. It would seem desirable to reinforce this concept through the in-service training process and by close supervision. As a minimum, social educators should participate in counseling and promotion activities at health clinics on a part-time basis.

Conclusion: The MOHSA is encouraged to promote the coordination between Social Action and clinical staff at all levels.

Recommendation: The Social Action personnel should participate in counseling and promotion activities at clinic sites on a part-time basis.

2) Training

The evaluation team members interviewed Social Action staff within the central MOHSA and at provincial and local social centers for their assessment of the training rendered by the National Training Team with the assistance of PCS. At all levels of service, respondents unanimously praised the theoretical and practical application of materials production and training.

The development of IEC skills through training is already ahead of its ultimate goal of 120 Social Action workers. There are now at work in all levels of the Social Action system 83 persons trained in the techniques, materials and practice of developing a comprehensive information and education program for use at social centers and as adjuncts to local health centers. The curriculum of the seminars includes theory and practice in developing materials, communication skills, pretesting, counseling, record keeping and reporting. The number trained signifies that the training effort is already two-thirds complete, with almost two years of project time remaining.

This progress is largely due to the close cooperation that exists between the MOHSA training team and the two cooperating agencies and to the fact that the trainers trained by the project have been able to swing rapidly into action and to plan and carry out a training program without delay. As mentioned elsewhere, these trainers (eight from the Social Action side) received intensive exposure to new approaches to training, management, evaluation, supervision and IEC through the series of courses and seminars which they received in-country and in other countries at the start of the project.

The evaluation team proposes that MOHSA develop a plan for refresher training which will allow those workers trained during the first seminars to receive brief refresher training to fill in the gaps they may have found after applying their skills in actual work settings. Many workers interviewed expressed their need for such additional support.

In addition to the training developed for Social Action personnel there is a far-reaching initiative to incorporate family planning content in the pre-service curriculum of the school for social workers and social

educators. Curriculum for the former already exists. The curriculum for social educators will be developed in 1989, probably in time for use when their training restarts next year.

Findings: Although it was not possible to get specific details, it appears that not all of those workers trained under the project are still working in positions for which they were trained. This would be a waste of training and should be reviewed by MOHSA administrators. There should be a policy that would assure that personnel who received valuable skills through the training effort should be appointed to positions in which they would use those training skills for the benefit of the project.

Conclusion: The MOHSA has demonstrated its capacity to plan, implement and evaluate its own training programs in all aspects of family planning. It has benefited from start-up technical assistance from the cooperating agencies and has expertly carried out its own training program.

Recommendation: For the follow-on project, MOHSA should continue to incorporate into its training schedule a brief refresher training in IEC work (and clinical as well) for personnel who have had at least a year of experience since initial family planning training. (It may be possible to develop a plan and initiate some efforts in refresher training during the remaining months of the present project, as well.)

Recommendation: MOHSA should make a strong effort to insure that those staff trained for this project are, in fact, continued in assignments related to their training. This applies not only to IEC staff, but to the clinical family planning personnel as well.

IEC Materials

The team was impressed with the productivity resulting from the collaboration of the MOHSA and PCS, augmented by the training inputs of INTRAH. The scheduled production of materials is being met, particularly with the decisions being made during this evaluation period by the PCS representative, whose presence in Ouagadougou coincided with the team visit.

All of the materials seen in use at social and clinical centers seemed appropriate to the milieu for which they were designed. They are available for the most part in

French and several local languages. The materials were pre-tested with sample populations prior to their printing.

This is not to say that there are no gaps in stock, however. Health sites exist where no posters are visible and there are no pamphlets available for the use of local workers. These shortages are known to the MOHSA staff, and corrective action is being taken.

The three posters currently used will be reprinted, as soon as MOHSA receives PCS approval, which is pending. Plans are also set for the reprinting (some 5,000 each) of the booklets on oral contraceptives and family planning methods. Bids have been let and a decision for printing will be made during the stay of the PCS representative.

New materials almost ready for production include three new posters on youth and sexual responsibility, male involvement in family planning and the family planning logo. Three new booklets are being prepared and will be approved shortly by the project staff in PCS/Baltimore after professional review for accuracy and impact. They concern the IUD and two barrier methods of contraception. Approval is also pending from PCS on a new general information flyer for use with the general public. In addition, the text and art work are ready for the production of a leaflet for young people entitled "Myth or Reality."

MOHSA is producing contraceptive sample kits, a model of which was examined by the team. It is a convenient carrying case with compartments designed to receive all types of contraceptives used here. It can be used to display and explain to clients the various types of contraception available to them. The case is lightweight, relatively inexpensive and easy to keep clean.

Flannelgraphs, useful for group or individual discussions and promotion of family planning, have also been pre-tested and will be included in the training and eventually in the portfolio of IEC activities. The team observed the usefulness of the flannelgraph in village "causeries," which are groups gathered together by the social workers at a social center or health clinic to demonstrate the benefits and uses of contraception as a means of child spacing.

