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**MIDTERM EVALUATION
OF THE BURUNDI POPULATION
AND FAMILY PLANNING PROJECT**

by

Norine C. Jewell
Laura Laski
Suzanne Plopper

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Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

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Glossary

ABEEF	Association Burundaise pour le Bien-Etre Familial (IPPF affiliate in Burundi)
AIDS	acquired immune deficiency syndrome
AVSC	Association for Voluntary Surgical Contraception
CAFS	Centre for African Family Studies
CARITAS	organization operating Catholic Church-sponsored health centers
CBD	community-based distribution
CPPF	Bureau de Coordination du Program National de Planification Familiale (Bureau of Coordination of the National Family Planning Program)
CPR	contraceptive prevalence rate
CYP	couple year of protection
EPI/CCCD	Expanded Program of Immunization/Combatting Communicable Childhood Diseases
HEU	Health Education Unit (Ministry of Public Health)
IEC	information, education, and communication
IFFLP	International Federation for Family Life Promotion
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JRR	young people's political organization in Burundi
KAP	knowledge, attitudes, and practice
LMIS	logistic and management information system
MCH/FP	maternal and child health/family planning
MIS	management information system
MOPH	Ministry of Public Health
NGO	non-governmental organization
PP	project paper
REDSO	Regional Economic Development Services Office (United States Agency for International Development)
STD	sexually transmitted disease
TOT	training of trainers
UFB	Burundi Women's Union
UNESCO	United Nations Education, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPP	Unit of Population Planning (Ministry of Plan)
UPRONA	national political party
USAID	United States Agency for International Development (mission)
VSC	voluntary surgical contraception

Executive Summary

Introduction

The purpose of the Burundi Population and Family Planning Project is to achieve a 7.6 percent contraceptive prevalence rate by making family planning services more available throughout the country. A major focus of the project is on expanding the pool of trained family planning providers and developing an information, education, and communication (IEC) campaign heavily oriented toward interpersonal communications. The project is also expected to develop alternative contraceptive distribution channels on a pilot basis, and to improve certain aspects of service delivery such as the contraceptive supply system.

Burundi is one of the most densely populated countries in Africa and among the poorest countries in the world. The most favorable aspect of the context in which the project operates is the high level of awareness and concern for the impact of population growth rates on the country's resources among the country's political leaders and among the bishops of the Catholic Church. One of the most difficult challenges facing the project is that it is heavily dependent upon the nation's health care delivery system to provide family planning services, and the system suffers from lack of human and material resources at all levels.

A three-person team was given the task of evaluating the project two and a half years into its operation, as well as making recommendations for USAID's long-term country strategy. The team conducted interviews with government officials, service providers, and staff of Pathfinder International (which administers the project), USAID, and other agencies. Staff from the Ministry of Public Health (MOPH) and the REDSO/Nairobi office joined the team during several interviews and field visits to four provinces.

Project Performance on Specific Objectives

The project has performed very well with respect to delivery, appropriateness, and quality of planned outputs as well as efficiency of management, within the limits imposed by factors beyond the ability of the project to control. Both the project resident advisor and Pathfinder have made highly commendable efforts. In view of the scarce human and material resources available within the MOPH, it is also to the credit of the director and staff of the Bureau of Coordination of the National Family Planning Program (CPPF) which supervises the project, as well as cooperating provincial officials and service providers, that the project has achieved as much as it has.

For purposes of the evaluation, activities and outputs (in the areas of training, IEC, service delivery, pilot alternative distribution channels, and project management) were grouped into "specific objectives" which best reflect approved workplans and expectations of both Pathfinder and USAID.

- **Training.** A broad range of human resource development and direct training activities have progressed as fast as they can and are appropriate to program needs; a faster pace for many activities would be possible if additional resources were available. Weaknesses in routine follow-up and supervision in the health care system, however, mean that the return for investing in trained personnel will not be as high as desirable.

- **IEC.** Activities are progressing at a slower pace than those in training, but in an appropriate direction; key elements already in place are trained IEC agents and a knowledge, attitude, and practices (KAP) study awaiting analysis. The absence of a national strategic IEC plan and sufficient high-level IEC management expertise in the MOPH will prevent activities from realizing their fullest potential.
- **Service Delivery.** A stronger contraceptive logistics management and supply system is now in place, but the information system is evolving slowly in the absence of a management information system (MIS) specialist; service protocols developed with project assistance have not yet been implemented.
- **Pilot Alternative Distribution Channels.** An excellent feasibility study has recommended three solid, but very ambitious possibilities for development of alternative channels.
- **Project Management.** Inputs and outputs have been efficiently managed. However, the MOPH has not yet instituted a donor coordinating mechanism or provided the number and range of professional staff for the CPPF originally envisioned for project interaction, and USAID has had insufficient staff to interact with the project as originally envisioned. The resident advisor is leaving soon and a replacement must be found. The project does not have a population planning and policy component. It has, however, cooperated in Ministry of Plan efforts to develop a formal population policy.

Recommendations on Specific Objectives

Recommendations on specific objectives are primarily aimed at actions which can be implemented with existing project resources. Following are highlights of those recommendations:

1. The project should proceed as planned to increase IEC staff, and should seek assistance from the private sector in materials development.
2. Certain actions are recommended to further strengthen the flow of supplies, to improve the exploitation of health data currently collected, and to assure that service protocols are responsive to client needs.
3. A proposal, scheduled to be developed in May 1992, for implementing alternative distribution channel pilot projects should include a workplan for phasing in activities at a level appropriate to the modest resources available to the MOPH for oversight of the pilots.
4. The resident advisor position should be filled as quickly as possible with someone who has management experience, and USAID should increase its presence in project management and donor coordination. The project could expand its population role by helping to develop the government's population policy.

Progress toward Purpose and General Objectives

Progress is slow toward achieving the purpose of increasing the contraceptive prevalence rate to 7.6 percent. Contraceptive prevalence is currently estimated to be about 2.6 percent based on numbers of reported users. Results of a recent KAP study may permit a more accurate measure of progress since the 1987 Demographic and Health Survey.

In addition to the project purpose, the project has four general objectives: to make quality information and services widely available; to serve 90,000 users; to ensure a capability for planning and managing training; and to ensure a capability for planning and managing and IEC program. Progress toward these general objectives is modest but encouraging.

The quality and availability of services is good in health centers where personnel have been trained, and services are further strengthened by a stable flow of contraceptive supplies. Personnel are limited, however, by the narrow range of contraceptive methods offered, the size of their total workload in the health centers, and deficiencies in the health care delivery system affecting all services.

There has been a 50 percent increase in the reported number of users in each of the first two years of project activities, although there are indications of a serious client drop-out rate. Thus, the target of 90,000 users by the end of a five-year period is not unrealistic, but greater attention needs to be given to the issue of drop-outs.

Number of Estimated Contraceptive Users, Burundi, 1985-91

1985	1986	1987	1988	1989	1990	1991
5,551 (Harter, 30)	12,726 (Boynton, 29)	13,000 (USAID PP)	13,000 est.	11,725 (MOPH)	17,740 (MOPH)	26,428*
						30,240** (MOPH, Project)

* protected women

** CYP

(Sources in parentheses are listed in Appendix C.)

There has been an increase in the capacity for planning and managing national training and IEC efforts, although progress toward institutionalizing these capabilities is hampered by a lack of professional staff.

Effectiveness of Project Activities

The project's impact on Burundi's family planning goals are facilitated by the design of the project and the government's overall strategy, which emphasize effective use of scarce resources. Features such as using service providers to act as trainers, development of pre-service training, and use of multi-sectoral IEC agents make it possible to expand availability of family planning services with existing resources. There are serious constraints on project impact, however, which are beyond the project's ability to control:

- First, the number and range of professional staff required to provide leadership to an emerging national family planning program are inadequate.
- Second, there is little follow-up and supervision of trained personnel to ensure that they are providing services as effectively as anticipated. There is a critical lack of supervisory skills and mobility among health sector chiefs, who are key to quality supervision.

- Third, there is no strategic plan for a national IEC campaign to direct the efforts of newly trained agents.
- Fourth, the health care delivery system, which is almost the sole source of family planning services, suffers from organizational weaknesses and lack of clear policies, and provides a narrow range of contraceptive choice. These weaknesses are reflected in the apparently high user drop-out rate.

There are at present, however, no viable alternatives to the health care delivery system and the MOPH for developing a strong family planning effort in Burundi. First, there are no other significant contraceptive distribution channels, which is precisely why the project plans to develop some on a pilot basis. Second, for all of its faults, the health care delivery system has been used to achieve very high rates of immunization and prenatal coverage. Third, there are no other government or non-government entities better positioned than the MOPH to provide leadership and direction to family planning so long as the health care delivery system is the primary distribution channel. Finally, creation of an autonomous, high-level family planning organization would provide no advantage over the present CPPF which was created by presidential decree. The CPPF lacks resources, not authority.

Recommendations to Increase Project Impact

1. USAID should continue to support the project, and should direct any additional resources toward expanding this approach as opposed to exploring other options.
2. USAID should increase the budget for items which, with additional resources, would increase the speed at which current activities are being carried out.

The project should undertake the following actions if they meet with the approval of the CPPF:

3. Conduct a management needs assessment of the national family planning program, clearly defining the minimal organizational requirements of the CPPF, preferably using someone already closely involved with the MOPH or the project;
4. Finance Burundian professionals to serve as long-term technical consultants in positions identified through the management needs assessment, using them to develop permanent program components;
5. Conduct a narrowly focused assessment of vehicle support, (including maintenance and repair facilities and policies, gas, driver training) and allocate additional resources to strengthen staff mobility;
6. Undertake an intensive program of supervisory training for health sector chiefs, taking advantage of visits to health centers for purposes of on-the-job supervisory training to conduct follow-up assessments of trained personnel;
7. Support actions to speed up the IEC strategy, including funding of additional professional staff;

8. Implement a demonstration project by using the project's proposed model clinics (for IUD insertion) to demonstrate various approaches for improving clinic-based services;
9. Expand the range of contraceptive choice by giving priority in IUD training to personnel of health centers attached to hospitals; collaborating with UNFPA and the Population Council in expanding the Norplant program; and working with the Association for Voluntary Surgical Contraception (AVSC) to renew sterilization efforts; and
10. Assess the feasibility of an outreach component for the health care delivery system during work on the pilot community-based distribution (CBD) alternative and the IEC strategy.

Long-Range USAID Strategy

USAID's first major family planning effort in Burundi has been as successful as possible given the constraints facing any donor effort in Burundi, and despite the small size of the mission.

The family planning program is just beginning to move toward the stage of "critical mass" on the supply side. The speed with which the delivery system reaches this stage directly affects the level and success with which the government can promote the use of family planning services; and the greater the IEC effort, the greater the demand will be. Eventually, the demand will surpass the ability of the public health system to respond and people will seek out the alternative distribution channels that will have been developed in the intervening years.

Although many current weaknesses in the family planning program are related to the health system in general, strengthening these deficiencies alone will never allow the family planning program to grow at a pace that can achieve needed contraceptive prevalence rates.

Furthermore, the present project does not include a population planning component, and USAID efforts in this area have been sporadic. Yet, unless long-term social and economic development is designed to encourage people to have fewer children, it does not seem likely that fertility will be significantly reduced.

A comprehensive and practical population policy is potentially in the making, but most government sectors do not have the expertise to fulfill the promise of such a policy. The RAPID IV project will be of some limited help, but systematic long-term training is required. Burundi's Seventh National Five Year Plan (1998-2002) presents an ideal opportunity to implement a population policy, if staff in all ministries are properly trained in the intervening years to take advantage of the opportunity.

Recommendations on Long-Term USAID Strategy

1. USAID should intensify its support to family planning for a five-year period, including activities which have recurrent costs attached, preferably in the context of a larger health sector support program; and it should increase the size of the mission staff to provide oversight and donor coordination.
2. USAID should develop and finance with the Ministry of Plan a five-year population training plan (1993-1997) which would include in-country training and research; study tours to countries, such as Mauritius, which have had some success with population planning; and training in universities (e.g.,

Boston University) and institutes (e.g., Dakar Institute of Population Development) which offer relevant programs.

1. Background

1. Background

1.1 Evaluation Scope of Work and Methodology

1.1.1 Scope of Work

A team of three persons was requested to conduct a midterm evaluation of the Burundi Population and Family Planning Project. The team consisted of a family planning program analyst/team leader, Norine C. Jewell, JD, MPH; a clinic services specialist, Laura Laski, MD, MPH; and an information, education, and communication (IEC) and training specialist, Suzanne Plopper, MPH. The four principal objectives of the evaluation were to 1) assess progress made in meeting objectives; 2) assess appropriateness of the project design; 3) make recommendations regarding continuation of the project, including changes in design; and, 4) assess the appropriateness of the project's objectives and USAID's role in the family planning sector and make recommendations for USAID's future role.

Although the focus of the scope of work was on family planning services, the Project Paper (August 1988) noted the absence of a population planning component in the project, and specified that other technical assistance would be identified to support such activities. It also became evident during the course of the team's visit that the country's contraceptive prevalence goal can only be reached if long-term economic and social development favors lower fertility. Such long-term planning requires a concrete population policy and strategy as well as a capability for collecting and analyzing necessary data to support planning efforts. Therefore, the team included findings, conclusions, and recommendations with respect to USAID's role in promoting population planning strategies.

Finally, the team found that no in-depth review of family planning and population efforts in Burundi had been conducted within the past five years that would provide sufficient context for many of its recommendations. With the support of USAID, the team prepared a more detailed country profile and background section in the report than had been planned.

1.1.2 Evaluation Methodology

The project's performance was measured on the basis of specific objectives achieved versus those that were planned; the relevancy and quality of activities undertaken; and the efficiency and effectiveness with which inputs were managed. Progress toward general objectives and overall purpose was measured by analyzing changes in availability and use of family planning services, and in institutional capabilities.

The soundness of the project design was assessed by analyzing constraints to family planning services in Burundi, the degree to which the project is able to overcome them, and changes in project design that could more effectively overcome constraints. To assess the appropriateness of USAID's current and future role in the family planning sector, the team identified those constraints to improved family planning and population planning that are beyond the scope of the population project to affect, but which could be addressed with USAID resources over the next few years.

To carry out their tasks, team members reviewed all pertinent documents; interviewed officials of USAID, the population project, the Ministry of Public Health and other ministries, other donor agencies, and NGOs; and conducted a three-day field visit to the provinces of Ngozi, Cankuzo,

Ruyigi, and Gitega. The team was joined in the field visits by Margaret Neuse, the REDSO health and population officer, and Dr. Fidele Karabagega, director of the National Institute of Public Health of the MOPH.

Before the team could evaluate the performance and progress of the project, however, it first had to clarify statements of goal, purpose, objectives, and activities contained in project documents. Language used in the documents is confusing. Expectations of what the project is to achieve are not clearly designated or arranged in a hierarchy of short-, medium-, or long-term goals. Very general and very specific goals are grouped together in different sections of the project description. Furthermore, no distinctions are made between outcomes that can be directly attributed to the project and outcomes to which the project might contribute. The team relied on approved workplans for guidance in organizing its evaluation, and the resulting statements of goals and objectives in Appendix D, which guided the team, may be useful for measuring future project performance and impact.

1.2 Country Profile

In March 1990, the president of Burundi delivered a speech in which he stressed the urgency of establishing an effective family planning policy to bring population growth into line with the country's resources. He warned that the rapid rate of population growth could lead to serious political and social disorder (14)¹.

The president's concerns are well justified. The country's population of 5.4 million has grown at 2.6 percent a year since the 1979 census, and may be growing by as much as 3 percent a year (18). It is one of the smallest but most densely populated countries in Africa, and in 1982 had 532 people per square kilometer of cultivated land. The population is about 93 percent rural, and population pressure has forced marginal land into cultivation; yet the population will double in just 23 to 26 years at its current growth rate.

Most of the small urban population lives in Bujumbura, the capital, which has 225,000 inhabitants. The majority of the population lives in the central highlands, and most live on small family homesteads dispersed across hillsides rather than in villages. Government is administered through 15 provinces, 114 communes, and nearly 2,600 *collines* (hills). Nearly two-thirds of the population are Catholic, while the remainder are classified as Protestant (15 percent) or "other," including Muslim.

Burundi is considered by UNICEF to be among the 20 poorest countries in the world (28), with more than 90 percent of the population engaged in subsistence farming. Cash crops include coffee, cotton, and tea, with coffee constituting the primary export earnings. The economy took a downturn in the early 1980s, and the current annual increase in gross domestic product (GDP) of 4 percent is nearly offset by the high population growth rate.

Information about women in Burundi reveals high fertility, a low educational level, limited employment opportunities, and restricted legal rights (18). The total fertility rate is 6.8 for women aged 15 to 44, and the contraceptive prevalence rate (CPR) for modern methods was estimated to

¹Sources are listed in Appendix C.

be 1 percent in 1987 (10) (now estimated by the project to be 2.6 percent). The 1979 census showed that 12 percent of women were literate compared to 30 percent of men. Women constitute a distinct minority among senior-level public sector employees (19 percent), and private sector employees (12 percent). Ninety-eight percent of women are engaged in agricultural production. Women have no inheritance rights or rights to property.