Ready for production this week is a new community relations project which uses a "pagne," which is a

length of cloth with colorful designs containing the family planning logo as an integral part of the pattern. Three of these are sufficient to make a traditional dress of the Burkinabe woman. They will be sold at modest prices to promote awareness at the village level of the availability of family planning as part of health services. For the men, t-shirts have been produced in the past. This supply is exhausted and hopefully will be resupplied for distribution in the near future.

Plans are being carried out per the project design to produce radio programs for broadcast in-country. The programs have been written with the assistance of local writers and producers. The content of the programs, however, has not been approved as yet by the MOHSA. It is hoped that this delay will be resolved soon, so that this component of the overall IEC program can begin.

Out for bid now is the theater series, which consists of plays with family planning content which will be presented by itinerant actors on a schedule established to reach audiences in key locations in the country. The plays have already been audience-tested and are ready to be premiered.

The intended production of videotapes of these plays and other television presentations has not been initiated. It is expected that this aspect of the IEC program will begin in 1989.

There have been contributions made to the IEC component of the project from sources outside the project. For example, 125 flip charts have been provided by FPIA. These are in much demand by Social Action workers. They demonstrate the family situations which benefit from good health practice and contraception and the anatomy of reproduction and contraception. They are very acceptable for presentation to groups of men, women, or mixed groups as a general introduction to family planning concepts. Other donations of films and slide shows from other countries have been made to the GOB by PCS in an effort to foster the exchange of such materials between nations. This is an embryo project which hopefully will continue to grow as the need for materials increases.

Findings: In summary, all aspects of the IEC program, including organization, training and materials production, are comprehensive and appear to be appropriate to the needs of Burkina Faso. MOHSA, in

cooperation with PCS, has produced a well-balanced communications package which, when all components are activated, should serve well the needs of the social action program. It is expected that the pending decisions will be made soon and enable the IEC component to become fully operational.

Recommendation: The MOHSA should insure that the IEC materials about to be printed reach all levels of the system in sufficient quantities. The project should consider reprinting IEC materials, as necessary.

G. Policy in Support of Family Planning

The favorable climate within Burkina Faso for acceptance of family planning and the supportive policies developed by the GOB have been described earlier in Section III of this report (Overview on Family Planning in Burkina Faso). Because of this favorable environment and policy support, project progress and the expansion of family planning, IEC and clinical services have been impressive. The laws of the country are supportive of the use of modern contraceptive methods for delivery of family planning. The government's recent policy decision to organize the publicly-delivered family planning services under one ministry (MOHSA) can only lead to a strengthened delivery system. The strategy which views family planning as a health measure for the benefit of mothers and the entire family through child spacing, should ensure a favorable reception for these services in a variety of religious and cultural contexts within the nation.

VIII. PROJECTED INSTITUTIONAL CAPABILITY OF MOHSA AT END OF PROJECT TO MANAGE FAMILY PLANNING INFORMATION AND SERVICE ACTIVITIES

At the end of project, MOHSA will have demonstrated the capacity to manage a nationwide family planning service. It has already demonstrated its ability to successfully organize and manage the various necessary elements. A model clinic and seven urban clinics are functioning well. Some 50 other clinics are scattered throughout 14 of the 30 provinces. The clinical staff training system, a logistic system and the IEC system are all in place and will be perfected by the end of the project. It remains only to extrapolate the present excellent systems in order to manage the family planning clinics needed for Burkina Faso.

The experience gained during the four years of this project in the social action area will enable the MOHSA to serve as the in-country training resource for the projected extension of IEC and counseling activities to the entire national network of family planning services. MOHSA will have developed and used

during this time a comprehensive portfolio of IEC materials which will have been thoroughly tested through field use at all levels for their applicability and acceptance in the Burkinabe culture. Media activities, including radio, TV and theatrical productions will also have been audience-tested and perhaps modified based on these tests. They should therefore be even more effective than their earlier prototypes. Based on this period of use, it is safe to say that with the continued input of technical assistance from PCS and the increasing skill of MOHSA personnel, Burkina Faso may well serve as an experiential model for other countries entering the stage of development at which GOB started two years ago.

With continued in-service training and occasional refresher training, the IEC personnel working within the MOHSA family network should be at peak performance by the PACD. If recommendations concerning integration of clinical and IEC workers at local levels are followed, it is the opinion of the evaluation team that an effective working force will be developed at the end of the project.

IX. COMPLEMENTARY ACTIVITIES

A. Family Planning International Assistance (FPIA)

FPIA assistance to the project comes through an ongoing centrally-funded project to provide training, equipment, contraceptives and IEC materials to midwives of the eight urban family planning centers and through a regionally-funded second project to develop the contraceptive logistic system. (In addition, regional funds provided contraceptives.)

With FPIA assistance, DSF has established a complete logistic system with a central warehouse at DSF and 14 provincial pharmacies. Of the projected 46 personnel, 32 have been trained in logistics management. The chief of the central warehouse has been trained and keeps an orderly, well-stocked warehouse with good records. From the central warehouse, supplies go to the provincial pharmacies from which the clinics are supplied. Appropriate forms are being used and a draft logistics manual is under preparation.

Finding: The clinics are served satisfactorily by the present logistic system with practically no interruption of stock.

Recommendation: The DSF should perfect the existing logistic system and should integrate it into the general MOHSA logistics system only when the general logistics system is capable of delivering similar reliable support.

B. Family Planning Management Training Project of Management Sciences for Health (FPMT)

The centrally-funded FPMT has assisted the MOHSA in improving management and supervision. The DSF has been assisted in developing job descriptions, supervision protocols and personnel management. Overseas training was provided for two short-term trainees in microcomputers. And training was also provided for two short-term trainees at the two-week Francophone Regional Advisory Committee Conference on family planning program management in the African context. In addition, USAID made a \$30,000 buy-in to the central cooperative agreement to support an FPMT workshop on supervision for 15 provincial medical directors in September, 1988.

C. Columbia University

Under a centrally-funded USAID cooperative agreement, Columbia University conducted a knowledge, attitudes and practice (KAP) survey of 600 Burkinabe. This study, conducted early in the project, provided the following important information for project design:

1. One third of the women and one fourth of the men with children wished to avoid further births.
2. Nearly half the women wanted to space births.
3. The Burkinabe respondents indicated that the ideal family should have 4 children.
4. Traditional methods (such as breastfeeding an average of almost two years and abstinence) have not brought total fertility from more than the present six to the desired four.
5. Most Burkinabe are receptive to family planning but have insufficient specific knowledge of methods.

The project design has taken the KAP survey information into consideration and progress to date tends to validate the survey findings. A similar KAP survey will be conducted in rural areas, as well as a survey of contraceptive sales by pharmacies.

Columbia University organized a seminar on operations research to present the KAP survey findings. Papers were also presented on injectable progesterones and the data concerning laboratory tests for lipids. The data demonstrated that the tests were not useful in family

planning programs and led to a discontinuation of the testing requirement before initiating hormonal contraception.

Columbia is currently studying the impact of the MOHSA policy of using existing MCH staff to deliver family planning services on both MCH and family planning.

X. FUTURE DIRECTIONS FOR THE FAMILY PLANNING PROJECT

A. Strategy

There is no question that the present project strategy has worked well for the implementation phase of the first two project years. And there is no reason to believe this strategy will not continue to be effective until the end of the project. The strategy was to develop institutional capability by a carefully planned manpower development effort through training of both clinical and Social Action workers at all levels. This included the development of a core of trainers who worked within the MOHSA and over time multiplied the number of trained staff capable of delivering a comprehensive family planning program within the 15 provinces chosen for the project. Use of the cooperating agencies' technical assistance has proven useful during this preliminary phase and will likely be continued in any follow-on activities.

Findings: This success suggests to the evaluation team that there is little to change from a strategic standpoint as plans are developed for a national program. The national training team concept should be continued. The curriculum developed for pre-service and in-service use should be refined as more training experience accrues. The management techniques learned from FPMT and from other donor sources should be applied to the expanded system for procurement, reporting, contracting, supervision and evaluation. The needs assessment concept will once again be called into play to develop the basis for staffing, equipping and activating a larger network of clinical and social services.

The positive policies developed by the GOB have proven themselves and need no apparent change as the MOHSA moves into an expanded family planning effort.

Recommendation: In summary, the strategy thus far for the project has worked immensely well. There would be no point in making changes at this time nor during the foreseeable future expansion of the project.

Recommendation: MOHSA should develop its plans to expand the present project to provide for increased coverage of

family planning, IEC and clinical services by the PACD. There is no need to change the project design or structure, but simply to perform a careful needs assessment and provide the resources to activate a larger number of clinical and social action facilities to meet the challenge.

B. Lessons Learned

There are many lessons to be learned from the experience thus far under the Family Planning Support Project. Primary among these, however, are the following:

- The modest scope of this project, i.e. the confinement of the project to 15 provinces instead of nationwide, was an effective way to begin.
- The development of self-sufficiency in training through the planned development of a national training team to serve as the core of trainers for the remaining personnel of the system yields results that should continue in the years to come.
- Discreet inputs of technical assistance for developing management capability, training skills, techniques for IEC activities, etc., are effective when their applications are planned and designed to complement each other in order to achieve specific targets.
- A well-designed project can move from very limited activity to large-scale coverage in a few years with careful planning, energy, and monitoring.
- Close collaboration and coordination among host country managers, USAID, and cooperating agencies leads to better management and monitoring of a project.

ANNEXES

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ANNEX A

SCOPE OF WORK OF EVALUATION

BACKGROUND

The purpose of the four year Family Planning Support Project is to reinforce the institutional capacities of the Burkinabe health and social welfare structures to develop and execute improved programs for family planning information and services. This project is a Phase I effort to assist the GOB in developing a strong public sector foundation from which to expand, nationwide, an integrated maternal and child health/family planning (MCH/FP) information and service program. Project activities are focused on three major project components: institution building; information, education, and communication (IEC); and service delivery. The institutional building component emphasizes training and the development of management systems and consists of the following specific activities:

- organization and training of a national training team to conduct various in-service training courses;
- implementation of a series of theoretical and practical courses for midwives, nurses, and physicians to develop clinical and management skills;
- implementation of a series of training courses for social educators in the techniques of communication, motivation, and counseling;
- development of essential management systems in the areas of record-keeping, supervision, evaluation, logistics, etc;
- development of pre-service expanded family planning modules to be integrated into the overall curriculum of the national schools of public health and social science;
- provision of out-of-country training for approximately 20 MCH/FP managers.