Life expectancy in Burundi is 50 years (18). The infant mortality rate is estimated to be between 75 and 116 per 1,000 (10,28), and 196 per 1,000 for all children under 5. There are no official figures for the maternal mortality rate but it has been estimated at 400 to 600 per 100,000 live births (18,27).

1.3 History of Population and Family Planning in Burundi

1.3.1 Government Policy and Strategy

In 1983, the country's sole political party (UPRONA) issued a strong policy statement in favor of reducing fertility (30). The UPRONA position created a favorable environment in which many agencies and donors began to support population and family planning activities that have continued to the present day. More detailed policies and strategies did not emerge until recently, however, with the result that resources and activities were not integrated into a cohesive national program. The reported number of family planning acceptors remained very low. Nonetheless, policy and planning actions by the government over the past two years point to more purposeful movement toward clear objectives, and there has recently been a marked increase in the reported number of acceptors.

1982-1989

Ministry of Public Health (MOPH) officials credit the 1982 RAPID presentation,² based on 1979 census data which had just been published, for alerting the government to the seriousness of Burundi's population growth rate (14). From the early 1960s, the country's Five Year Development Plans had reflected a growing awareness of the consequences of rapid population growth, but the UPRONA statement in the year following the RAPID presentation was a milestone, because it called explicitly for reduced fertility and the inclusion of family planning in health care services. The message, however, was conveyed to the population by means of the party's grassroots structure without a planned and tested IEC campaign. The message reportedly caused some backlash in the community, which may have slowed the response to family planning services that were made available in subsequent years.

Between 1983 and 1987, with UNFPA assistance, IEC activities were initiated and family planning services were made available in 90 percent of public health centers. This was achieved through a series of three- to five-day training seminars for large numbers of staff and the provision of contraceptive methods. During 1986 there was a measurable increase in the reported number of acceptors, but the number remained the same in 1987.

²The RAPID presentation developed by the Resources for Awareness of Population Impacts on Development project is an interactive computer simulation model which uses colorful graphics generated on a large screen to show population and development relationships.

By 1988 and 1989, an increasing number of population and family planning activities were being sponsored by several other agencies including the Ministries of Primary and Secondary Education, Communications, Plan, Interior, and Promotion of Women and Social Protection; the Catholic Church through its health facilities and Action Familiale; and other donors such as UNICEF and the World Bank. The reported number of acceptors continued to remain the same, however, and actually declined by 1989.

Neither the National Five Year Plan (1988-92) nor the 1988 Health Sector Policy statement were sufficiently detailed to fill the continuing void in policies and strategies needed to give strong guidance to the growing amount of family planning activity. For example, no clear direction was provided to different ministries for undertaking social and economic development efforts aimed at slowing population growth, or for collecting and analyzing the demographic and socio-cultural data required for such efforts.

Furthermore, there was no institutionalized authority or responsibility within the MOPH for developing and directing a national family planning IEC and clinic service program. The ministry supervised donor-funded projects through a small Maternal and Child Health/Family Planning (MCH/FP) unit located in one of the offices of the Department of Hygiene and Prevention. The unit's existence was heavily dependent upon continued donor support. The level of the MOPH in which this unit was placed, along with the unit's lack of resources, deprived it of the necessary credibility and authority to mobilize the resources of other offices within the ministry, or of other ministries and donors, to direct them toward a coherent national program.

1990-1991

The absence of policies and actions to slow population growth was prominently highlighted in a November 1990 report published by the Economic and Social Council, whose creation earlier in the year had been the occasion for the president's strong warnings. The council, created to advise the president on critical economic and social needs, concluded that population growth was the central development issue for the country (17). It also concluded that current activities to limit births were insufficient, and that the contraceptive prevalence rate would have to be increased to 25 percent. The report went on to say that it was urgent to have in place an energetic policy of limiting births, since its effects would not be manifested for at least another generation.

Officials involved in both population and family planning activities credit this report with giving prominence and greater credibility to important policy actions which followed. First, in December 1990 a Unit of Population Planning (UPP) was created in the Ministry of Plan with UNFPA assistance. This initiated a process aimed at the adoption of a comprehensive, multi-sectoral population policy. A series of conferences and work sessions, which started in November 1991, are providing a forum in which representatives of multiple sectors are developing strategies for responding to the needs of a growing population and for encouraging reduced fertility. The resulting population policy is intended to provide clear direction to efforts to bring population growth and resources into line, particularly with respect to preparation of future national five-year plans.

Second, the president issued a decree on January 17, 1991, creating the Bureau de Coordination du Program National de Planification Familiale [Bureau of Coordination of the National Family Planning Program] (CPPF), under the supervision of the MOPH (24). The bureau is mandated to coordinate all family planning efforts and to ensure quality services. The decree institutionalizes family planning functions within the MOPH and creates the necessary authority for family planning officials to plan

and direct a national family program. Within 12 months from the date of its creation, the CPPF submitted for MOPH approval a Medium Term Plan for Family Planning and Maternal Health Services (1992-96). The proposed plan sets out the goal of 10 percent contraceptive coverage with the most effective methods and 25.8 percent for all methods, as well as identification and care of 80 percent of high risk pregnant women. The bureau is in the process of developing terms of reference for a consultant to be financed by the World Bank, who will assist the bureau in the preparation of an operational plan.

During the period prior to the Economic and Social Council's report and coinciding with the policy actions that have followed, the USAID-Pathfinder Population Project was undertaken to support a vast improvement and expansion of clinical and IEC training, constituting USAID's first major family planning effort. At about the same time, UNFPA initiated a number of small projects related to IEC, demographic data analysis, women in development, and family planning services. By the end of 1990 the reported number of acceptors had increased by over 50 percent, the first increase in four years, and by another 50 percent in 1991 (see table below). The visibility given to population and family planning issues, the stronger policy and direction in this area that are emerging, and the expansion of donor support may explain some of these encouraging signs.

1.3.2 Position of the Church

An important development paralleling the government's increasing expressions of concern about population growth rates, has been the supportive attitude of the Catholic Church toward efforts to reduce fertility. As early as 1969, the church expressed concern about the diminishing availability of cultivable land in the face of demographic growth (2). In 1979, the Church introduced natural family planning services into its health facilities, and the International Federation for Family Life Promotion (IFFLP) awarded a five-year, \$100,000 grant to CARITAS, the organization that operates Catholic Church-sponsored health centers, to strengthen these services. In 1985 it created Action Familiale with the explicit purpose of contributing to the government's efforts to expand family planning and reduce the population growth rate. The organization's proposed five-year plan (1993-1997) emphasizes the urgency of balancing population growth with resources, and officials are actively seeking to collaborate with all population and family planning efforts.

1.4 Current Family Planning and Population Planning Activities

1.4.1 Overview

The Demographic and Health Survey (DHS) of 1987 indicates that despite the very low contraceptive prevalence rate there is a significant unmet demand for family planning: 23 percent of women want to have no more children and 54 percent want to space their pregnancies. The expansion of service availability after 1986 did not attract many users, however. Nevertheless, since 1990 there have been encouraging signs that this situation is changing. The number of users reported is as follows:

Number of Estimated Contraceptive Users, Burundi, 1985-91

1985	1986	1987	1988	1989	1990	1991
5,551 (Hamer, 30)	12,726 (Boynton, 29)	13,000 (USAID PP)	13,000 est.	11,725 (MOPH)	17,740 (MOPH)	26,428*
						30,240** (MOPH, Project)

- * protected women
- ** CYP

(Sources in parentheses are listed in Appendix C.)

Direction and coordination of current family planning information and service activities are provided by the newly created CPPF, which supervises the USAID-Pathfinder Population Project. Clinic services are delivered almost exclusively through the organized health services system, including many private facilities. IEC activities are carried out by health personnel and, more recently, multi-sectoral personnel who have completed a one-week training program.

A detailed national population policy is being elaborated under the leadership of the UPP in the Ministry of Plan. A high priority in population planning is the improvement in the status of women from an economic, educational, legal, social, and health perspective.

1.4.2 Family Planning Services Delivery System

Family planning services are delivered through the organized health services system. Information sources conflict, but the MOPH reports 269 health centers, of which 204 are operated by the state, and 32 hospitals, of which 28 are operated by the state. One of the largest providers in this system is the Catholic Church, whose facilities are directed by CARITAS. CARITAS reports that it operates 33 health centers, 4 hospitals, 10 education centers with some basic health interventions, and 2 maternities located in public hospitals. CARITAS estimates that its catchment area covers a third of Burundi's population. The recent USAID/Burundi Health Sector Assessment reports that various Protestant churches operate 20 health centers and 6 hospitals.

The MOPH reports nearly 4,000 employees in these facilities, which according to the USAID 1988 Project Paper were built for 9,000 employees. Current staff include 170 physicians, 604 medical technicians who are equivalent to registered nurses, and 680 auxiliary nurses. There are an additional 380 employees in the central MOPH.

It is estimated that 90 percent of the population lives within a 6.5 kilometer radius of a health facility, and 60 percent within a 5 kilometer radius (32). These figures, however, do not convey the actual distance that needs to be traversed in the mountainous terrain where most people live. Estimates of the proportion of the population using the health service system vary from 25 percent to 35 percent. The MOPH reports that in 1990 there were 6.2 million consultations in health centers, in most of which the average was three consultations per client. The MOPH figures appear to support the higher estimate of coverage.

These estimates are not very useful for assessing whether family planning objectives can be achieved through the health delivery system, since they do not reflect who uses services and why. Furthermore, other health data indicate much higher utilization by important target populations. For instance, the proportion of pregnant women receiving at least one prenatal consultation was estimated by the DHS at 80 percent, the MOPH reports an average 98 percent coverage in 10 provinces in 1990, and CARITAS reports 100 percent coverage in the same year. The highly successful immunization program reached 80-90 percent coverage, primarily through these facilities.

Family planning services are integrated into public health facilities, in that all health personnel at the provincial, sector, and facility level are responsible for managing, supervising, and delivering all health services. The only specialized personnel below the CPPF are the proposed family planning and maternal health coordinators who will be under the supervision of provincial medical directors, and who will carry out program development activities with no responsibility for direct supervision. In the mid-1980s there was a family planning supervisor in each of four regions, but the MOPH eliminated the positions in favor of integrated supervision at the service delivery level.

Within the context of this generally integrated program, resources from the CPPF staff and consultants specifically targeted at family planning include training, IEC campaigns, information collection and analysis, commodities and equipment, a logistical support system for contraceptives, and technical assistance for managers, service providers, and consultants.

Family planning services have reportedly been available in some form in most public health centers since 1987. The definition of availability appears to be that the health centers have a stable supply of at least some contraceptive methods, and that most health centers have at least one person who attended a three- to five-day seminar in family planning. There is little readily accessible information to indicate what proportion of non-public-health facilities offer family planning, and at what level. Catholic-operated facilities offer natural family planning, and many are willing to refer their clients for modern contraceptives. This has been particularly true among those staff from these facilities who have participated in family planning training programs.

The organization and quality of services is further described in later sections of this report.

1.5 Government, Non-Governmental Organizations, and Donor Activities

1.5.1 Government Activities

As stated above, the lead government agency for family planning information and services is the CPPF, created by presidential decree in January 1991 and placed within the MOPH with a direct link to the minister. The CPPF is mandated to determine which family planning methods will be made available in the country, to coordinate all IEC activities aimed at promoting use of family planning, and to ensure that the quality of services is controlled. The bureau currently has seven professionals as well as support staff, all located at the central level, including the director, deputy director for services, the deputy director for the logistics system, and three IEC staff. UNFPA recently provided a long-term technical advisor who is a physician, and who will assist in quality assurance activities.

The CPPF has only a few more professional staff than the former MCH/FP Unit, and they are not sufficient in number or in areas of expertise to fulfill many functions required for directing an emerging national program. Such a program requires strong leadership in planning and program

operations, as well as a management information system, a logistical support system, and the technical expertise to ensure quality services, to plan and manage a continuous training program, to direct appropriate IEC campaigns, and to carry out research and evaluation. There must also be a sufficient number of personnel to provide adequate oversight at all levels of the delivery system. There are no current CPPF staff experienced in management information systems, the development and management of nationwide training programs and IEC campaigns, and research and evaluation. The MOPH has staff with expertise in these areas who have offered support to the CPPF, but they are overwhelmed with the demand from all health service areas.

The CPPF's proposed five-year Medium Term Plan establishes general and specific objectives, strategies, activities, resources required, and indicators of progress for family planning and maternal health services, as well as an IEC program. Among the strategies adopted for expanding services are increased contraceptive method choice, a postpartum program, pilot testing of alternative delivery approaches, and reduction of drop-outs. Family planning/maternal health coordinator positions are proposed for the provincial medical director's staff.

Several other government agencies are involved in population planning activities: the Ministry of Plan oversees development of the national five-year plans and its Unit of Population Planning provides technical expertise and coordination in the effort to produce a comprehensive population policy; the Ministry of the Interior has a Population Department which is responsible for conducting the national census and which oversaw the DHS; the university has a research institute (CURDES), which carried out the project's knowledge, attitudes, and practice (KAP) study; some ministries such as the Ministry of Agriculture have a capability for projecting and analyzing demographic variables affecting their constituencies; and the Ministry of Promotion of Women and Social Protection has family planning promotion as a specific objective and has participated in some related studies.

1.5.2 Non-Governmental Organizations (NGO)

Among the NGOs involved in family planning are a newly formed International Planned Parenthood Federation (IPPF) affiliate (ABBEF), and the Catholic Church's Action Familiale. The IPPF affiliate, incorporated in October 1991, estimates that it will take at least a year to develop its organizational structure, hire staff, and train a volunteer board. It plans to send some staff and volunteers to visit affiliates in other countries. Within two years, it hopes to undertake IEC activities.

Action Familiale receives about 75 percent of its funding from Misereor, a Christian organization partially financed by the German government. The current grant period is 1990-92. Action Familiale has full-time representatives in each of seven dioceses to oversee training and counseling activities of volunteers at the parish level who work with youth and married couples. The director of the organization is directly accountable to the bishops of the seven dioceses, and has been directed by them to establish close collaborative relationships with all organizations and donors working in population and family planning. In the mid-1980s, funding from USAID through the IFFLP was provided for staff to participate in natural family planning training in Louisiana and Mauritius. The director met with a representative of IFFLP from Nairobi within the past few months and was told that no funding from that organization was currently available. The representative did indicate, however, that IFFLP would support some travel to a Pan African conference next August in Cameroon, and that it would provide some technical assistance when possible.

1.5.3 Donor Agencies

UNFPA has been an active donor in Burundi. Its first grant agreement was signed in 1982, and it was primarily with UNFPA support, including financing of a pilot program in Muramvya, that family planning services were extended throughout the country by the end of 1987. The most recent UNFPA projects include

- a population education project (1989-92) located in the Ministry of Communication, Culture, and Sports, to raise the awareness of the rural population about the relationship between agricultural production and population growth, and about family planning;
- a project initiated in 1990 in the Ministry of Promotion of Women and Social Protection, aimed at strengthening centers of women's development in the provinces of Babanza and Cankuzo;
- a family life and population education project (1988-92) also supported by UNESCO, located in the Ministry of Primary and Secondary Education; and
- financing for the creation in 1990 of the Unit of Population Planning in the Ministry of Plan, and supported by technical assistance from the International Labor Organization.

USAID funding has provided training, supplies, and some technical consulting services for family planning through a variety of mechanisms, including centrally and regionally funded projects and grantees such as the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO). CARITAS received funding from the IFFLP in the early 1980s to expand its natural family planning services. The present population project, signed with Pathfinder in April 1989, is USAID's largest family planning effort to date.

USAID has also supported such population planning efforts as RAPID II, which provided training, research, and commodities; training for staff of the census office; and improvement of health information systems through the EPI/CCCD³ project. USAID is currently supporting a RAPID IV effort which will include orientation seminars for mid-level personnel from multiple sectors regarding the impact of demographic variables on planning and program activities.

The World Bank has provided a health and population project, but its primary thrust has been renovation of facilities. Family planning services also presumably benefit from assistance to the health care system by such donors as UNICEF, since their assistance strengthens the delivery structure through which all programs are offered.

1.6 USAID-Pathfinder Population Project

The Burundi Population and Family Planning Project is administered by Pathfinder International. It was funded for a five-year period (October 1988-October 1993) for \$4.5 million but experienced a year-long delay in start-up. The project is supervised by the director of the CPPF, and a Pathfinder resident advisor is responsible for its management.

³Expanded Program of Immunization/Combating Communicable Childhood Diseases

At the time the project was proposed, most health facilities were offering some form of family planning services and large numbers of staff had attended three- to five-day seminars. Despite the DHS indication of unmet demand for family planning, the number of users was low and most growth in numbers appeared to have tapered off. IEC efforts were confined to a few activities carried out by a small MOPH Health Education Unit.