The IEC component includes the following major activities:

- development and/or reproduction of IEC materials to support clinic-based and community education activities;
- conducting of a series of orientation sessions to introduce the concepts of family planning and child spacing to various interest and leadership groups;
- conducting of a series of dramatic presentations on health and family planning topics;
- development of a functional IEC unit in the Ministry of Health and Social Action (MOHSA).

The service delivery component of the project includes support for family planning service delivery and the diagnosis and treatment of sexually transmitted disease (STDs). Specifically, the following activities are planned:

- support for the delivery of family planning services in approximately 40 sites in 14 provinces by providing essential family planning equipment, training, and improving supervision and record-keeping;
- establishment of a model family planning center in Ouagadougou;
- establishment of three reference sites for the diagnosis and treatment of STDs.

In 1984, the project implementation document was approved for a \$4.4 million bilateral population initiative. Due to budgetary and political considerations, the subsequent project paper was limited to training of health and social welfare professionals and IEC activities. The project was obligated on June 30, 1986 at a cost of \$1,250,000. In June 1987, the project was amended to add \$672,000 and to expand the service delivery component. In addition, the project was complemented and made fully operational with the addition of centrally-funded support in the areas of management systems (FPMT project) and contraceptive logistics (FPIA project).

After 20 months of project implementation, progress has been achieved in the following areas; (a) development and training of a national training team; (b) the training of 48 service providers and 40 social educators; (c) the development of supervision protocols; (d) the rationalization of service statistics; and (e) the production of family planning panels and logo stickers. On the other hand, the project has had a slow start in the execution of IEC programs and the development of an improved contraceptive logistics system.

ARTICLE I - TITLE

Interim Evaluation of the Family Planning Support Project.

Project data:

Project No. 686-0260
PROAG signature date: 6/30/86
Project completion date: 6/30/90
A.I.D. contribution: \$1,922,000

ARTICLE II - OBJECTIVE

The objective of the evaluation is to answer specific questions which will enable the Mission and the MOHSA to improve the implementation and management of project activities and to make future programming decisions with regard to family planning. Major emphasis will be placed on the identification of constraints and lessons learned during the first two years of the project. Specific questions to be answered are detailed in Section 2 of Article III.

ARTICLE III - STATEMENT OF WORK

1. General Responsibilities:

A) Review all appropriate project documents including but not limited to the following: project paper, project paper supplement, project grant agreement and amendments, implementation reports of cooperating agencies (INTRAH, JHU/PCS, MSH, JHPIEGO, FPJA), and other USAID documents.

B) Conduct extensive interviews with MOHSA personnel, representatives of INTRAH, JHU/PCS, MSH, USAID, and selected other population donors. (Interviews with representatives of several of the cooperating agencies may need to be conducted by phone in the States).

C) Undertake field trips as necessary in order to complete the specific evaluation activities listed below.

2. Specific Responsibilities:

A) Assess the projected institutional capability of the MOHSA at the end of the project to manage family planning information and service activities.

B) Examine the following specific issues and make appropriate recommendations for future actions:

- the effectiveness of the organizational structure of the MOHSA in terms of the management of family planning information and services;

- constraints to the expansion of family planning information and services;
- the development of medical standards for family planning;
- the development of an improved contraceptive logistic system and a family planning information system;
- the effectiveness of in-country family planning training.

C) Make recommendations concerning the use of the remaining person-months of short-term technical assistance available under the project.

D) Identify lessons learned that emerge from the evaluation analysis.

Evaluation Team:

The evaluation team will consist of two persons who collectively have experience/expertise in the following areas: evaluation, training, family planning IEC, and family planning service delivery.

ARTICLE IV - REPORTS:

1. The team leader will brief the USAID Health/Population Officer at least once a week and more often as necessary concerning the progress of the evaluation.
2. No later than seven working days in-country, the Team Leader will deliver a draft evaluation report outline to the Health Population Officer for Mission approval. The final evaluation report will follow the approved outline unless explicit permission for further revisions has been received. In preparing the outline, team members should familiarize themselves with the A.I.D. Evaluation Handbook (A.I.D. Program Design and Evaluation Methodology Report No. 7, April 1987), specifically Section 7., Reporting Requirements and Appendix B, Executive Summary Outline.
3. A draft final report will be delivered to the Director, USAID/Burkina (four copies in English) no later than three working days prior to the departure of the team leader from Burkina. The team leader will make himself/herself available to discuss the report and receive comments prior to leaving the country.
4. A final report will be prepared by the contractor's home office to be delivered in accordance with the following schedule:
 - within 30 days following receipt of USAID's comments, 15 copies, distributed as follows: USAID/Burkina - 10; AFR/SWAP - 1; AFR/TR/HPN - 1; AFR/SWA - 1; SER/OP - 2.
 - within 60 days following the submission of the draft report, a French language abstract of the final report shall be delivered in ten copies to USAID/Burkina for transmission to the GOB.

The final report must contain an executive summary stating the findings (evidence), conclusions, and recommendations of the evaluation.

ARTICLE V - RELATIONSHIPS AND RESPONSIBILITIES:

The contractor shall perform the evaluation on an independent basis, and will coordinate with the USAID Health/Population Office, and with the GOB.

ARTICLE VI - TERMS OF PERFORMANCE

The preferred period is between November 14 - December 2, 1988 exclusive of final report preparation. A six day work week is authorized with no premium pay.

ARTICLE VII - WORK DAYS ORDERED

1. Team leader (2 days in U.S. in preparation, 17 field days, and 3 days final report writing).
2. Family Planning Specialist (2 days in U.S. in preparation, 17 field days, and 2 days final report writing).

ARTICLE IX - OTHER

1. Duty Post: Burkina Faso, Ouagadougou and several other cities as designated at time of evaluation.
2. Language Requirements: French S3/R3 for both team members.
3. Other Requirements:
 - Prior LDC experience is mandatory for both team members;
 - The evaluation specialist must have prior experience in the assessment of health/population projects.
4. Access to classified information: none
5. Support: USAID will provide the following:
 - Office space;
 - Exchange accommodations;
 - Use of one Wang computer and available IBM compatible software;
 - First class letter pouch for personal mail for U.S. citizens only.
6. See attached memo concerning Health Unit privileges.

A certificate of Good Health is required for all consultants for full health unit services. Failure to provide such will allow only emergency access to the Embassy Health Unit with approval from the Embassy Administrative Officer.

ANNEX B
Child Spacing Initiatives (686-0260)
Logical Framework

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
PROGRAM GOAL: The broader objective to which this project contributes:	MEASURES OF GOAL ACHIEVEMENT:		
<p>To increase the availability of child spacing information and services in an effort to improve the well-being of Barbadian families.</p>	<ol style="list-style-type: none"> 1. Improved social and political climate favorable to child spacing programs. 2. Improved health of mothers and children resulting from child spacing practices. 3. Improved understanding of the benefits of child spacing. 4. Increased contraceptive prevalence from an estimated 1 percent to 3 percent. 	<ol style="list-style-type: none"> 1. Change of legislation and regulation concerning information and delivery of services. 2. MOPH health and nutrition statistics. 3. KAP and special studies 4. MOPH service statistics, FVO statistics, pharmacy statistics. 	<p>Continued political support of child spacing concept by GOB.</p> <p>Continued unmet demand for child spacing services.</p>
PROJECT PURPOSE:	CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED (MOPS):		
<p>To reinforce the institutional capability of GOB structures to develop and execute improved child spacing information and service delivery activities.</p>	<ol style="list-style-type: none"> 1. Functional units of family planning within the Ministry of Family Welfare and in the Ministry of Public Health with trained personnel experienced in program planning and implementation service delivery techno and IEC programs. 2. A model clinic used for the provision of information and services, and training of health and social agents. 3. A cadre of over 100 health and family welfare professionals who can plan and implement various family planning information and service activities. 4. Increased number of potential clients receiving IEC information by trained social educators and health agents. 5. FP services available at 2 national hospitals, 5 regional hospitals, and 11 health facilities in 11 provinces. 6. Increased number of FP clients utilizing MOPH hospital clinics and provincial health facilities. 	<ol style="list-style-type: none"> 1. On site verification; MOPH and MOPW documents; training reports. 2. On site verification 3. Training curricula; training reports. 4. MOPW referral cards; IEC materials distributed. 5. Service statistics; client referral records; contraceptive supply records. 6. MOPH service statistics; contraceptive supply records. 	<p>Ministry officials are designated to manage projects.</p> <p>Medical, paramedical, and education staff made available for child spacing at all levels.</p> <p>Staff are adequately trained according to schedule.</p> <p>Contraceptive supplies arrive in a timely manner.</p> <p>Potential users request services.</p>

OUTPUTS:

A) Training:

A1. A pre-service family planning module for midwives and nurses which is integrated into overall curriculum of National Schools of Public Health in Ouagadougou and Bobo-Dioulasso.

A2. A cadre of trained clinical and administrative personnel in MOPH and MOPW central administrative facilities and service delivery facilities.

MAGNITUDE OF OUTPUTS:

A1. Training Curricula
 A1.1 Theoretical and practical pre-service family planning curriculum developed, adopted, and incorporated, into 3 year EMSP program for midwives and registered nurses (40 grads/yr)

A1.2 Theoretical pre-service family planning curriculum developed, adopted and incorporated into 3 year practical nurses and auxiliary midwives course. (120 grads/yr)

A2. Trained Personnel
 A2.1 In-country Training of Trainers (team of 10, 2 weeks/session)*

	Year 1	Year 2	Year 3*
MOPH staff	2x5	2x5	2x5
MOPW staff	2x5	2x5	2x5

A2.2 In-country Theoretical Training (2 weeks)*

	Year 1	Year 2	Year 3*
MD/MM	1x5	2x10	3x10
Nurses	1x5	2x10	3x10
MOPW	1x5	2x10	3x10

A2.3 In-country Practical Training (4 weeks)*

	Year 1	Year 2	Year 3*
MD/MM	1x5	2x10	3x10

A2.4 In-country IEC Training (2 weeks)*

	Year 1	Year 2	Year 3*
MOPH Staff	2x10	2x10	3x10
MOPW Staff	2x10	2x10	3x10

* courses : 10 participants

A2.5 Out-of-Country Training (4 weeks)

	Year 1	Year 2	Year 3*
MOPW staff	4	4	4

A1. Training; curricula; M/MM graduate competency tests; on-site visits to classes; contractor reports.