Ministry officials identified as project priorities the quality training of health service providers and an IEC campaign based on research and delivered through interpersonal communications, thought to be the most appropriate medium in the social and cultural setting of Burundi. In addition, it was decided that the logistics and health information systems should be strengthened to ensure a stable flow of contraceptives and to improve planning and programming with more accurate data. Furthermore, in view of the inability of the organized health delivery system to meet the apparent unmet demand for services, the project proposed to test alternative delivery mechanisms.

USAID also identified the lack of coordination and collaboration among ministries and donors as an important gap to be filled, and emphasized the need for the government to assume a stronger role in this regard. Therefore, covenants to which the government agreed prior to project implementation included establishment of donor coordinating mechanisms and the institution of routine meetings to ensure a more coherent national program.

Thus, it was determined that the overall purpose of the project would be to expand the availability and use of family planning services in order to increase contraceptive prevalence. General objectives are to make services more available, increase the number of users served by trained providers, increase the capacity to train personnel, and increase the capacity to develop and conduct IEC programs.

2. Project Performance on Specific Objectives at Midterm

2. Project Performance on Specific Objectives at Midterm

The project was funded for a five-year period ending October 1993. Due to the year-long delay in start-up, the assessment of performance is based on what has been achieved after two and a half years of operation, with a year and a half remaining. During the first six months, Pathfinder/Nairobi provided project management so that activities could move ahead while a search was conducted for a resident advisor. The MOPH participated fully in establishing criteria and interviewing candidates, a process made difficult by the requirement that the incumbent be a French-speaking physician.

This evaluation measured performance on the basis of quantity and quality of outputs and activities planned for the project, as well as the efficiency with which they were managed. For purposes of the evaluation, activities and outputs were grouped into "specific objectives" which best reflect approved workplans and expectations of both Pathfinder and USAID.

2.1 Training

A large number of project activities are directed at training objectives. About half of the training objectives are related to developing an ongoing family planning training capability (standardized curriculum, training of trainers, pre-service training) and the other half are related to equipping clinical and IEC service providers with specific skills.

2.1.1 Training of Clinical Trainers

The project agreement called for the training of 27 regional trainers in training skills necessary to train clinical family planning service providers.

Findings

A training needs assessment was conducted by Pathfinder in 1989 in preparation for the training of trainers (TOT) and subsequent training of service providers and IEC agents. The assessment identified a much wider range of training needs than could be covered effectively in two weeks. Ultimately, priorities identified for the TOT included the planning, implementation, and evaluation of family planning training programs, and IEC in family planning which had not previously been included in family planning training programs.

Twenty-seven regional trainers received two weeks of TOT training in May 1990. The training was conducted by an outside consultant and the director of training of the MOPH. Participants included provincial health officers, health sector officers, hospital directors, and the MCH/FP instructors of three paramedical schools. Among the participants, all but three had previously received family planning training. Of this group, 19 are currently available as trainers of service providers in family planning. Others are unavailable due to transfers to other positions in the MOPH or to long-term training overseas. In addition, two physicians trained in the delivery of family planning services in 1990 have participated as family planning trainers in their respective provinces.

The TOT gave participants an introduction to, and practice in, the planning, implementation, and evaluation of family planning training programs. Time did not permit a solid introduction to

interpersonal communication, IEC, family planning motivations in the context of socio-cultural values, and quality of care — all of which are essential to the education and counseling of family planning clients. Instead, only IEC was addressed, and it was treated in the same way as the clinical components of family planning training: a group of participants elaborated a short curriculum on IEC and taught it to the group. Participants did not receive training in contraceptive supply management, record keeping, and reporting as policies and procedures have not been finally worked out for these elements of the CPPF.

Conclusions

Participants had little if any previous training in the interpersonal aspects of family planning service delivery, and time did not permit sufficient emphasis on these concepts during the TOT. As a result, there is a weakness in the subsequent service provider training for which they have been responsible. Six of the regional trainers who worked with the outside consultant/trainer in the implementation of the initial family planning service provider training programs benefitted from this initial exposure to these concepts. These six individuals perceive themselves as confident and effective in conducting this part of the training. According to trainers interviewed, most other trainers, while appreciating the importance of this aspect of training, are reticent to take responsibility for it, due to their lack of experience. Because of this situation, one of the above six trainers must participate in every training program and often conducts this aspect of training alone. In addition to the difficulties involved with one person monitoring and reinforcing participant learning, the effectiveness of this aspect of training is also compromised by 1) the size of the groups being trained (generally about 25, see Section 2.1.3) and 2) the limited amount of time available to practice skills.

Interpersonal communication and group IEC skills are perceived by the CPPF, the project, family planning trainers, and service providers as being important elements in the delivery of quality family planning services. Therefore, all the regional trainers should be capable of conducting this aspect of training as well as capable of reinforcing these skills among personnel in their own work settings.

Training to ensure effective management of the family planning program is deficient because some management components (e.g., record keeping) have not yet been developed in final form by the CPPF.

Recommendations

1. The project should provide regional trainers with 1) a one-week TOT in family planning motivation in the context of socio-cultural values, interpersonal communication and group IEC skills, and quality of care issues in the delivery of family planning services, and 2) additional reference materials to support the teaching of these concepts.
2. Once the logistics, record keeping and reporting policies have been finalized by the CPPF, the regional trainers should receive one week of training in these areas to enable them to effectively train service providers in these skills during refresher training.

⁴Recommendations are numbered consecutively throughout the report and are collected together as Appendix E.

2.1.2 Standardized Training Curriculum (Clinical In-Service Training)

The project agreement called for the development of a standardized training curriculum for clinical in-service training of health workers.

Findings

A standardized training curriculum for a two-week in-service training program was developed in project year 1. There are 25 participants per training program. The first week focuses on clinical family planning information: anatomy and physiology of reproduction, methods of contraception, and the components of a family planning consultation. The second week focuses on interpersonal aspects of the delivery of family planning services: values related to family planning, motivational factors related to the use and non-use of family planning, interpersonal communication skills, group IEC activities, integration of family planning services, and issues of quality in the provision of family planning services. Two half-days are reserved for practical application of training in health centers. The trainers have programmed the practical training time as follows:

Week 1. Participants are divided into three groups — one group studies the use and organization of client records in a health center; one group does family planning consultations; and one group talks individually with women in maternity and pediatrics wards about family planning.

Week 2. Participants are divided into four groups — in each group, one participant conducts a group IEC session in one of the following environments: health center, maternity ward, adult in-patient ward, pediatrics ward, and/or in the community (according to local possibilities).

The clinical part of the training curriculum was developed by local consultants and the communication/IEC part by the consultant who had conducted the earlier TOT. It was then reviewed by three trainers who had participated in the TOT training.

Discussions with trainers and family planning service providers who have received the training indicate that the training is perceived as being pertinent to the tasks of health workers in the provision of family planning services. All commented on the importance of the interpersonal communication and IEC components of the training to which health workers had little or no previous exposure.

Conclusions

Although the content and training methodology used in the curriculum are appropriate to tasks of health workers in family planning, there are several areas which merit further attention. First, there are concerns about the level of performance desired and the degree to which the curriculum and training time available for interpersonal communication and group IEC skills enables participants to master these skills to be able to apply them effectively following training. The opportunity to apply interpersonal communication and group IEC concepts taught during training is minimal due to time constraints, the large number of participants per training program (generally 25, as discussed below in 2.1.3), and the fact that only six of the current trainers have had much exposure to the concepts and are therefore capable of effectively monitoring participant application of concepts and giving feedback during practice sessions. Additionally, participants lack opportunity to apply their

knowledge of family planning service provision in the conduct of consultations during training due to the limited number of family planning clients at some training sites.

Several factors indicate the importance of communication skills to the quality of family planning service delivery in Burundi: 1) the repeated expression of these training needs by service providers attending training; 2) the existence of numerous rumors about family planning to which service providers must be able to respond adequately; 3) low numbers of new acceptors in most clinics (which may reflect inadequate IEC activities and/or weaknesses in service provision, among other factors); and 4) high numbers of drop-outs among new family planning acceptors which may reflect problems in quality of service (quality of interpersonal interaction and confidence in service providers, quality of information provided to clients and verification of client understanding, etc).

Given the current organization of training, approximately three and a half hours are available for the practice of interpersonal communication skills in the classroom; in principle, all participants conduct one group IEC session. The training of 25 participants at a time, often with only one trainer with experience in these areas, and with minimal or no opportunity for supervised practical application, raises serious questions as to the ability of participants to correctly apply the concepts taught following training.

Second, the curriculum needs to devote further attention to rumors about family planning and how to respond to them. Although family planning rumors are addressed in the training, it is essential (in light of the number of rumors circulating about family planning and the effect that they have on the acceptance of family planning services) that service providers be aware of the variety of rumors and their possible origins, and that they be able to respond correctly and sensitively to them. In the training of service providers, additional emphasis needs to be put on current family planning rumors in Burundi and how to respond to them. This element could be integrated into sessions on interpersonal communication.

Third, further attention needs to be given in the curriculum to skills in organizing family planning services to meet client needs, since the apparently high numbers of drop-outs may reflect the organizational aspect of quality of service.

Fourth, there is a need for the curriculum to include strategies to ensure follow-up of family planning drop-outs. This has been a major problem in service provision and will need to be addressed both in terms of causes and in terms of strategies for follow-up.

Fifth, such management components as the ordering of contraceptive supplies and the preparation of family planning statistical reports have not been emphasized during the training curriculum of service providers because not all of the protocols and guidelines had been worked out when the service provider training began, as mentioned in Section 2.1.1. Without such management components, the CPPF cannot expect uniformity in service provision or clinic management.

Finally, sexually transmitted diseases (STD) and AIDS were not included as content in this training program due largely to a lack of time.

The above observed gaps in the training curriculum reflect weaknesses in family planning service delivery. These weaknesses need to be further analyzed in order to determine to what degree they reflect training as opposed to resource needs, and to be able to respond to them effectively. Health sector officers (with support from the family planning regional coordinators), in the course of their

supervision, should be encouraged to pay particular attention to the above service delivery problems and to possible training-related causes.

In order to assess training needs underlying service delivery problems, health sector officers and family planning regional coordinators (who are to be named), must have the ability and tools to recognize and address these issues as a part of their supervisory responsibilities. Current family planning supervisory tools focus largely on material organization of clinics, logistics, and reporting, all of which are important to clinic functioning. However, little attention is given to the *qualitative/interpersonal* aspects of service provision, which likely underlie problems.

A major barrier to improving qualitative supervision is the continuing lack of family planning standards and protocols. It is critical that family planning standards and protocols be completed in order that they guide family planning service provider training and thus strengthen the organization and provision of services. Once standards and protocols are established, qualitative standards of care can then be integrated into supervision forms, and training can be provided to health sector officers and family planning regional coordinators in techniques of qualitative supervision. Thus, until standards and protocols are finalized and implemented, efforts by supervisors to assess training needs and CPPF efforts to improve training curriculum will be constrained.

Recommendations

3. The project should assist the CPPF with the elaboration of a concise reference document for health workers on existing rumors and how to respond to each one. Information for such a document could be gathered from the KAP studies and from the experiences of the trainers.
4. Once family planning service delivery standards and protocols are adopted, they should be incorporated in the training curriculum for supervisors and providers.
5. Once the contraceptive supply/logistics, record keeping, and reporting systems have been finally worked out, the project should ensure that a curriculum is developed for the training of trainers and service providers in these areas.
6. At the end of the training of service providers in 1992, the project should assist regional trainers in the review and update of the family planning service provider curriculum in order to produce a comprehensive training manual in family planning.

This review should focus on a) the completeness and clarity of the curriculum, b) new family planning methods and/or information available since the elaboration of the initial curriculum, c) time frames and methodologies for various training sessions to ensure adequate application of concepts, d) necessary support documents, and e) other subjects that may need to be added and/or reinforced, including rumors about family planning and how to respond to them, quality of care issues in the organization of family planning services, strategies

for follow-up of family planning drop-outs, STDs and AIDs, logistics (contraceptive supply management), and record keeping and reporting. (The last two topics will need to be developed separately, by the CPPF assistant director for administration and finance and an outside consultant with experience in these areas.)

The curriculum revision will require a period of one week and will require outside consultation. It will provide the MOPH with a solid family planning curriculum based on two years experience, and will strengthen MOPH staff skills in needs assessment and curriculum development. These skills are essential if the MOPH is to develop a strong institutional capability to sustain the family planning program.

The curriculum revision could be conducted independently or be combined with one or both of the activities in Recommendations 1 and 2 above. In either case, it is essential that a week be reserved for each activity.

2.1.3 Training of Service Providers

According to the project agreement, 450 health personnel are to receive training in the delivery of family planning services. These service providers (physicians, medical technicians, and nurses) are to receive two weeks of training in the provision of family planning services (50 in project year 1; 100 in project year 2; 125 in project year 3; 125 in project year 4; and 50 in project year 5) and an update refresher course (project year 3).

Findings

A total of 212 service providers (including 177 nurses and 35 physicians) have been trained as of March 1992 (55 in project year 1; 61 in project year 2; and 91 in project year 3). Training is programmed for an additional 137 nurses in the remainder of project year 3, bringing the total number of trained family planning service providers to 349 by the end of project year 3. Refresher training is not programmed for project year 3.

The current strategy for training health service providers builds upon earlier MOPH strategies for training health workers in family planning. Family planning training began in 1982 with training of physicians and chiefs of health centers. The USAID-Pathfinder Population Project has supported the MOPH strategy of focusing on categories of health workers not reached in the earlier family planning training. Project-supported training began in July 1990 with the training of physicians not previously trained in family planning (largely hospital-based physicians). This was followed by the training of auxiliary nurses in health centers by province. Selection of nurses for training, approximately 25 per training program, is done by provincial medical officers and their health sector officers. Selection criteria specify the participation of at least one auxiliary nurse per health center. Other participants include additional nurses from health centers and hospital- and maternity-based nurses.

To date, training has been completed in the following provinces: Cibitoke (August 1990), Kayanza (February 1991), Ruyigi (April 1991), Ngozi (June 1991), Bururi (October 1991), Cankuzo (November 1991), Muramvya (February 1992), Makamba (March 1992), and Karuzi (April 1992).

Training is scheduled for the remainder of 1992 as follows: Muyinga (May), Urban Bujumbura (May), Kirundo (June), Gitega (July), Bubanza (August), and Rutana (September).

Unforeseen factors (a period of civil unrest in December 1991-January 1992 and a cholera epidemic in March-April 1992) have necessitated the postponement of several scheduled training sessions. The project plans to double up the scheduling of training sessions later in 1992 in order to keep with its projected level of training activity. (Rural Bujumbura remains to be rescheduled.)

The planning and coordination of training activities has been carried out by two members of the training team whose primary roles are sector health chief and provincial medical officer, in collaboration with the CPPF assistant director for technical services and the administrative assistant of the population project.

There has been little follow-up and supervision of trained personnel in the work place, so there is no feedback on effectiveness of training or use of skills.

Conclusions

The project has progressed well in the training of service providers. It should be able to complete the anticipated training within the projected five years of project activity.

Most concerns with the training of service providers have been discussed under Sections 2.1.1 and 2.1.2. Other concerns include the inadequacy of follow-up and supervision (see Section 3.2.2 for further description of this issue) and a lack of adequate reference documents for participants. At present, each participant is given a copy of *Family Planning in Africa* (in French) and a series of "Technical Guidelines," prototypes of MOPH standards and protocols for family planning service delivery still being developed. *Family Planning in Africa* is the most comprehensive guide for family planning service providers in Africa. Due to its level of detail, however, it is more practical for back-up reference than as a reference guide for use during a consultation. The Technical Guidelines provide a more basic and practical guide for immediate reference for routine matters, and once in final form and adopted by the MOPH, will represent the standards and protocols to be followed in the provision of family planning services in Burundi. Training 25 service providers in so short a time does not allow for optimal monitoring of the learning process of individual participants.

Recommendation

7. The project should postpone the refresher/contraceptive update training originally planned for project year 3 until project years 4 and 5 to allow for completion of the initial series of training which is scheduled to finish in September 1992. The content for refresher training should be based upon training needs defined during supervisory visits, taking into consideration the possible training needs referred to under Section 2.1.2. This training should be planned for a period of up to a week as necessary to respond effectively to priority training needs. In order to facilitate application of skills, a maximum of 15 participants should be trained at a time, with close monitoring by trainers skilled in the subject areas.

2.1.4 Training in Voluntary Surgical Contraception (VSC)

The project agreement calls for the training of 20 family planning service providers in voluntary surgical contraception (five teams of "physician/nurse" to receive training in VSC and 10 counselors in counseling techniques for VSC).

Findings

This output has not been achieved due to factors beyond the control of the project. The training was to be conducted with technical assistance from AVSC, which is also committed to providing the necessary equipment. Prior to the USAID-Pathfinder Population Project, AVSC provided funds to renovate and equip a VSC unit in the Prince Regent Charles Hospital in Bujumbura. There were problems with the management of the money and completion of the necessary renovations, however. AVSC is awaiting completion of renovations before agreeing to participate in this activity. Construction of the facility is essentially complete; virtually all that remains to be done is the installation of equipment.

Conclusions

As the training of personnel in VSC gets under way and this method of family planning becomes increasingly available, trainers and supervisors of health workers and IEC agents will need to ensure that their colleagues present VSC to clients and the population in general with the same objectivity as they present other methods. This will be necessary in order for VSC to become a viable method choice.

Recommendation

8. The project should pursue with the CPPF the steps that remain to make the VSC unit in the Prince Regent Charles Hospital functional, and with the CPPF and AVSC the programming of VSC training as originally planned.

2.1.5 Management Training for Provincial Medical Officers

According to the project agreement, the project is to provide training to 15 provincial officers in family planning program management.

Findings

Through UNICEF funding, the MOPH was able to offer to 25 provincial health officers and health project/program directors four weeks of management training. As there would have been overlap in the content of the two training programs (the two-week training program planned under the project and the four-week UNICEF program conducted by Clark Atlanta University) for provincial medical officers, the MOPH elected to authorize the longer training. The USAID-Pathfinder Population Project co-funded this activity.

Conclusions

The decision to provide provincial medical officers with a more extensive management training program was good. Other management training needs such as supervision and technical support have not yet been addressed. Many sections of this report highlight the need for improved supervision. Furthermore, the CPPF has a proposal in its Medium Term Plan (see Section 1.5.1) for provincial level family planning and maternal health coordinators, and the CPPF is considering use of sanitation technicians (see Section 2.2.2) to coordinate IEC activities at the provincial level.

The CPPF needs to analyze the intended management roles and tasks of these proposed staff, as well as those of health sector chiefs. The purpose of this analysis would be to determine 1) necessary competencies required for effective technical support to, and supervision of, health personnel and IEC agents, and 2) existing levels of competence among personnel in, or proposed for, these posts.

Recommendation

9. The project should support the CPPF in a) assessing the training, technical assistance, and material support needs of provincial-level coordinators and health sector chiefs in the area of supervision; and b) providing training, technical assistance, and material support as needed to the above personnel in order to reinforce the competencies needed to effectively fulfill their roles.

2.1.6 Pre-Service Training

The project calls for revision of the family planning/reproductive health curriculum in the four paramedical schools and the Faculty of Medicine in order to institutionalize family planning training and to provide the country with training manpower in family planning.

Findings

Objectives (or outputs) of the project address service provider training in terms of in-service training for health workers. Family planning curriculum revision in the Faculty of Medicine and the four paramedical schools is described as an activity in the technical proposal workplan. During the Training and Service Delivery Needs Assessment conducted by the project in October 1989, it was noted that health workers received minimal reproductive health training as part of their education either in the Faculty of Medicine or in the paramedical schools. It was recommended that family planning education be institutionalized in these schools by the introduction of reproductive health in pre-service education.

The project has subcontracted with JHPIEGO to provide technical assistance to the Faculty of Medicine and the paramedical schools. In the case of the four paramedical schools, the MOPH has revised the curriculum with assistance from the African Development Bank. An initial awareness seminar was held with medical school and paramedical school faculty and JHPIEGO in March 1992. Currently JHPIEGO is providing technical assistance in a two-week workshop for teachers of family planning in the four paramedical schools. This workshop is oriented toward refresher training, contraceptive update, and use of the new curriculum. At the Faculty of Medicine, further consultations are planned for July 1992 for the revision of the family planning curriculum, including

the addition of client counseling and IEC components, and training of faculty in the use of the new curriculum.

Conclusion

Project inputs are appropriate at this time.

2.1.7 Training in Intrauterine Device (IUD) Insertion

The project technical proposal workplan calls for the training of 12 trainers in IUD insertion.

Findings

Objectives (or outputs) of the project technical proposal and the project paper do not address training in IUD insertion. As in the case of pre-service training, however, training in IUD insertion is addressed in the technical proposal workplan. Specifically, it was planned that 8 to 12 trainers would receive further training in IUD insertion techniques in Bujumbura.

As IUD services are not yet widely available in Burundi, there are not enough clients to organize a TOT in IUD insertion. This has necessitated sending selected IUD trainers to a regional IUD training course outside the country. Four trainers participated in this training in Morocco in October 1990. These clinicians are expected to serve as trainers in IUD insertion at regional model clinics which are currently being set up as training sites for the practical training of physicians and nurses in family planning.

Conclusions

External training of trainers in IUD insertion was appropriate. It is essential now that the trainers be able to begin training additional staff in order to 1) increase the number of trained IUD service providers, and 2) reduce the need and expense of continuing to send service providers out of country for this training.

As this method of family planning becomes increasingly available, trainers and supervisors of health workers and IEC agents will need to ensure that their colleagues present IUDs to clients and the population in general with the same objectivity as they present other methods in order that IUDs become a viable method choice.

2.1.8 Long-Term Fellowships and Short-Term Grants

The project calls for two long-term fellowships for masters in public health degrees with specialization in family planning, and 12 short-term grants in IEC, service delivery, and program management training.

Findings

A total of nine short-term grants have been provided to assist health personnel upgrade their skills in family planning-related areas. Two trainers of service providers participated in five weeks of TOT organized by the Centre for African Family Studies (CAFS) in Dakar, Senegal (November 1990). Two staff of the IEC unit of CPPF participated in five weeks of training in the development and

management of IEC/family planning programs at CAFS in Lome, Togo (July-August 1991). The CPPF assistant director for administration and finance participated in five weeks of family planning management training at CAFS, in Lome, Togo (July 1991). Four clinicians participated in an IUD TOT in Rabat, Morocco (October 1990). These clinicians are expected to serve as trainers in IUD insertion at regional model clinics which are currently being set up as practical training sites for physicians and nurses.

In 1990, USAID communicated to the MOPH the availability of the two long-term fellowships and asked for proposals of candidates. According to USAID, the MOPH has not proposed qualified candidates. As the project is scheduled to end in October 1993, it is now too late for possible candidates to be able to complete their studies before the end-of-project date.

Conclusions

All short-term external training has been appropriately directed toward reinforcing the skills of key family planning personnel and thus contributing to the technical competence of the MOPH. Two new staff members without previous family planning training have been added to the CPPF in the last year: the assistant director for technical services and an additional person in the IEC unit. These individuals could benefit from short-term training to upgrade their skills related to their respective roles.

Recommendation

10. The remaining funds available for short-term external training should be used to help upgrade the skills of two new CPPF staff — an assistant director for technical services and an additional person in the IEC unit.

2.1.9 IEC Training Curriculum

The project agreement calls for the development of a training curriculum for community-based IEC agents in family planning IEC.

Findings

A curriculum was developed for a one-week training program for IEC agents. The curriculum was developed by an outside consultant in collaboration with participants of a TOT in family planning IEC in Bujumbura (November 1990). The curriculum, which was developed prior to the completion of the family planning KAP studies, focused on principles of adult learning, family planning in Burundi, an overview of methods of contraception available in Burundi, socio-cultural values related to family planning, and how to conduct group education sessions in the community. The proposed IEC approach is for agents to tailor their messages to the expressed interests of the group.

Conclusions

Based on training reports and discussions with 10 of the IEC trainers, the IEC training curriculum was appropriate for the tasks of the IEC agents. The main concern expressed was the lack of time to practice conducting IEC sessions. Trainers did not feel that any part of the curriculum could be reduced, nor that the period of training could be lengthened. They also noted a lack of reference

material for IEC agents following training. Such materials are necessary to back up the training received. The IEC project of the Ministry of Communication is in the process of developing such a document. In its current form, however, it is too lengthy to be very useful.

Finally, there are two elements which have not yet been seriously felt due to the newness of IEC activities. The first concerns how to respond appropriately to family planning rumors as discussed in Section 2.1.2. Second, there are no visual aides to accompany IEC messages. Visual aides are an important support to an IEC message and help to attract and keep a group's attention.

Recommendations

11. Once the results of the KAP studies are available, the project should assist the IEC unit in reviewing the training curriculum to ensure that it responds to socio-cultural values and perceptions of family planning identified in the KAP studies.
12. A concise reference document for health workers on existing rumors and how to respond to each one, as recommended in Section 2.1.2, should be adapted for use by IEC agents.
13. The project should assist the IEC unit in reviewing the reference guide for IEC agents which is being elaborated by the IEC project and assist in its modification so that it responds to the information needs of IEC agents.
14. The project should pursue production of several series of visual aides (in the form of flip charts) adapted to the socio-cultural context of priority themes of IEC sessions. For IEC agents already trained, the use of these visual aides will have to be introduced in the course of local group supervisory visits.

2.1.10 Training of Trainers of IEC Agents

According to the project agreement, the project will train 12 trainers in skills necessary for the training of family planning IEC agents.

Findings

Seventeen trainers, representing five ministries (Ministry of Public Health; Ministry of Communication; Ministry of the Promotion of Women; Ministry of Youth, Crafts and Trades; and the Ministry of Primary and Secondary Education) and the Burundi Women's Party, were trained in family planning IEC training techniques, with the understanding that they would in turn be available to conduct IEC training for the CPPF. Of this group, six work actively with the CPPF and the project in the training of community-based IEC agents in family planning. Another three do the same training under the Ministry of Communication family planning IEC project. Two additional staff of the CPPF have received on-the-job training and participate actively in family planning IEC training.

The trainers interviewed stated that the TOT they received prepared them well for their roles as trainers.

Conclusions

Although the number of trainers available for IEC training is not as many as anticipated, participation of those whose ministries have seconded them to CPPF IEC activities has been excellent. The Ministry of Communication has a parallel IEC project supported by UNFPA. Thus, while its staff are not available to the CPPF, they are doing parallel training, thus contributing to the training of IEC agents in family planning.

Despite the positive collaboration that has existed, it would be difficult to imagine other ministries being able to second their staff to the CPPF on a continuing basis. The fact that the MOPH and the CPPF are building at the provincial level a cadre of family planning coordinators and supervisors for IEC activities will provide the ongoing capacity for IEC training as well. (See Section 2.2.2 for further details)

2.1.11 Training of IEC Agents

According to the project agreement, 350 IEC extension agents from the public sector and from the national political party will be trained in family planning IEC.

Findings

One hundred and eighty-nine IEC agents have been trained under the project as of March 1992. Agents are given one week of training. Twenty-five agents are trained at a time by a team of three trainers and a clinician (usually the provincial medical officer) who conducts sessions on contraceptive methods.

Since November 1991, service provider training and IEC agent training (both through the USAID-Pathfinder Population Project and through the Ministry of Communication IEC project) has been conducted at the same time and same training site (see Section 2.1.3 for dates). Due to the difference in the length of training, service provider training begins one week before IEC agent training so as to maximize the interaction between the various personnel and to facilitate the logistical aspects of training.

IEC agents, whose function is to inform the population about the importance of family planning and availability of family planning services, are selected in collaboration with political-administrative authorities at the provincial level. The following criteria are used in their selection:

- permanent contact, and credibility, with the population;
- men and women between the ages of 20 and 40;
- able to read and write in Kirundi;
- already has the role of community extension agent; and
- availability to do family planning IEC activities following training.

The following categories of persons are represented among these agents: sanitarians; social service animators; local leaders of the Burundi Women's Union (UFB), the national political party (UPRONA), and the young people's political organization (JRR); and local community groups.

There is as yet no officially adopted IEC strategy or workplan. Due to the lack of a system for the supervision of IEC agents at the provincial level, staff of the IEC unit of the CPPF and the Ministry

of Communication IEC project are carrying out supervisory visits by province on a quarterly basis. Since the beginning of 1992, they have visited IEC agents in six provinces.

Conclusions

In general, based on interviews with 10 IEC trainers, participant evaluations of the training, and trainers' supervisory reports, the training was responsive to the anticipated tasks of IEC agents. In addition to concerns expressed concerning the curriculum (see Section 2.1.8), trainers and participants expressed concern about a lack of time to practice conducting IEC sessions. As in the case of service provider training, training 25 people in a short period of time in skills that demand a fair amount of practice and feedback is difficult. Smaller groups (15 participants per training) would have allowed for more individual practice.

Related to the above concern is the inadequacy of follow-up and supervision to date. Follow-up is helpful to IEC agents and valuable to trainers, but it is not frequent enough either in terms of reinforcing skill development and problem-solving, or in maintaining motivation among agents who are receiving no remuneration for their family planning IEC activities. The issue of supervision of IEC agents needs serious attention if the benefits of training are to be sustained. (See Section 2.2.2 for further description of this issue and possible solutions.)

Recommendations

15. Once supervision of agents is improved (see Section 2.2.2), feedback should be used to strengthen training and refresher courses.
16. For future IEC training, group size should be limited to 15 in order to allow maximum participation and practice.

2.2 Information, Education, and Communication

2.2.1 Materials Production/IEC Skills Development

The project agreement calls for the development, pre-testing and dissemination of two posters, seven hand-outs, two flip charts, six radio messages, and three radio talk shows. The project agreement also calls for the project to assist members of the Health Education Unit (HEU) of the MOPH to develop their skills in the conduct of formative research and evaluation of IEC activities.

Because these two objectives are closely linked, they are treated together. They complement each other in that the HEU is the logical unit for the planning, implementation, and evaluation of all health-related IEC interventions (including the determination of family planning IEC messages and the production of materials and media campaigns) and, therefore, should be reinforced in terms of technical skills needed to carry out its functions.

Findings

IEC materials production to date has included the development, pre-testing, and dissemination of one family planning logo, two posters, and one hand-out. The family planning logo and posters are widely distributed in health facilities and in various community centers around the country. Additionally,

three radio spots and 36 radio messages have been prepared and broadcast. An evaluation of the impact of the poster and radio program was recently carried out by the CPPF's IEC unit in collaboration with the HEU. As soon as the results are transcribed, the analysis will be done. This will allow the CPPF to know the effectiveness of its 1991 IEC campaign and to improve the next campaign.

Prior to the development of IEC materials, an initial IEC needs assessment was done (in 1989) to examine current family planning IEC efforts, to assess in-country capabilities for the production of IEC materials, and to examine other donors' inputs into family planning IEC. This was followed in 1990 by a two-week workshop organized by the project for the IEC coordinator of the CPPF and five members of the MOPH HEU with whom the project subsequently collaborated in conducting the qualitative research necessary for the development and pre-testing of messages and materials. Participants were trained in the development and implementation of baseline research for IEC, in the conduct of focus groups and KAP surveys, and in the elaboration of research tools. A workplan was developed for the following year for research activities necessary to define family planning messages for print materials and radio. Between October and December 1990 research tools were finalized for the focus group and individual interviews, 30 focus group and 14 individual interviews were conducted, data were analyzed, communication strategies were developed, and preliminary messages were elaborated for print materials and radio. Research focused on family planning knowledge, attitudes concerning ideal number of children and interval between births, positive and negative attitudes about family planning, rumors related to family planning, characteristics of users and non-users of contraception, and actual and preferred sources of information about family planning.

The Economic and Social Research Institute (CURDES) at the University of Burundi has contracted with the project to conduct quantitative research (in the form of a KAP survey) on the percentage of the population with certain knowledge, attitudes, and practices relative to family planning. The proposal to do this study was submitted to USAID and approved in October 1990. It was also submitted to the MOPH and was approved in June 1991. The fieldwork was executed in September 1991 and the results are expected to be available by the end of April 1992. When the results of this survey are compiled, the information will be used to define IEC strategies (in terms of selecting target groups, message content, and media).

Conclusions

The two objectives of materials production and skill development for HEU staff are somewhat conflicting due to 1) the need of the project to achieve certain targets by the end of the project period and the volume of effort needed to achieve them, and 2) the HEU's inability to devote sufficient resources to family planning IEC activities because of its responsibilities for health education interventions in many other areas, and the limited number of HEU staff available to respond in a timely fashion to all of these demands.

The development of mass media messages and materials has followed a systematic approach. The principal problems encountered in materials production were related to an inadequate number of personnel to carry out activities as scheduled.

Important materials not anticipated in the project design are the visual aides for IEC agents. The project calls for the development of one flip chart, presumably for family planning IEC activities in health centers. IEC agents also have need of visual aides to support and emphasize their messages.

Recommendations

17. In light of the need for IEC materials to promote family planning, the project should utilize the private sector as necessary to ensure the timely production of these materials. The project should also proceed with hiring a local IEC specialist as planned to strengthen the management of the CPPF IEC unit.
18. The project should support the development of at least three simple flip charts for IEC agents, each with a different orientation to the promotion of family planning. Messages would be based on the results of the KAP studies regarding the population's concerns and attitudes relative to family planning.

2.2.2 Deployment of IEC Agents

The project anticipates that trained IEC agents will conduct family planning IEC sessions at national party meetings, meetings called by the communal administrator, and at other community gatherings.

Findings

The project addresses community-based group IEC activities through training objectives and activities. In project documents, however, little reference is made of expectations of trained agents or of possible strategies to be followed. The project, in collaboration with CPPF and Ministry of Communication IEC project staff responsible for the training of IEC agents, has asked IEC agents to commit themselves to conducting at least one IEC group session per month in their communities.

To date, IEC agents have targeted the following groups in their activities:

- young adults planning marriage;
- youth (girls and boys);
- married couples of reproductive age; and
- groups of adults gathered for other reasons (various community associations, work collectives, political meetings, etc.).

Subjects of group sessions have included

- advantages of family planning for the family and the country;
- problems caused by a high population growth rate;
- available family planning methods; and
- advantages of giving birth in a hospital.