A2. Training curriculum; course outlines; achievement certificates; trainee reports; contractor reports; ministry reports.

Contractor reports

School officials agree to review/ change curriculum to include FP information.

Schools continue to train students.

Current curriculum can accommodate increased family planning modules.

GOB will release trainers and participants from daily positions to participate in courses.

Trainers are sufficiently trained and available to train.

Participants will be assigned to appropriate position upon completion of training.

Sufficient patient case load for practical training.

B1. Information, Education and Communication:

B1. A variety of IEC materials available to support clinic based and community education programs.

B1. IEC Materials Made Available:

- a) New IEC materials developed:
 - pill brochure for service providers
 - IUD brochure for service providers
 - ponjos and T-shirts for service providers and public

b) Existing IEC materials reproduced:

- logo sign for service sites: 100
- logo decals: 15000
- posters 1500 & 3 posters
- client brochures for each of 5 methods: 100,000 total
- duplication of film: 10 copies

c) Purchased materials available:

- counseling flip charts 250
- film/av materials and teaching materials
- anatomical models: 100 male
100 female

B1. Pretest reports; examination of outputs; contractor reports; IEC inventory.

In-country capability to create and print materials continues to be available.

IEC distributed and used appropriately.

B2. A series of family planning orientation sessions held for key special interest groups (CBOs, women's groups, labor groups, physician association, midwives association, pharmacists, youth groups)

B.2 Orientation Sessions Held

	Year 1	Year 2	Year 3
a) Update workshop	2	2	2

	Year 1	Year 2	Year 3
b) Round table discussions	2	2	2

	Year 1	Year 2	Year 3
c) Community meetings	3	3	2

B2. MOPW activity reports; contractor reports; observation; MOPW referral cards.

The willingness of the special interest groups to attend the workshops.

B3. A series of dramatic presentations on related health topics produced for community audiences.

B.3 Dramas produced

- a) Scripted piece on 2-3 selected FP themes

- b) Presentations: 12/yr after year 2

B3. Script review; performance viewings.

The dramatic troupe available to develop and present performances.

COS authorization given to display each presentation.

C) Service Delivery Support:

C1. A renovated and equipped MCH/FP clinic to serve as a model service-site and training facility.

C2. Management plans produced and distributed.

C3. A record-keeping system.

C1. One building renovated and equipped

C2. Plans:

a) clarified roles and responsibilities of MCH and MFPV personnel and other agencies involved in child spacing activities.

b) revised 3-year action plans for MCH and MFPV.

c) in-service training plan developed.

d) supervision and evaluation system developed and tested in model clinic.

C3. Record System:

a) present record-keeping system reviewed and revised as appropriate.

b) forms printed to MCH and MFPV specifications including:
- registration forms
- patient exam records
- contraceptive supply records
- patient referral forms

C1. Contract completed, observation.

C2. Consultant reports, MCH and MFPV plans.

Questionnaires completed, recommendations made.

C3. Consultant reports, forms.

MCH selects the site.

Imported equipment arrives in timely fashion.

Appropriate consultants are available when required.

COB officials will devote adequate time for planning.

(USAID/Burkina)

BUDGET BY YEAR (\$000)

	Year 1	Year 2	Year 3	TOTAL
A) Training:				
A1. In-country NOPM training (INTRAM buy-in)	70	70	60	200
A2. Short-term out-of-country training (\$10,000 X 18 pm)	60	60	60	180
B) Information, Education:				
B1. In-country NOPM IDC activities (PCS buy-in)	70	70	60	200
C) Commodities:				
C1. Equipment and supplies for model clinic(s) and priority sites	38	0	0	38
C2. Printing of client forms	4	3	3	10
D) Renovation of Model Clinic:	32	0	0	32
E) Technical Assistance:				
E1. Long-term technical advisor (30pm)	100	123	137	360
E2. Short-term technical assistance (7pm)	40	60	40	140
F) Project Evaluation:	0	0	30	30
G) Contingencies/inflation (10%):	20	20	20	60
Total USAID/Burkina Inputs:	434	406	410	1,250
(Government of Burkina)				
A) Personnel Salaries:				
A1. Training time	28	28	28	84
A2. Services time	24	48	72	144
B) GOB Facilities:	28	20	20	68
Total GOB Inputs:	72	96	120	288

A1. Contractor financial reports;
AID Controller reports;
AID project files;
procurement/purchase orders
documentations.

Cooperating agency buy-in
negotiated in a timely manner.