Likewise, the project, in collaboration with the CPPF and the Ministry of Communication IEC project, has pursued certain strategies with IEC agents in an effort to support and reinforce their activity. Recognizing the importance of follow-up and supervision of IEC agents, the CPPF IEC unit (with the support of the project) and the Ministry of Communication IEC project are attempting to respond to the current lack of infrastructure to fill this need. First, agents are asked to form committees at the communal level for the purposes of planning and monitoring their activities. They are to send monthly reports of activities by commune to the regional medical officer who in turn

sends the reports to the Ministry of Communication IEC project; the ministry in turn shares a copy with the CPPF IEC unit. These reports are used to monitor agent activity and to identify issues needing particular attention. Second, staff of the IEC unit and the Ministry of Communication IEC project have planned quarterly supervision visits by province, in order to support agents in their activities and to resolve problems encountered in the course of these activities (six visits were conducted during January-February 1992).

At the same time, the MOPH is studying alternatives for reinforcing its peripheral infrastructure in order to strengthen the support of IEC activities in the field. (See Section 3.2.2 for further details.)

A possible solution to the supervision of IEC agents is emerging from broader concerns within the MOPH regarding IEC efficacy and the efficient use of peripheral health personnel (i.e., sanitation technicians). The CPPF and the Department of Hygiene and Preventive Health have discussed the possibility of promoting one communal-level sanitation technician to the provincial level (in each province) to become the intermediate link between community-level IEC activities and the central level. These individuals would be responsible for the support and supervision of IEC agent activities in the field.

Conclusions

Although the current system of supervision (from central to peripheral level) is not practical in the long term due to staff-agent ratios and distance, it is filling an important need until such time as other alternatives are found. The option being considered by the MOPH makes much sense given the numbers of sanitation technicians already employed by the MOPH and the increasing orientation of their work toward IEC in primary health care. Nearly all of them have participated, or will participate, in the family planning IEC training currently being conducted.

Recommendation

19. The project should support the option being discussed by the CPPF/MOPH to decentralize the support and supervision of IEC agents.

2.3 Service Delivery

It is expected that the combined project efforts in training and IEC described above will contribute to higher-quality, more available family planning services in an integrated setting. In addition, the project has specific objectives for selected interventions in service delivery deemed to be important to ensuring quality and availability of services.

2.3.1 Service Protocols

According to the project agreement, the project is to provide assistance in developing protocols in order to ensure that standardized high-quality family planning services are provided by every health center. The elaborated protocols should also serve as the basis for the elaboration of a service provider training curriculum.

Findings

In 1990, a technical working group of representatives of the MOH, the Population Project of the World Bank, the USAID-Pathfinder Population Project, and the UNFPA-UNESCO Family Life/Population Project of the Ministry of Primary and Secondary Education was constituted to develop a preliminary protocol outline with the goal of standardizing family planning service delivery procedures. Preliminary guidelines on standards and protocols were drafted for the group by the USAID-Pathfinder Population Project resident advisor and the UNICEF technical advisor. Pathfinder's background materials were used for this activity.

Recently, a UNFPA technical consultant was appointed to work at the CPPF to provide technical assistance in the area of clinical service delivery. Among other activities, the consultant will be in charge of overseeing the development of the final version of the guidelines on service delivery standards and protocols. The material will be incorporated into a Manual for Maternal and Child Health produced by the EPI/CCCD program. The second volume of the manual, which will include a family planning section, will be distributed to all health centers and will serve as a ready reference source for routine matters.

The preliminary guidelines on family planning standards and protocols focus on policies for recommending oral and injectable contraceptives, IUDs, and condoms. For each contraceptive method there is a description of clinical contraindications and side effects, as well as discontinuation policies. Additional sections of the guidelines discuss family planning counseling and the preparation of statistical reports.

Technical experts who are participating in the development of these materials believe that the guidelines, although preliminary, could be of enormous help in establishing uniformity in the delivery of services throughout the country. (There are important differences among regions in terms of policies for the delivery of services. For example, some health centers allow women to start using contraceptives prior to the onset of menstruation while others do not.) Technical experts interviewed also think that the guidelines will need to be tested and adapted to Burundi's needs.

The preliminary guidelines nevertheless include a variety of service delivery policies and procedures that can significantly influence the degree of access to family planning services, the kinds of contraceptive choices offered the patient, and successful use of contraceptives. Although the guidelines include detailed and complete information on contraceptive eligibility, there is an over-emphasis on restrictions and contraindications for the use of each method. The net effect of this emphasis is to restrict contraceptive access to women with special needs. For example, in the section on policies and procedures for IUDs, only women with certain specific pre-existing conditions are defined as eligible for IUD use, whereas healthy women are not included in this list. A literal reading of this section could clearly prevent health providers from recommending IUDs for healthy women.

In their current form, the guidelines pay little attention to strategies on how to organize services and staff. In addition, there is no policy system that deals with complicated cases or with referring candidates who are appropriate for sterilization.

Conclusions

Preliminary guidelines on family planning standards and protocols to standardize service delivery policies have been developed. Further refinement is needed in some sections, and it is clear that the guidelines are preliminary and must still be adapted to Burundi's particular service delivery needs. The input of health providers has not been included in the development of the guidelines.

Some contraindications currently included in the guidelines, such as proscribing the use of IUDs until three months after delivery (instead of a month and a half), could in some cases be technically unnecessary, and result in missed opportunities for some women who are in fact ready for earlier IUD insertion. Also, health providers know that if women go away either empty-handed or with their second choice of a contraceptive method, they may never come back. Critical to the effort to prevent discontinuation is a complete clinical assessment of the woman's reproductive needs, including any contraindications to the use of specific methods.

Recommendation

20. The project should continue to support the CPPF in the further development and refinement of standards and protocols for family planning service delivery. This support might be provided through direct technical assistance or through financing of a workshop to bring together managers, providers, and other professionals. The project's support should ensure that the final product is responsive to client needs, and should take the following into account:

- All standards and protocols should be sensitive to any possible impact that recommended practices might have on relative degree of access to family planning services. Standards and protocols should be developed within the context of, and with an emphasis on, increasing access to services.

- Standards and protocols should be developed with service provider input and should be tested before being introduced in health centers.

- Standards and protocols should be included in the second volume of the Maternal and Child Health Manual that is being prepared by the EPI/CCCD program. Toward this end, all necessary activity required to develop a final version of the guidelines should be pursued as expeditiously as possible.

2.3.2 Management Information System (MIS)

According to the project agreement, the project is to assist the CPPF in the design and implementation of a reporting system to support a management information system.

Findings

In October 1990, the family planning service data collection system was extensively reviewed with support provided by Pathfinder's MIS consultant. At that time, information was sent directly to the

MCH/FP Unit (and subsequently to the newly created CPPF). As a result, a new data collection form was developed to fulfill the CPPF's needs for improving monitoring activities and program management. The new form was designed to gather only information on the number of new users and the amount of methods distributed, discarding the collection of unnecessary variables such as number of protected women and number of drops-outs, both of which could be estimated from the two first variables. In addition, variables such as number of IEC activities conducted as well as information on referrals were included in the new form.

The current data collection form, which is also used for logistics, provides a basis for estimating the number of new users, the number and type of contraceptive methods distributed, couple years of protection (CYP), and CPR. Although there is some evidence that the number of client drop-outs is very high, estimates of drop-out rates are currently not being calculated. The form was to be gradually introduced into health centers starting in January 1991, but was actually implemented in all health centers at the same time without providing systematic training.

In March 1991, the MOPH directed that all information collected by health facilities be sent directly to a central unit (EPISTAT), which now has responsibility for collecting, processing, and disseminating data. Health officers are in charge of gathering data from health centers and submitting that information to the EPISTAT office. A printout of the raw family planning data (rather than a disk) is provided by EPISTAT to the project, which re-enters the data into its computer, thereby increasing the potential for errors. During 1991, EPISTAT asked all programs to define their information needs in order to furnish them with more analytical data, but the CPPF has not yet been able to respond to this request.

As of 1992, EPISTAT showed that 265 health centers were reporting, although the number that report family planning clients was not readily available. Observations made during field visits indicate that data collection is not always complete and accurate. For example, by April 1992, only 11 out of 25 health sectors had submitted family planning statistics for January 1992. Generally, it takes about three to four months for the health sectors to submit complete program information. Furthermore, differences were observed in the number of contraceptive users reported at the national level and those shown at the provincial level during field visits, clearly indicating that data are not uniformly recorded. To improve data quality, questions on data collection methodology were included in the logistics supervision forms recently produced by the CPPF. During the course of subsequent supervisory visits, it was determined that data collection is poorly understood at the local level. Issues of data collection skills are not included in the family planning training curriculum, as noted above.

It was also observed during field visits that health workers who are not involved in setting objectives have little understanding of the usefulness of the data they collect, which probably underlies the weaknesses in accurate reporting. On the other hand, where workers are involved in goal-setting, there is greater interest in good information. A health sector chief who had formerly been responsible for a health center that performed very well in family planning, was conversant on goals, objectives, and prevalence rates. Another health sector chief in a province where objectives are closely monitored expressed the desire for training in health information systems.

The analysis of 1991 data for evaluation and planning purposes has been conducted by the project resident advisor at the central level. The CPPF has yet to develop such a capacity. As a result of the introduction of new collection forms, it is difficult to do a comparative analysis of 1990 and 1991 statistics.

Conclusions

The project has provided useful technical assistance in the development of a reporting system. Indicators for monitoring family planning progress have been developed as well as a system for the collection of ongoing information. The system remains weak in important areas, however.

- Problems with quality and timely submission of data undermine the reliability of estimates of contraceptive prevalence. At the local level, health workers have not been trained in data collection and analysis; and since they do not generally have input into elaboration of local program objectives, the utility of the data they provide is poorly understood.
- The capacity has not yet been developed to perform data analysis for monitoring program progress at the national, provincial, and local levels. As there are not enough human resources at the national level to perform data analysis, the CPPF has made only limited use of the service provided by EPISTAT. Its main output is an annual assessment of progress toward goals, which is not sufficiently detailed or accurate to provide the basis for a management information system or for the development of realistic family planning objectives.
- There is as yet no systematic analysis of patient drop-out rates, which is critical given the evidence of high numbers of drop-outs.

Recommendations

21. The project should continue to provide technical assistance to the CPPF in order to improve its reporting system and to build CPPF analysis capabilities.
22. The project should assist the CPPF in working with EPISTAT to develop tables of organization of family planning data to assure routine and timely data analysis.
23. Given the high drop-out rate, the project should assist the CPPF in working with EPISTAT to institute a routine calculation of drop-outs.
24. A section on record keeping and reporting should be included in the training curriculum. The project should also discuss with the CPPF the possibility of training health care providers in data use, particularly if they are permitted to have input into the elaboration of objectives, so that the significance of the data they collect could be fully understood.
25. The project should assist in training a specialist on data analysis at the national level.

2.3.3 Contraceptive Logistics Management and Supply

The project calls for development of a system to support contraceptive supplies.

Findings

In October 1990, a Pathfinder consultant assisted with the analysis of the logistics/commodities management capabilities of the National Family Planning Program. This assessment indicated that the internal controls of the CPPF supply system needed to be strengthened and that program administration with regard to contraceptive commodity reporting and accountability needed improvement. It was recommended that certain improvements in the contraceptive supply system be made in the areas of warehouse management procedures, estimation of orders for contraceptives, supervision in logistics management, and data collection. In light of these recommendations, a nationwide contraceptive inventory was conducted in April 1991 and again in September 1991 in order to assess short- and medium-term contraceptive needs and availability. As a part of these visits, the contraceptive reporting system including recording and reporting forms was reviewed, contraceptive procurement tables were developed and provisional estimations of contraceptive needs were made for 1992.

The following recommendations were made: 1) refinement of the existing reporting forms and procedures, critical to the establishment of a complete logistic and management information system (LMIS), and 2) the assignment of a logistics management specialist to the office of the deputy director for administrative and financial services. It was suggested that requisitions be made on a monthly basis to provide data for estimating contraceptive needs at the national level and to provide essential information for program managers at the central level for planning, monitoring, and evaluation functions. Although a logistics management specialist has yet to be hired, there is a full-time warehouse manager who is responsible for commodity purchases and distribution. Improvements have been made in warehouse management procedures which include consistent use of stock cards and requisition forms, placement of supplies in well-ventilated and dry areas, contraceptive supplies accessible for "first in, first out" distribution, and visibility of identification marks and other labels, etc.

In December 1991, a third visit was made to Burundi by Pathfinder's logistics and commodities director to provide technical assistance in determining contraceptive requirements for 1992 and the subsequent three years based on the nationwide contraceptive inventory conducted in September 1991. Service data for the first three trimesters of 1991 were compiled and reviewed. Patterns of requisition and distribution of contraceptives as well as acceptance levels for each health center were determined. Estimates of the number of users and contraceptive needs for 1992 were validated by comparing data obtained from logistics, services, and COCOPLAN (a computer program for contraceptive commodities planning).

The deputy director of finance and administration received training in the management of family planning programs at CAFS in July-August 1991, and in the use of COCOPLAN and the development of contraceptive procurement tables by Pathfinder's logistics and commodities director in December of 1991. Recommendations were made to send the project resident advisor and the deputy director of finance and administration to Zimbabwe to examine Zimbabwe's logistics management system. A supervision form for conducting logistics management supervision activities was produced and a workplan has been developed for 1992 for the quarterly supervision of health centers. Supervision forms were first used in the February 1992 supervision visits to approximately

eight health centers. (Visits scheduled for March had to be discontinued due to gasoline shortages in the system).

Problems in logistics management and supply were discussed with health center personnel during supervision visits. Common problems encountered were inappropriate calculation of maximum and minimum contraceptive stocks (due to an incorrect formula), unavailability of adequate minimum supplies (which are supposed to last for three months), shortages of some contraceptives such as the Microgynon 30 oral contraceptive pill and condoms, and frequent errors in data collection. All of these findings concur with evaluation team observations during field visits. The action plan for 1992 also includes the development of a training manual, a training curriculum, and training for field staff.

Forms currently used at the health center level include a daily register of family planning activities (which is not consistently used in all health centers), a monthly report form for family planning activities (used also for the MIS), a requisition form that includes the incorrect formula to calculate minimum and maximum stock (and thus is poorly understood and little used), and a stock form. Forms utilized provide information on contraception distribution and use in health centers. Information on contraceptive distribution by brand is not included in the forms, however.

Contraceptives for the CPPF are provided by UNFPA and stored in the central warehouse in Bujumbura. In principle, health officers pick up supplies on a monthly basis. Contraceptive supply orders are established primarily on the basis of available transportation, however, rather than on contraceptive supply needs. In order to optimize health sector officers' trips to the capital city for supplies and to ensure adequate supplies, contraceptive requisitions are often inflated and not based on stock and consumptions needs. This results in a misinterpretation of contraceptive demand which, in turn, generates errors in the reporting system that is based on contraceptive consumption. (During 1991, the number of visits to the central warehouse for contraceptive supply provision averaged three per health sector, with some health sectors, e.g., Ngozi, visiting up to nine times.)

Although some contraceptive brands such as Noristerat and Microlut were widely available in the majority of health centers visited, Microgynon 30 was not in stock in most of the provincial warehouses and health centers. UNFPA, the only provider of contraceptives to the Burundi family planning program, is experiencing difficulties in providing Microgynon 30 and other contraceptives as requested because its global 1992 budget has not yet been approved. Although Pathfinder was supposed to contribute \$50,000 in contraceptive supplies, the CPPF has asked to use that money in developing model clinics for training in Gitega and Ngozi. The request has been approved by Pathfinder.

As of March 1992, Pathfinder had provided a total of four technical assistance visits for the development and refinement of the contraceptive recording system of the overall National Family Planning Program contraceptive supply system.

In summary, major outputs have been the following:

- a workplan has been developed to improve contraceptive supply management;
- contraceptive inventories for projecting contraceptive requirements for 1992 have been made through COCOPLAN, using logistics and service data;

- a monthly reporting form for monitoring contraceptive supplies and utilization has been developed, which should reduce workload at all levels and improve accuracy; and refinements have been made in the requisition and stock forms;
- personnel have been trained at the national level in logistics management techniques;
- a supervision system for logistics was developed including supervision forms, schedules, etc.; and
- expired contraceptives have been removed from program shelves, the warehouse has been properly organized, and new contraceptive supplies have been distributed.

Conclusions

Critical improvements have been made with respect to contraceptive commodities logistics and in the quality and timeliness of reporting. The CPPF has made a concerted effort to improve warehouse management procedures. There are still some problems in the estimation of contraceptive orders, however, due to the limitations on available transport to pick up supplies.

With respect to the availability of contraceptive supplies, if UNFPA is unable to meet its commitment of contraceptive supplies to the CPPF, unexpected increases in contraceptive demand in the country could well cause shortages. By March 31 there were, for example, only 26,200 doses of Noristerat left in the central warehouse. Current distribution demand of Noristerat is around 30,000 ampules per quarter.

The CPPF has made considerable effort and has provided substantial central staff time to refine the logistics system. Further training, supervision, and monitoring at the provincial, health sector, and health center levels can respond to certain problems in the ordering and distribution of contraceptive supplies. Other problems go beyond the scope of the project and affect the entire MOPH logistics system. Until the CPPF logistics system is fully operative, it cannot be optimally used for general planning and management.

Recommendations

26. The project should continue to provide technical assistance to the CPPF to improve the contraceptive supply system, exploring mechanisms to improve distribution of supplies on a quarterly basis. Efforts to streamline reporting should continue. Once the logistical, record keeping and reporting systems are firmly established, health workers will need training in all of these areas. Such training could logically be included in the refresher training planned for project years 4 and 5.
27. The project should continue to provide whatever assistance it can to the CPPF in the resolution of the contraceptive procurement problem, particularly the immediate problem created by the lack of approval of the UNFPA 1992 budget.

28. The project should encourage CPPF to take an active role in seeking a long-term solution to the transportation problem (see Section 4.1.2).

2.4 Pilot Alternative Contraceptive Distribution Channels

The project calls for the development of pilot alternative contraceptive distribution channels, based on the premise that the health service delivery structure may be inadequate to meet the demand for family planning services.

Despite high coverage of immunization and pre-natal services (80-90 percent) through health service facilities, general coverage of the population is much lower. There is insufficient information to determine whether the population's perception about the need for immunization and pre-natal services — and the ability of health facilities to meet them — holds true for family planning services. Furthermore, many facilities are religiously affiliated and unable or unwilling to provide effective contraceptive methods.

Finally, an unstated but important reason for early development of alternative distribution channels is that once the population approaches desired levels of contraceptive prevalence, the demand for services will almost certainly be greater than the public health resources required to meet it. Unless the investment in alternative systems is initiated soon, the population will have no other place to turn in the future.

Findings

A feasibility study on alternative distribution channels was carried out in July 1991. The study defined the elements required to ensure successful distribution channels, and explored the potential of the most likely available mechanisms. The study took into account the social, economic, and health context of Burundi by citing what is known about needs and attitudes of the population in rural and urban areas, disposable income, the pharmaceutical industry, service delivery structures used by other sectors, attitudes of those whose participation would be essential, and current activities of government and donors in related areas such as AIDS and community-based health services. Many questions remain unanswered because there are large gaps in information about the population's family planning attitudes and practices, and the results of KAP studies will help to fill the gaps.

The three alternative distribution channels recommended for development on a pilot basis were social marketing through private and parastatal structures, work place distribution, and community-based distribution (CBD). Arguments for and against the potential for success were elaborated, and the implications of each were examined in detail: price and product; role of the commercial sector, health professionals, and government officials; and promotion and distribution approaches. Recommendations were also made with respect to strengthening the existing health care delivery system and profiting from certain AIDS activities to expand family planning IEC efforts. The observations underlying these proposals are both pertinent to and supportive of recommendations made in this evaluation report for increasing the project's impact on the national family planning goals, and are thus discussed under that section of this report (see Section 3).

The feasibility study was submitted to the MOPH through the CPPF. The study included an extensive list of actions and decisions required by the MOPH for the initial stages of implementing

the recommendations. Actions include extensive negotiations with private and parastatal employers, the pharmacy profession, businessmen, and parastatal and public agencies which would be integrally involved in any of the three channels of communication. Decisions include approval and authorization required for developing the many modes of distribution and for provision of the contraceptive methods involved. Successful negotiations, approval, and authorization would have to precede the development and training activities for each pilot. There has been no formal, direct response to the study, but the Medium Term Plan for family planning proposed by the CPPF includes pilot alternative delivery systems as a strategy for expanding access to contraceptives. The project's resident advisor, with the agreement of the CPPF director, is now preparing a follow-up visit by a team that will include specialists in CBD, IEC, and social marketing. The team will submit a proposed design of an integrated pilot project to use as a basis for discussions with MOPH officials.

Conclusions

The recommended contraceptive distribution channels — private and parastatal structures, work place distribution, and community-based distribution — are probably the most promising options available in Burundi. The feasibility study is a high-quality product, and its recommendations are solidly supported by what is currently known about Burundi's economic, social, and health context. Some unanswered questions should be answered by the KAP study, while others can only be answered by carrying out the pilot projects.

An aspect of the CBD proposal which may become problematic is the choice of the UNICEF project in Muyinga as a site. According to the team of the recent Health Sector Assessment, the London School of Tropical Medicine and Hygiene raised serious concerns about the project in a recent visit. *Even if* these concerns are addressed, however, it may not be advisable to tie together the destinies of two related but separately controlled experiments by placing them in the same location, since problems with one will taint the other.

The recommended channels of distribution are practical and highly desirable, but they also require enormous preliminary efforts to implement. They will involve extensive negotiations and collaboration with — as well as training of — large numbers of disparate individuals in private business, the pharmacy profession, the public and private health sector, and the community.

As the document is currently written, the list of actions and decisions suggested as the next steps for the MOPH to implement the recommendations, are necessary. They are far beyond the resources of the MOPH to consider doing all at once, however. Although some are grouped in chronological phases, they are not sufficiently prioritized to permit the MOPH to easily select among them in order to phase in the pilot programs gradually.

Thus, to respond adequately to the document in its current form, the MOPH would have to simultaneously judge the feasibility of the proposals and commit considerable resources to undertake immediate actions. Regardless of the project's ability to provide consultants and resources for the effort, the MOPH would still have a responsibility to assign the type and number of personnel needed to oversee such a pioneering effort adequately, forge new relationships, and mobilize research and evaluation resources.

The lack of a formal response to the study by the MOPH should therefore not be viewed as disapproval or refusal to consider changes in current health care practices. Based on interviews with CPPF personnel, and the proposal in the Medium Term Plan to initiate such pilot activities, it is more

likely that the study is simply overwhelming. MOPH officials are cautious about changing such health care practices as medical consultations for oral contraceptives. Even to move forward cautiously on an experimental program, as the MOPH seems willing to do, requires sufficient professional staff and an appropriate range of expertise within the ministry for officials to be confident that they can provide leadership and oversight.

Recommendations

29. It is essential that the follow-up team being brought in by the project to develop a more concrete proposal also propose a phase-in of the pilot projects so that the amount of work required by the MOPH is in line with its capacity for high-level management and oversight.
30. To phase in the pilot projects as practically as possible, the team needs to work closely with those who are likely to be designated by the MOPH to oversee the projects.
31. The selection of Muyinga as a site for the CBD pilot project should be reviewed even if concerns about the current UNICEF-supported activities are addressed. Before finally deciding to use the Muyinga site, consideration should be given to the following alternative sites: a) the Gitega model clinic, if it proceeds in a timely fashion; and b) a demonstration program, as recommended in Section 3.4.2, which would be developed for the purpose of strengthening health center services. (The latter alternative was also suggested in the feasibility study.)

2.5 Project Management

This section assesses project management, and not CPPF management of the national program. Project management responsibilities are generally described in project documents, and not in terms of specific objectives. It is reasonable to expect that project management includes efficient use of resources, implementation of activities according to workplans, provision of timely and appropriate technical assistance and other inputs, and proper stewardship of funds. Project management also includes cooperating and coordinating with other MOPH offices, other ministries, and donors.

Under terms of the project agreement, the government is expected to provide a permanent interministerial donor coordination mechanism and to convene regular donor meetings, in which the project will participate as appropriate. The government is also expected to make available sufficient personnel to carry out project activities, and in general to commit to integrating project activities into the national program.

USAID/Burundi, in view of the small staff available to assume management responsibilities, expressly elected to administer the project through a cooperative agreement with an appropriate and qualified agency, Pathfinder, in order to keep USAID's administrative tasks to a minimum. USAID is expected to approve workplans, to monitor and evaluate progress of the project, to make site visits and meet with ministry and project staff, and to participate in the selection of the resident advisor.

Findings

Specific objectives and activities have generally been carried out according to approved workplans, and where they departed from plans the causes for changes are clearly documented. The most common departures from planned activities have occurred as a result of needs assessments that have identified alternative or additional strategies, or because personnel and resources of the MOPH have been insufficient to achieve targeted objectives in the time period anticipated. Delays have also occurred when vehicles have been unavailable, or as a result of certain time-consuming procedures, such as the government's requirement that three curricula vitae be submitted through a cumbersome procedure for each consultancy.

Extensive documentation is available on the timing, content, and outcome of technical assistance and other interventions. Project quarterly and annual reports, trip reports, consultant documents, and a recent internal evaluation provide a detailed accounting of project activity, problems, successes, and level of actual versus expected output.

Most of the training outputs are generally on target or ahead of target, taking into account decisions to modify some activities, such as IUD training. The most noticeable delays have been in the areas of IEC program development, pilot alternatives, and management information. Fieldwork for a KAP study critical to IEC, developed in July 1990 and approved by USAID in October 1990, was not conducted until October 1991 as a result of delays in obtaining ministry approval, and results are not expected until the end of April 1992. As stated in Section 2.4, the feasibility study for pilot alternatives was conducted and submitted to the MOPH over six months ago, but the ministry has not yet acted on it. The MOPH central health information division has waited for the past year for the CPPF to present it with specifications on how CPPF wants family planning data analyzed and presented. Currently, the division merely provides print-outs of raw data and the project enters the data into its own system for analysis.

In general, over 70 percent of the total amount of technical assistance inputs planned for the first three years of operation has been provided in the first two and a half years (42.4 of the 59 person-months envisioned). Since the assistance for the first six months of project management had not been planned, however, the proportion of inputs in the four technical program areas is significantly lower than planned for three years: one third of planned inputs have been provided for each in training and IEC, one half of planned inputs have been provided in management information and logistics, and one fourth of inputs provided for pilot alternatives.

Pathfinder has provided financial oversight through audits. No serious problems have been identified in financial management. It is anticipated that by the project completion date there will be a fund balance, and a no-cost project extension has already been informally requested.

The government has not yet provided a formal mechanism for interministerial donor coordination. Nonetheless, several collaborative efforts have been undertaken with other MOPH offices, other ministries, and donors. These include joint sponsorship of training and conferences, development of draft clinic protocols, production of a training curriculum, and IEC activities.

It was clear from interviews with different donors, however, that there is little purposeful coordinated planning of support for the national family planning program. For example, the first secretary of the German Embassy stated that her government was not funding family planning activities. Nonetheless, other persons interviewed were certain that such assistance was indeed being provided. Furthermore,

interviews revealed that there are differences in outlook between UNFPA and the project which the UNFPA and project staff have not resolved. The UNFPA representative expressed a strong desire to have a closer working relationship with the USAID mission, apparently in part due to these differences.

The government has also not yet provided sufficient personnel to carry out all activities as planned, and there are vacancies in a number of positions planned for the CPPF. The director and staff, however, as well as staff from central MOPH IEC and training divisions and the periphery, have participated to the limits of their ability in implementing project activities. Particularly noticeable is the absence of full-time personnel in the high-level management functions, IEC, training, and management information systems. The project has received approval to bring in a long-term advisor in IEC to strengthen activities in this area.

The USAID mission does not have a health or population officer, but it has approved all workplans and has been available to discuss the project when needed. More recently, staff have instituted regular health meetings to increase mission participation in project developments. The mission also provided the necessary support and guidance for evaluating the project.

The resident advisor will be leaving within the next two months, and a replacement will have to be recruited. The director of the CPPF believes that the recent arrival of a physician on his staff, financed by UNFPA, may make it less imperative that the next resident advisor be a physician. The director believes that the next incumbent should be an experienced manager.

It should be noted that the project does not include a population planning or policy component. Nonetheless, the project has participated in conferences and meetings aimed at developing a population policy, which has been urged by high-level officials, including the president. The Ministry of Plan hopes to finalize the policy in 1992 but may not have the funding required to complete a series of workshops.

Conclusions

The resident advisor, and Pathfinder generally, have provided high-quality, competent management for the project, and have overcome a number of significant obstacles. Pathfinder and CPPF staff have worked very hard to carry out activities as planned, despite the government's inability to meet expected commitments of personnel and mechanisms for coordinating with other ministries and donors.

Due to the small size of the USAID mission, the resident advisor has had less support for management than was originally hoped for. Furthermore, there is no regular donor coordinating mechanism, resulting in more pressure on the project to communicate with donor agencies on matters more appropriate to the USAID mission. This is not an entirely appropriate role for a project.

Technical assistance and other inputs have been appropriate, timely, and effective. There has been a welcome continuity in the individuals who have provided consulting services. Documentation is meticulous and provides a valuable history of family planning program development in Burundi. Changes from approved workplans are reasonable. In view of the good performance on specific objectives, the changes from the original project strategy, and delays in certain areas, the amount of input provided to date in comparison to what was planned seems very reasonable.

The departure of the resident advisor raises the potential of disruption in project activities. It also provides an opportunity to bring other kinds of expertise into the national family planning program, however, because a resident advisor has a dual role of administering the project and acting as technical consultant. The CPPF director is particularly interested in someone with management experience. In Section 3 of this report, a high-level management capacity for directing a national program is identified as an area in need of strengthening. Someone with solid management skills would therefore make a significant contribution to family planning in Burundi.

In view of Burundi's dense population and the urgency with which high-level officials view the need for population planning to slow fertility, the project has an opportunity to expand its support in this area.

Recommendations

32. To strengthen the capacity of the CPPF to participate in the management and coordination of project activities, the project should proceed as planned to fill the approved long-term IEC position, and other such positions should be considered for funding in those areas which are critical to achieving specific project objectives.
33. USAID should increase its health and population presence in order to fulfill its role in project management and donor coordination, and should take immediate steps to forge a closer working relationship with UNFPA.
34. The selection of the next resident advisor should be heavily weighted toward someone with strong management experience.
35. The project should participate in all financing required to finalize a population policy in 1992.

3. Impact of Project on Burundi Family Planning Goals

3. Impact of Project on Burundi Family Planning Goals

3.1 Progress toward the Project's General Objectives and Purpose

3.1.1 General Objectives

Expanded Availability of Services

It was anticipated that project activities would meet critical gaps that had been identified in the national family planning program, thereby expanding availability of services. Although it is difficult to qualitatively measure "availability," and therefore to quantify progress in this regard, it is possible to identify a relationship between the project activities and expanded availability.

In the health centers visited, it was apparent that those who were trained are able to organize services, they have a good level of understanding of the benefits of family planning, and they recruit clients within the health facility who come for other services. In view of the number of providers who have now been trained, it can be reasonably assumed that similar quality is being provided in many more health centers. Contraceptive logistics management is ensuring a more stable source of contraceptive supplies. In a province where the provincial medical chief had been trained as a trainer under the project, the number of users has increased markedly in 1991 over 1990. The provincial medical chief believes community outreach activities — initiated even before IEC agents were trained — have been partially responsible, an effort which trained IEC agents are expected to continue.

There continue to be restrictions on availability of services in areas where the project had hoped to have an impact. The range of contraceptive methods offered is limited primarily to injectables and pills. Expansion of methods including IUD insertion, VSC, and Norplant requires a number of actions in training, provision of equipment, and donor coordination. Standardized service protocols — developed with project assistance — have not yet been implemented, presenting an obstacle to more effective training and services provision. The impact of training inputs are limited by lack of supervision and follow-up, which are system-wide weaknesses affecting all services. Finally, the IEC effort has been slowed by delays in the KAP study, and the absence of a strategic IEC plan. These and other limitations on availability result from constraints which are beyond the capability of the project to address unilaterally and are discussed in Section 3.2.

90,000 Active Users Served by Trained Personnel

According to the project agreement, by the end of five years there are to be approximately 90,000 active users of family planning services served by trained personnel. At the end of two and a half years, a total of 212 of the targeted 450 health personnel have been trained in family planning. It is difficult to estimate the number of family planning users served by trained personnel, however, since data showing trained personnel by health center and number of users are not readily available.

During the four years from 1986 to 1989, the number of clients was reported to remain at 13,000 and dipped to 11,725 in 1989. It was projected that in the first 12 months of the project the number would increase from 13,000 to 16,000, and in 24 months the number would reach 32,000. In the 15th and 27th month of the project the numbers increased to 17,740 (1990) and 26,478 (1991), the latter figure estimated to equal 30,492 couple years of protection. During the first of these two years the

project carried out such preparatory activities as research into attitudes and practices, training of trainers in clinical and IEC skills, and management training for provincial medical directors. Thus, progress in the number of users is encouraging considering that the impact of all these preparatory activities has been felt only recently.

Clearly it is not within the project's ability to control all the factors that lead to increased numbers of contraceptive users. The goal of achieving 90,000 active users is realistic, however, if the current rate of a 50 percent increase per year is maintained. If the apparent problem of a high drop-out rate is addressed, the target may be surpassed.

Increased Capacity to Plan and Manage Training Programs

The capacity for planning, conducting, managing, and evaluating family planning training has not yet been institutionalized, but it has been significantly strengthened by the project. In the initial clinical family planning TOT in May 1990, a Pathfinder consultant worked with the MOPH director of training on the elaboration of the training curriculum. During the TOT, the regional training team was introduced to, and applied, the concepts of training needs assessment, adult learning theory and techniques, elaboration of training curricula, participatory training techniques, and evaluation of training. Practical exercises were used at each step to facilitate application of concepts taught. Time did not permit sufficient practice and feedback, however, to enable trainers to master all elements of planning training (including needs assessment and curriculum development).