Cooperating agency buy-in
negotiated in a timely manner.

Equipment and material are ordered
and arrive in timely manner.

Local contract negotiated in timely
manner.

Technical advisor hired and in
place at scheduled.

Participants are accepted in
short-term training courses.

Prices of goods and services do not
rise significantly beyond what is
allowed for contingencies.

GOB is willing to provide inputs
as required.

ANNEX C

DOCUMENTS REVIEWED

1. Population Needs Assessment, November, 1983.
2. Project Identification Document, Upper Volta Assistance In Population Planning, May, 1984.
3. Burkina Project Paper Family Planning Support (Project No. 686-0260), May, 1986.
4. Amendment #1, Project No. 686-0260.
5. Amendment #2, Project No. 686-0260.
6. Convention Entre L'Universite De Caroline Du Nord A Chapel Hill Et Le Gouvernement De Burkina Faso Ouagadougou, February, 1987.
7. Subagreement between The Johns Hopkins University and the Ministry of Social Welfare and National Solidarity.
8. Project Agreement Between MOHSA and FPIA, August, 1987.
9. Final Du Project De Recherche Operationnelle "Consolidation Des Services De Presentation Sanitaire En Direction De La Famille Au Burkina Faso," December, 1986.
10. Presentation Des Resultats Du Suivi Des Prestataires De Services (Clinique Et IEC) Formes Par INTRAH/PCS Eu 1987.
11. Integration De La SMI/P.F. Dans Le Programme Revise De Formation Des Infirmiers Et Infirmieres D'etat.
12. Burkina Faso: Family Planning Curriculum Design For The National School Of Social Work.
13. Evaluation: Strengthening Health Planning Capacity Project No. 686-0251, July, 1987.
14. Curriculum De Formation De Prestataires Cliniques En Planification Familiale.
15. Grant Agreement between USAID and Burkina Faso for Private Sector Activities.
16. Trip reports of cooperating agencies.
17. Workshop reports of cooperating agencies.

ANNEX D

LIST OF INDIVIDUALS AND AGENCIES CONTACTED

1. Ministry of Health Personnel

Dr. Amade Ouedraogo, Secretary General, MOHSA

Dr. Michel Sombie, Director of the Direction des Etudes de la Planification

M. Georges Outtara, National School of Public Health

M. Hamadou Ouedraogo, Chief of Direction de la Formation Professionnelle

Dr. Meba Kagone, Chief of Sante Urbaine de Ouagadougou

Mme. Barry Delphine, Direction de la Promotion de la Famille

M. Bonifacio Sombie, DEP Economist

Mme. Fatimata Legma, Director DSF

Mme. Franceline Ilboudo, liaison to National Family Planning Training team (NTT)

Mme. Pascaline Sebgo, Chief of FP division of DSF

Mme. Therese Yugma, Assistant to Director of DSF

Mme. Pauline Cassolom, GOB designated Project Manager for family planning IEC activities

Mme. Tassini Baro, Evaluator

Mme. Felicite Traore, member of NTT

M. Felix Compaore, member of NTT

Mme. Delphine Mariam Traore, midwife, NTT

M. Joanny Kabore, DFP, NTT

Mme. Colette Zoungrana, co-trainer

Mme. Aissata Sawadogo, member of DFP

Mme. Marie-Blanche Ouedraogo, DFP

Mme. Alima Abjibade, FP Record Keeping

Mme. Elise Balima, SMI, DSF

Mme. Ramatou Boly, SMI, DSF

Mme. Helene Oudraogo, DSF

2. Local Private Voluntary Organizations

M. Andre Gnoumou, ABBEF (IPPF affiliate)

3. USAID and Cooperating Agencies

Herbert Miller, Director, USAID, Ouagadougou

Richard Greene, Chief, Health and Population, USAID

Roxana de Sole, Project Manager, USAID

Perle Combarry, Program Specialist, USAID

Joyce Holfeld, REDSO Regional Population Officer

Ismail Buka, Program Officer, FPIA, Nairobi

Philippe Langlois, IEC Specialist, PCS

Pape Gaye, Training Consultant, INTRAH/Abidjan

Dr. Anne-Charlotte Royer, INTRAH Representative, Ouagadougou

Dr. Everette Midy, Chief of Party, Health Planning Project, Pragma

Dr. Abraham Bekele, Health Economist, Pragma

Mamadou Lougue, Assistant Representative, UNFPA

4. U.S.-Based Resource Persons

Ms. Elena M. Casanova, PCS Consultant

Mr. Ken Heise, FPMT, Boston

Mr. Clayton Vollan, A.I.D. Project Officer for PCS

5. Field Site Visits in Burkina Faso

ABBEF Clinic, Ouagadougou

Central MCH/FP Clinic, Ouagadougou

Midwives Association Clinic for MCH/FP, Ouagadougou

Dapelgo Medical Center Oubritenga Province
Bousse Medical Center, Oubritenga Province
Yatenga Provincial Health Administration Headquarters at
Ouahigouya (Dr. Diatonge Benoit)
Yatenga Provincial Regional Hospital
Social Action Center--Ouahigouya, Yatenga
Maternity Naaba Tigre--Ouahigouya, Yatenga
Kappalin (CSPS)--Center for Health and Promotion of Health
Tetao Medical Center
Cassou Dispensary, Sissili Province
Provincial Health Headquarters, Leo, Sissili
LEO MCH/FP Clinic--Sissili Province
Social Action Center--Sissili Province
Dr. Yameogo Lambert, Director, National School of Social
Service, Gaoua, Ponia Province
Provincial Directorate of Health, Poni Province
SMI Center, Fada, Gourma Province (Baliemon, Lea Pepin,
midwife)
Action Sociale Center, Fada, Gourma Province (Zongo T.
Gregoire, Chief of Service and five former trainees of the
project)
Director, Health and Action Sociale, Gourma Province