In turn, the director of training and the CPPF assistant director for technical services elaborated the curriculum for clinical family planning training. The Pathfinder consultant worked with several members of the regional training team on the elaboration of the interpersonal skills aspect of the family planning training curriculum. Both components of the curriculum were slightly modified by members of the regional training team based on their experience with it in training service providers in family planning.

Two members of the regional training team were sent to an external training for trainers. This experience has added to their skills in planning and evaluating training.

With the recommended curriculum revision session (see Section 2.1.2), regional trainers will be able to reinforce their skills in needs assessment and curriculum development. Likewise, training in communication/IEC skills and logistics/MIS (see Section 2.1.1) will make them more effective family planning trainers and will provide them with skills that are transferable to other aspects of service provision.

The CPPF does not have a professional staff person experienced in human resources development, however, and has relied on the assistance of the MOPH director of training who has ministry-wide responsibility and few staff. As a result, there is as yet no long-range planning and management function for training programs within the CPPF that would ensure ongoing, national needs assessments for both new skills and refresher courses, as well as systematic and prioritized training by personnel category and geographic area.

Increased Capacity to Plan and Manage IEC Programs

The project has also contributed to the strengthening of the institutional capacity to plan and manage IEC programs by supporting IEC staff of the CPPF and the staff of the Health Education Unit (HEU) of the MOPH — which has ministry-wide responsibilities — in the following ways:

- in-country training on techniques of formative research for IEC;
- guidance in
 - planning, implementation, and analysis of qualitative research in IEC;
 - development of IEC audio and visual material;
 - evaluation of IEC materials and radio programs;
- external short-term training on the management of family planning IEC programs (CPPF staff); and
- training in training techniques for family planning IEC (CPPF staff).

The CPPF IEC unit and the HEU do not yet have the capacity to effectively plan and manage a national IEC program, including the production of materials and the training and supervision of IEC personnel. A major limitation to their capacity to meet this challenge at present is a lack of personnel. The CPPF has four professional staff working in IEC (one physician, two nurses, and a social worker) who are primarily involved in training. The HEU has approximately 12 staff to meet the IEC needs of all health services.

In an effort to overcome these obstacles, the project has had to use the private sector to accomplish its objectives in materials production, and is trying to hire a local IEC specialist to reinforce the management of IEC activities.

3.1.2 Purpose: Increased Contraceptive Prevalence Rate

According to the project agreement, by the end of the project period in 1993, the CPR for all methods will have increased from 1.2 percent to 7.6 percent.

Based on the number of users in the health care delivery system alone, the project estimates the CPR has increased from 1.9 in 1990 to 2.6 in 1991. Although CPR has increased only 0.7 points, these figures have doubled in at least seven health sectors out of a total of 25. Compared to 1990, the CPR has shown an increasing trend in all 25 health sectors.

As with numbers of users, there are many factors that affect CPR which are beyond the control of any single project, including the type of contraceptive chosen. It is interesting to note that the UNFPA had targeted a 7 percent CPR for their 1988-90 project period, and that the World Bank targeted a 14 percent CPR for the project period ending in 1992.

The targeted increase to 7.6 percent was based on the CPR found in the 1987 DHS, which measured the CPR based on interviews. Since the project bases CPR only on reported number of users in health centers, the CPR may be somewhat higher. The KAP study should provide the basis for estimating CPR comparable to the DHS, and for revising the target, if appropriate.

3.2 Determinants of Project Effectiveness

3.2.1 Facilitating Factors

A strength of both the project design and the overall family planning strategy pursued by the CPPF, is the effective use of scarce resources to achieve what might not otherwise be possible. Investments are focused on activities that can become permanent components of the national program, and the extensive project activities are carried out using existing human resources rather than creating large cadres of new personnel.

For example, training has been expanded by making an initial investment in curriculum development and training health providers as trainers, then using the trainers — who have other responsibilities in the health care system — to train other service providers. An investment is also being made in developing pre-service training to ensure that future entrants into the health care field are already skilled in family planning.

Another example is development of the IEC program, which must be heavily weighted toward interpersonal communications to be effective in Burundi. Rather than creating a corps of national outreach workers, training is provided to people from multiple sectors who have other functions in the community. These IEC agents will integrate family planning information and outreach into their other activities.

Another factor enhancing project impact is that efforts have been made by the MOPH to improve the quality of the organized health care delivery system through which family planning services have been delivered, as well as to strengthen certain family planning areas. The number of personnel is being increased in some health centers; provincial medical chiefs received short-term in-country management training while some have been receiving longer-term training abroad; some health center personnel who have performed well in preventive health and family planning services have been moved into key positions (e.g., paramedical school faculty, health sector chief in model clinic area); the capacity of a centralized health information system in the MOPH is being expanded; and steps toward decentralization have provided more direct control at the health sector level over medical supplies and gas for vehicles.

3.2.2 Constraints

There are limits to resources no matter how efficiently they are used. This section describes how those limits prevent the project from have a greater impact on national family planning goals.

Resources for Managing the National Program

The CPPF has reached, if not surpassed, its absorptive capacity. It is unrealistic for donor agencies to continue offering assistance to strengthen institutional capability, when there simply are not enough staff whose capabilities could be strengthened. In light of the general scarcity of MOPH human resources, it is to the credit of CPPF staff, the resident advisor, and peripheral staff, that project activities have been carried out as well as they have. This is due in part to the project design which calls for using peripheral staff as trainers, rather than building up a full- time central level training staff.

The creation of the CPPF is an encouraging sign of high-level commitment to a strong family planning effort in Burundi. Management of the national family planning program, however, is carried out by a small number of professional staff not much larger than the one that supervised project activities in the very low-level former MCH/FP Unit. The project is hiring someone to help speed up IEC activities, and an expatriate physician was recently placed in the CPPF with UNFPA financing to strengthen quality assurance efforts. For the most part, however, the primary change in management since the creation of the CPPF is an increase in responsibilities and pressure on a small staff. Although a balance must be struck between management and service delivery demands, given the emergent nature of Burundi's family planning program, the current level of management resources will undermine services delivery efforts.

There are no professional staff to develop, direct, and evaluate a nationwide IEC program, to plan and manage a national training program, to develop and maintain a management information system, and to conduct research and evaluation. The existing staff are insufficient to carry out responsibilities for planning, managing, and supervising quality family planning services throughout the country.

Although it is not intended that the CPPF duplicate the health education and training resources which other MOPH offices are supposed to furnish, it must be able to draw on those resources to ensure that family planning IEC and training activities are implemented. Staff from these MOPH offices are cooperative, but have apparently also reached their absorptive capacity.

The lack of human resources for directing a national program which is just emerging threatens to undermine recent gains in expansion of services and increased numbers of users. The impact can be measured in a number of ways. For instance, the development of the Medium Term Plan for family planning and maternal health services by the CPPF is a potentially significant step toward a more coherent and vigorous national program. The CPPF director made a commendable effort to mobilize professional expertise from several agencies to produce the plan. It promises to give far stronger direction to other ministries and donors, reducing the discouraging fragmentation that has characterized family planning activities in Burundi. In the absence of more high-level management professionals and appropriate technical staff, however, the CPPF cannot possibly translate the plan into effective action. As it is, the CPPF director must rely on a consultant financed by the World Bank to develop the operational phase for the plan, just as he had to rely on UNFPA assistance to develop the plan in its earliest stages.

An inadequate amount of central level human resources also has an impact at the provincial level, which is critical to a successful national program. The provincial level needs strong direction toward strategic national goals, quality assurance guidelines and technical resources, feedback on its performance, and technical support for carrying out training and IEC objectives established in the context of national goals. These require frequent, continuous contact with appropriate professional staff. The lack of sufficient management and technical staff at the central level weakens the ability of the provincial level to plan, direct, and evaluate family planning activities and to support health sector chiefs in carrying out critical supervision of health centers.

An encouraging development is the introduction of family planning and maternal health coordinators on the staff of provincial medical directors, who will have program development — as opposed to supervision — responsibilities. These staff will measurably expand the ability of those directors to organize resources for training and IEC activities in their geographic areas, so long as the coordinators are equipped with sufficient resources to be mobile. The CPPF director will shortly be recruiting part-time coordinators in the five most populous provinces.

Some officials who were interviewed indicated that the government is willing to hire Burundian professionals on a consultant basis to perform program tasks, but it was unclear whether such practices are ad hoc or part of a policy. It was also suggested that donors consider paying salaries to hire needed staff. UNFPA has already expressed a willingness to provide additional long-term expatriate advisors to help fill the void, and is waiting for a response from the MOPH to its offer.

In addition to the number and type of staff required to launch a vigorous national program, a critical determinant of their effectiveness is their mobility. The issue of mobility is defined in terms of gasoline, vehicle maintenance and repair, management of the motor pool, and the quantity of vehicles. It was not possible in this evaluation to determine the adequacy of vehicle support for the CPPF generally. The UNFPA representative reported that seven vehicles had been given to the central level over the years. Nonetheless, project activities are often delayed, and routine supervision has not been possible, because only two vehicles are specifically designated for project support and that number is insufficient. Other vehicles may be available but only by chance.

Follow-Up and Supervision of Trained Personnel

A major constraint on project impact is the lack of supervision of both service providers and IEC agents. In the absence of follow-up and supervision of trained personnel it is not possible to assess the effectiveness of the training, to identify and resolve obstacles to performance of trained personnel once they are back on the job, and to meet needs for additional or refresher training.

In principal, the MOPH has a structure for the supervision of its personnel in the field. This structure consists of provincial and health sector officials, supervisory forms, and a vehicle for each health sector chief. This structure is not at present functioning in a way that provides the necessary support to health workers, however. This is due to a variety of reasons including inadequate transport, lack of orientation to quality of care issues in supervision (as reflected in supervisory forms), and lack of a realistic strategy for supervision. For example, health sector chiefs who were interviewed expressed differing opinions regarding necessary frequency of supervision. Finally, health workers have not generally been involved in setting program objectives, so that even when supervision does occur it is not based on performance goals into which they had input.

Although lack of supervision is noted as a constraint in the project technical proposal, the project is not designed to address it. For instance, the health sector chief is in charge of supervising all preventive and curative services offered in health centers, including family planning. Although the project planned for, and supported, management training (including supervisory training) for the provincial level officials, no provision was made for training at the sector level. Additionally, the project technical proposal acknowledged, but did not address, problems of mobility (vehicles, gas, and vehicle maintenance) as constraints to supervision.

The CPPF has made an effort to furnish service providers with the technical support they need in delivery of family planning services through a family planning clinical supervision plan by central staff for 1992. Due to transportation problems, the plan has not been routinely implemented. In the first trimester of 1992 supervision, was only conducted in February out of a schedule planned for every month.

Thus, given the system-wide weakness in supervision of health care facilities and the centralized nature of technical support for family planning services, follow-up and supervision of trained personnel is sporadic.

The MOPH is beginning to address the problem of adequate and decentralized staffing for both technical support and supervision, with the creation of two new cadres of health workers at the provincial level (both from internal movement of personnel): family planning coordinators and IEC/hygiene coordinators. Family planning coordinators will have an important role in providing program and technical support in family planning to health sector chiefs, but will not provide direct supervision; IEC/hygiene coordinators will assist with the training and supervision of IEC agents. In order for these health workers to be effective, the CPPF/MOPH will have to ensure adequate direction and support from the central level. (See discussion of central level constraints above.)

Strategic Plan for Coordinated National IEC Campaign

Until recently, there has been no national strategic plan for IEC activity. Family planning IEC is being done by several ministries and with the assistance of several donors, each with its own mandate. Ministries include the MOPH, Ministry of Communication, Culture and Sports, Ministry of Promotion of Women and Social Protection, Ministry of Primary and Secondary Education; donors include UNFPA, UNESCO, UNICEF and USAID. On the one hand, this multi-ministry, multi-donor approach enables far greater coverage of the population than would be possible if such activities were centered in only one ministry (and/or assisted by only one donor). On the other hand, it is a challenge for all involved in family planning IEC activities to coordinate their messages so that they are uniform and their activities so that they are complementary. The lack of a national family planning IEC strategy, which would guide all partners in these endeavors, has contributed to the creation of a number of IEC "projects" and to a certain amount of duplication of effort and confusion.

There have been increasing efforts to overcome these problems through collaboration between ministries and between donors. Examples of such collaboration include the following. Ministries (principally the MOPH and the Ministry of Communication) and projects involved in the production of materials consult each other so as to avoid duplication of materials and to ensure that materials benefit from diverse reviews and feedback. In the TOT/IEC training, personnel of five ministries and the Burundian Women's Union (UFB) participated and pledged support of IEC activities in the field, and all ministries represented in the TOT have involved their personnel in family planning/IEC training in one way or another. It is not clear how the UFB has utilized this training.

In the training of IEC agents in the field, the Ministry of Primary and Secondary Education and the Ministry of Promotion of Women and Social Protection have seconded staff trained in the TOT to assist the USAID-Pathfinder Population Project/CPPF. The Ministry of Communication has its IEC project with its own strategies. In that the strategies are very similar to those of the USAID-Pathfinder Population Project, they participated in the TOT and they conduct parallel IEC training at the same sites at the same time as the USAID-Pathfinder Population Project/CPPF, thus doubling the number of agents trained at a time. The two ministries/projects also collaborate in the use of vehicles to support training activities and in supervisory activities.

The Medium Term Plan of the CPPF (published in December 1991) includes an IEC strategy. Although this strategy still needs further refining, it is a good beginning and is a sign that the CPPF is taking leadership responsibility for this element of the family planning program. The full development of this strategy will serve as a guideline for all IEC inputs and help interested partners to focus their efforts. As for other central level activities, the elaboration of this strategy suffers from the lack of sufficient human resources within the CPPF IEC unit.

Health Services Delivery System

In the past few years, the MOPH has taken many steps to improve the national health care delivery system. Within the limits of its resources the MOPH is attempting to expand the number of service providers, which currently number about 4,000 in a system apparently built for 9,000 (32). Last year a health information system, EPISTAT, was installed to improve planning and evaluation of all health services (see Section 2.3.2). The training and IEC activities of the project make maximum use of existing resources by using service providers as trainers, and using community-based personnel of other agencies as IEC agents.

Nonetheless, the organized health care delivery system presents problems that prevent the project from having a greater impact on national family planning goals. This section focuses on weaknesses in the organization of clinic services, the range of contraceptives available, and health service delivery policies. Although supervision of health center personnel is another problem, it is discussed more fully in the previous section related to follow-up of trained personnel.

Organization of Services. Family planning services were first introduced at the health center level in 1982 with support provided by UNFPA, and are currently available through most public and some private health facilities, with the quality of services assured by the CPPF. In addition, natural family planning is provided in health centers run by the Catholic Church, although information is not readily available on the level of these services.

Government figures show that 90 percent of the population lives within a range of 6.5 kilometers from a health center. Access to services is probably limited, however, by long walking distances due to the mountainous terrain, particularly during the rainy season, making it difficult for women to return for their fixed appointments for pill refills and injections. There is no outreach component built into the health care delivery system, although special informational campaigns have been undertaken in conjunction with a particular service such as immunization or family planning.

Family planning services are usually delivered by physicians, medical technicians, and nurses for whom the delivery of family planning services is only one among many other preventive and curative activities with which they are generally charged. In some health centers, particularly those attached to hospitals, health workers provide only MCH/FP preventive services. The number of health workers per health center ranges from two to four or five. Average client load is 60 to 100 patients per day. Curative activities carried out in health centers, which generally function as out-patient clinics, are often limited to providing medicines without performing many physical examinations.

Training of providers in family planning seems to have produced a positive influence on quality of services. In health centers where trained personnel were interviewed, the services are well organized and particular attention is given to family planning. For instance, family planning services are provided in an area physically apart from other services by a different staff, so that clients do not have to wait in line with everyone who comes to the center. Knowledge of contraceptive methods was fairly appropriate, although oriented toward issues of side-effects and contraindications. There appeared to be fewer drop-outs in these centers. Medical screening prior to provision of methods is important to ensure the healthiest choice of contraceptives. Given the very basic infrastructure existing in health centers, simple procedures such as blood pressure checks are performed for clients in those places where instruments are available.

Provision of high-quality routine family planning operations needs to include a rationale for the organization of services, particularly with respect to waiting. To avoid long waiting, some health centers that are not able to organize services in an area physically apart, provide family planning services at separate hours, for example, in the afternoons. Otherwise, services are generally provided on a first-come, first-served basis. Women coming to collect their re-supply of oral contraceptives also have to wait in a queue. Although clinics visited tended to be overcrowded, clients were treated with respect.

It was apparent from staff interviews and observations that some groups with special needs are not particularly targeted for family planning. In some cases, family planning services are not systematically offered to all mothers coming for well-baby services, but only to women over 35 with high parity. Young women, who tend to be more motivated for birth spacing, are not usually targeted for family planning at all.