ANNEX E

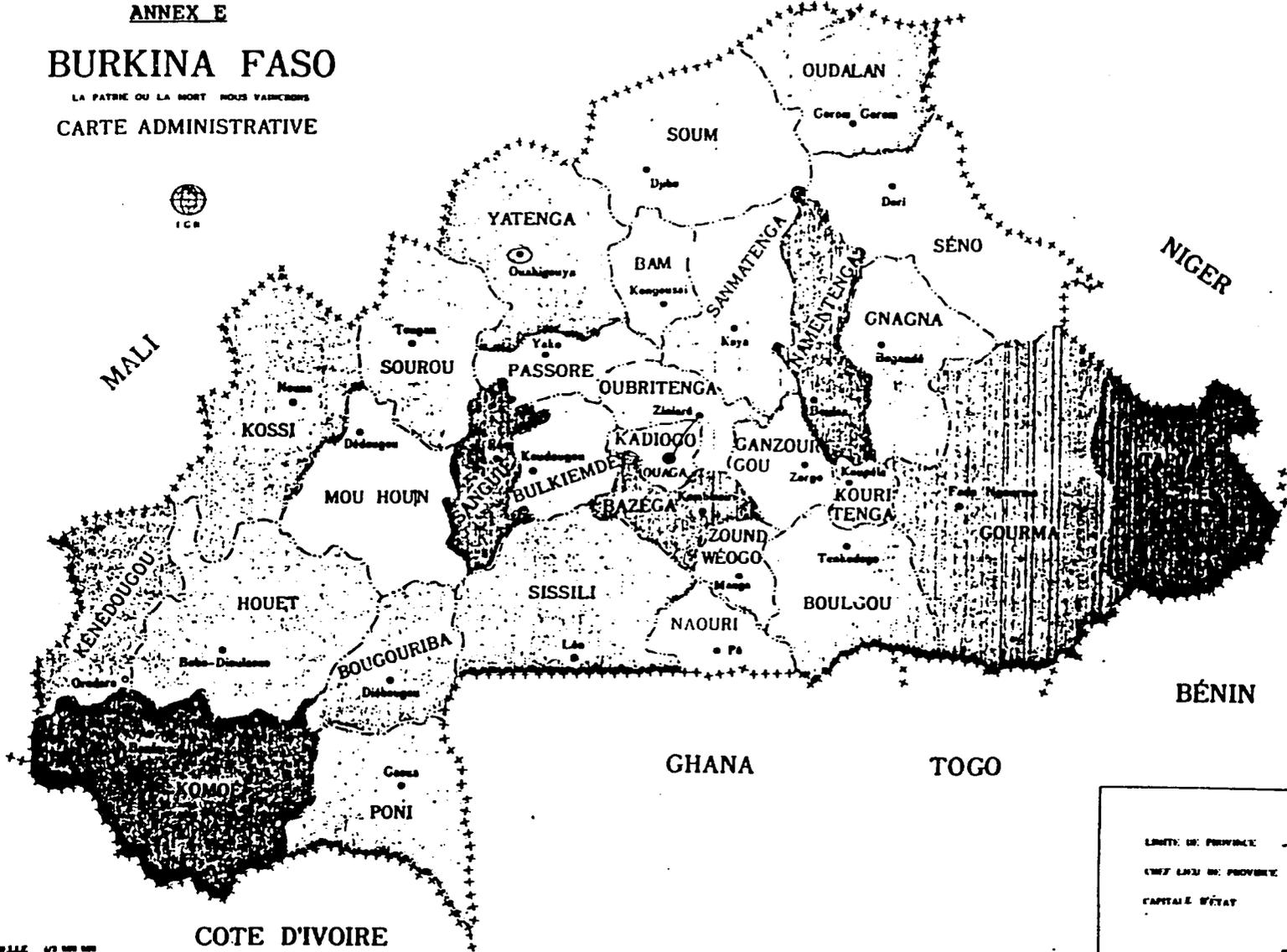
BURKINA FASO

LA PATRIE OU LA MORT NOUS VAINCRONS

CARTE ADMINISTRATIVE



48



MALI

NIGER

BÉNIN

GHANA

TOGO

COTE D'IVOIRE

LIMITE DE PROVINCE 
 CHEF LIEU DE PROVINCE 
 CAPITALE NÉTAT 

ÉCHELLE 1:500 000 D'APRÈS 1984