Availability of Contraceptive Methods. Although a variety of modern contraceptive methods have been introduced in Burundi, choices are generally limited to injectables, pills, and condoms at the health center level. Injectables and pills (only Microlut) supplies were adequate in the seven health centers visited. Mycrogynon 30, however, was not in stock at either the central warehouse or at the health centers because UNFPA, the only provider of contraceptives to the program, is having some difficulties in shipping in new stocks of contraceptives. The limited choice of contraceptives in general is due to a lack of personnel trained in other methods and lack of equipment and sterile conditions for the IUD and VSC. Health workers tend to recommend what is available in their own health centers, thus the IUD and VSC services are not usually offered nor are clients referred for these services.

The referral system for IUD and VSC is almost nonexistent in health centers located far from hospitals. Although services for IUD insertion and VSC are sometimes available at the hospital level, referral linkages from health centers attached to hospitals are also very weak. The level of contraceptive knowledge of the providers interviewed — although much based on side-effects and contraindications — was fairly appropriate for those who have already been trained.

IUDs are available in only a few places that have trained personnel and equipment. Health workers appeared to be enthusiastic about being trained in IUD insertion, however. Equipment and sterile conditions for IUD insertion will need to be improved. Model family planning clinics are being established in Gitega and Ngozi which will offer training opportunities in IUD insertion for health workers.

VSC procedures are performed in some hospitals of the country. A training facility being built with support from AVSC and the government is nearly completed. Some physicians have already been trained elsewhere to perform VSC with minilaparotomy and local anesthesia techniques. Where there are trained physicians, several women have chosen VSC. VSC is not consistently offered as a family planning method, however. There are no laws and regulations applying to surgical contraception nor printed consent forms. Critical regulations such as the establishment of a minimum age to perform VSC procedures have not yet been established. Generally, minimum age for VSC is being established directly by providers. Some providers, however, restrict access by employing arbitrary age and parity formulas. Utilizing the "rule of 120," a woman would qualify for VSC only if her age multiplied by the number of living children equals 120 or greater, i.e., a 30-year-old woman would need four or more children to qualify. Vasectomy has not yet been introduced in Burundi.

Norplant, the registered trademark of the Population Council for contraceptive subdermal implants, has been brought into the country by UNFPA. Customarily, the Population Council is the agency in charge of conducting clinical trials before formally introducing Norplant to any country. To avoid high rates of drop-outs, the Population Council ensures that Norplant users are carefully selected and their profiles precisely established. The Population Council has not yet begun work in Burundi but has apparently agreed to come to Burundi in response to UNFPA's request. Four physicians have already been trained by Norplant trainers from Senegal who were invited by UNFPA. Approximately 70 women were recruited for the trial program. A newly appointed UNFPA physician advisor to the CPPF is responsible for conducting follow-up studies on Norplant users recruited during the training program.

Service Delivery Policies. Service delivery policies — including administrative regulations, clinic procedures, and service protocols — are critical to family planning programs. They affect not only the services provided but the patient's choice and successful use of contraceptives. There are no specific written service delivery policies in Burundi, although some policies regarding clinic procedures are transmitted through training and supervisory activities, and the patient record form for contraceptive visits includes a detailed questionnaire that guides contraceptive counseling. In the absence of written policies and detailed procedures and protocols, however, family planning practices can change from one center to the other.

In some facilities visited, there appears to be little consideration given to the impact that practices may have on access. For instance, women may be required to have their husband's consent before choosing any contraceptive. Women may also be required to be menstruating in order to receive a Noristerat dose, without being offered an alternative temporary method. There are also a number of regulations regarding contraindications which tend to limit access to services (see Section 2.3.1). In contrast, the potential health benefits of family planning are not usually emphasized, and the risk of contraceptive use is not compared to the risk of another pregnancy. In addition, cultural, social, ethnic, or political issues do not appear to have been taken into account before administrative decisions and policies were established.

With respect to clinic procedures, a practical patient medical record is generally filled out by health personnel. Where instruments are available — which is not always the case — procedures such as weight and blood pressure checks are being performed. It did not appear that counseling of family planning clients was accorded much attention. The referral system for complicated cases appears to function in health centers attached to hospitals. For example, women who have been on injectables for a while and are experiencing problems in becoming pregnant are usually referred to hospitals for treatment.

With respect to supervision of health center activities, interviews revealed an approach which appears to be hierarchical and authoritarian in nature, as opposed to helpful in the sense of a collegial search for solutions to problems in order to benefit clients.

Although accurate national figures are not available, available client data indicate that drop-out rates may be very high. In one province, for example, records show that almost 50 percent of users apparently discontinue use within three months. Some measures have been taken to follow-up on clients such as cards sent to patients missing appointments, etc.

Summary. The quality of family planning services provided is very uneven. In some health centers visited, including those where personnel are trained, quality services are provided within the limits

imposed by numbers of clients and size of the staff. Health personnel are often overworked which seriously limits the quality of services provided.

Contraceptives are limited to clinic-based distribution at fixed facilities, which restricts access of those women living far away from clinics. There is no systematic outreach component using mobile clinics or outreach workers.

Contraceptive availability is very much limited to two contraceptive methods which are available at the health center level. There is no formal and structured referral system established for IUD and VSC services. Availability of IUD and VSC services remains limited to hospitals, and in the case of IUD, to some health centers attached to hospitals. Equipment and conditions in health centers are not adequate for delivering IUD services.

In the absence of standardized, written policies, access to services is limited by the abundance of regulations regarding contraindications for contraceptive methods. The emphasis is therefore on restricting eligibility for certain methods, so that health benefits of family planning are not emphasized, and priority is not given to increasing access.

The lack of emphasis on promoting family planning is reflected in the weakness in counseling and follow-up, which in turn may explain the apparently high drop-out rate for users. Without counseling or follow-up, many new acceptors stop using the method after a short period of time. In fact, continuing satisfied users are usually the best promotion for any contraceptive.

The absence of practice opportunities in clinical training (see Section 2.1.1), as well as lack of training in management and goal-setting, may explain some of the weaknesses observed in service delivery. Such training presumes that health workers would be invited to participate in planning and evaluation.

As noted in the previous section, supervision is another problem. The family planning supervisory system is highly centralized within the CPPF, which has experienced transportation and human resource problems, while the integrated supervisory system at the health sector level is undeveloped in many respects and suffers from lack of resources.

There is not enough information to determine if services are delivered in a culturally appropriate way. The KAP survey recently conducted and supported by the project should provide useful information regarding this issue. More operational research is needed to investigate this important aspect of the delivery of family planning services, however.

3.3 Alternative USAID Strategies

In view of the constraints to achieving a greater impact on national family planning goals, it is important to examine whether alternative USAID strategies in the family planning sector need to be pursued.

3.3.1 Conclusions regarding Current Strategy

The project is apparently having some success. The project initiated activities toward the end of the fourth year of a decline in reported numbers of users. It has performed well in delivering anticipated

outputs in its first two and a half years of operation, and during that time reported client numbers increased by 125 percent. In light of these encouraging signs, it would be premature for USAID to abandon its first major family planning effort in Burundi for another strategy.

Project activities are highly appropriate in the context of Burundi's national family planning program. In the mid-1980s, services had been extended throughout the health delivery system through the provision of contraceptives and short seminars for health center staff. Numbers of users remained very low, however, and it was concluded that little would change in the absence of quality training at all levels of the system, and an organized, culturally appropriate IEC campaign. It was also recognized that alternative means of delivering family planning services would be essential, once demand reached the level required to have an impact on population growth.

Factors that interfere with project performance or progress toward long-range goals and objectives are generally external and are not inherent in the project design. Many of the problems are at least partially resolvable. The major factor slowing delivery of project outputs relates to insufficiency in numbers and type of professional staff — as well as resources to support them — that are available to carry out the activities. The major obstacle preventing these outputs from having a more effective influence on services is the lack of follow-up of trained personnel, and the absence of a strong direction to guide IEC agent activities. These problems can be partially overcome by intensifying support in targeted areas during the remainder of the project period.

The major external constraints which undermine the impact of project activities relate to inadequacy of human resources to ensure leadership and direction at the national level, and weaknesses in the health care delivery system in the areas of supervision and quality assurance. These external constraints can be partially overcome by making changes in the type of support the project provides.

3.3.2 Feasibility of Other Strategies

There are few other viable alternatives to the current strategy that are immediately available:

First, there are currently no other significant structures for delivering family planning services outside the organized health care structure. There are some potential distribution channels which were identified in an exhaustive feasibility study and which need to be tested on a pilot basis, which the project is already moving to do.

Second, for all its faults, the health care infrastructure has been used to achieve 80-90 percent coverage for immunization and pre-natal services. Until alternative distribution channels have been developed, it is not unreasonable to invest in the existing health care delivery system.

Third, family planning outreach — a component of programs in other countries that has achieved some success — is beginning to emerge through the IEC effort, which is heavily weighted toward interpersonal communications through personnel who are already working in the community. Development of a full-time, outreach program for family planning does not appear to be practical in the context of the country's resources. It is more practical to continue supporting the current approach and to evaluate its results, although such an option can be assessed as the IEC effort progresses.

Fourth, it is unlikely that another government entity would be as well positioned as the MOPH to develop family planning services through the only delivery infrastructure available. Although several

other ministries have responsibilities in related areas, such as community development, promotion of women, population planning, and family life education, there is nothing to indicate that any of them could more effectively promote and deliver family planning services than the MOPH.

Fifth, there are no NGOs through which financial support could reach any sizeable segment of the population. The IPPF affiliate, ABBEF, has just been incorporated and will not be ready to undertake any activities for at least a year.

Sixth, it is highly unlikely that the Government of Burundi would be interested in creating a separate entity outside existing ministries, nor would such an entity provide any advantage. The CPPF — although located within the MOPH — was created by presidential decree and is explicitly authorized to assure quality family planning services and coordinate family planning/IEC activities, even outside the MOPH. The problem is not one of a high-level mandate: the CPPF does not have the resources to carry out its mandate.

3.4 Recommendations for Increasing Project Impact

3.4.1 Accelerated Pace of Current Activities

36. The project should identify and finance specific items which, with additional resources, would increase the speed at which current activities are being carried out. For example, to accelerate the pace at which service providers are being trained, and to train in smaller groups, the project should hire additional training professionals on a consulting basis, and should finance gas and vehicle repair or rental; to speed up availability of VSC services, the project should finance equipment and renovation of an additional VSC unit and training.

3.4.2 Resources for Managing the National Program

37. The project should discuss with the CPPF options for using its resources to increase professional staff. This might include paying Burundian professionals to serve as long-term technical consultants, and in that case the project should obtain a commitment from the MOPH to sustain as many of these positions as possible at the end of the project period. To improve the chances for future sustainability, these consultants should be used to develop permanent program components. For example, the MIS, an annual planning and programming process for overall operations as well as IEC and training, and a quality assurance system are all aspects of a national program that require intensive resources and expertise to develop. They require fewer high-level professionals to maintain them, however. Another option would be to increase project staff, as is already being done for IEC activities.
38. The project should offer to finance a management needs assessment of the national family planning program, clearly defining the minimal organizational requirements of the CPPF. This should include

preparing functional job descriptions in key management areas including training, IEC, supervision, and management information; and making recommendations for the most effective use of existing human resources. This should preferably be conducted by someone already closely involved with the MOPH or the project, who is in a position to carry it out effectively with minimal disruption to operations, and by someone who will be available to participate in follow-up assistance.

39. The project should propose to CPPF that project financing be used to conduct a narrowly focused assessment of vehicle support at the central level, as well as at the supervisory level recommended below, and the project should consider additional resources to strengthen central staff mobility appropriate to the findings of the assessment.

3.4.3 Supervision and Follow-Up of Trained Personnel

40. The project should finance an intensive, one- to two-year program of supervisory training for the 25 health sector chiefs which includes supervisory visits to health centers with trained personnel, thereby combining on-the-job training in supervision with needed follow-up of trained personnel. Training should be conducted with as small a group as possible in different regions of the country to permit maximum coverage of health centers. Supervisory skills should be generic, but demonstration of specific application of skills should be in family planning.
41. The project should offer to finance a needs assessment and should identify budget items for additional resources to increase mobility of health sector chiefs: analyze underlying problem of mobility; identify non-recurrent cost obstacles (maintenance/repair capability, motor pool management skills, driver training and supervision); review allocation of resources (gas budget, vehicle use); assess usefulness of alternatives (mobilettes, bicycles); and propose coordinated donor support in selected, non-recurrent cost areas. Items for increased funding might be narrowly confined to transport during supervisory training with field visits to health centers, for health sector chiefs, or support for repair and maintenance to put more vehicles into operation for routine supervision.

3.4.4 IEC Strategy

42. The project should continue to support and seek ways to speed up the IEC strategy contained in the medium-term plan of the CPPF, including support for additional professional staff during the planning and early implementation stages of the strategy.

3.4.5 Services Delivery System

43. The project should consider expanding support for its proposed model clinics (for IUD and other clinic training) to include a project to demonstrate various approaches for improving clinic-based services, as follows:
- a) develop and test general delivery policies for promoting access and high-quality services;
 - b) implement the delivery of a wide range of contraceptive methods including the IUD, VSC, and Norplant to follow up and measure clients' satisfaction and side effects;
 - c) provide opportunities for clinical training, particularly for IUD insertion and VSC;
 - d) introduce new channels of contraceptive distribution to ease access for women living far from health centers;
 - e) try innovative management models such as the participation of health care providers in the elaboration and monitoring of objectives;
 - f) integrate effectively family planning activities within MCH;
 - g) conduct operations research to investigate women's satisfaction with the delivery of services, culturally appropriate ways of delivering services, and causes of service discontinuation;
 - h) try different approaches for client follow-up and outreach to drop-out cases;
 - i) try different approaches for supervision that reflect needs as well as health sector capabilities; and
 - j) use patient flow analysis to improve organization of services, use of space, etc.

All proposed activities would provide operational strategies to improve the effectiveness of the delivery of family planning services. The major focus of the demonstration project should be in developing innovative and workable models ("learning laboratories") which in turn could be used as models for training and replication in other health sectors. One of the already four proposed model clinics in Gitega, Ngozi, Bururi, and Bujumbura and health centers that are part of the same health sector, could well be the right site for launching this demonstration project.

In addition to the demonstration project, the following general recommendations are also being made for consideration of the project:

44. Guidelines should be developed for staff to systematically use child health and well-baby clinics as sources of referrals for family planning services. Efforts should be made to monitor the effectiveness of such recruitment, perhaps within the context of the demonstration project.
45. Efforts should be made to expand the range of contraceptive methods currently available:
 - a) As soon as the Gitega, Ngozi, and two other model clinics are operational, priority should be given to providing IUD training to personnel of health centers attached to hospitals. IUD training should then be made available to staff of health centers who are highly motivated and where the health center can be properly equipped to offer IUD services.
 - b) Although the current status of Norplant is still not certain, the project should collaborate with UNFPA in following up studies of current users and collaborating with the Population Council when it begins working in Burundi.
 - c) The project should work with the CPPF and AVSC to complete the site for VSC and expand services as quickly as possible.
46. The feasibility of developing a separate outreach component in the health care delivery system should be assessed during the evolution of both the CBD pilot alternative and the expanded IEC campaign. If it is determined that such a component is feasible, results of the study should be presented to the MOPH.

4. USAID Long-Term Strategy

4. USAID Long-Term Strategy

4.1 Family Planning and Health Sector Support

USAID's first major effort in supporting Burundi's family planning program has been timely and appropriate, and is as successful as possible given the external constraints facing any donor effort, and despite the small size of the mission.

4.1.1 Context

Burundi's family planning program is just beginning to move toward the stage of "critical mass" on the supply side. Many family planning functions and activities are coming together as a coherent part of a national program: responsibility for family planning is institutionalized within the government, and there is a national pool of trainers, a growing number of trained health providers, a stable supply of contraceptives, proposals for alternative distribution channels, and the makings of an appropriate IEC program.

With respect to the demand side, the speed with which the delivery system emerges as a permanent source of services in Burundi, will directly affect the level of intensity with which the government 1) can promote the use of family planning services in the short term, and 2) can undertake long-term social and economic development that encourages people to have fewer children. As the demand grows, people will seek out all available distribution systems. Thus, if in the future public health facilities are unable to satisfy the demand, other options will need to have been developed such as pharmacies, the IPPF affiliate, or community distributors.

Many of the obstacles in the way of a strong family planning force in Burundi are unique to family planning: the personal and cultural sensitivities surrounding contraception, as well as underlying sexual attitudes and practices; the social and economic advantages of having large numbers of children; and the inappropriateness of health facilities as a distribution channel for certain types of contraceptives and certain kinds of clients.

Many obstacles are those shared with the expansion of all health services: number and skill level of service providers and supervisors; availability and capacity of managers and specialists; information and supply systems; and material resources.

4.1.2 Alternative Strategies

One approach to speeding up the process of developing a cohesive national family planning program is to expand the existing support for family planning-specific services and IEC, in both the public and private sector. The faster the program expands, the more vigorous IEC efforts can become and the greater the possibility that demand will increase. Financing should include family planning activities that have recurrent costs attached, for a definitive period of time. The type of support provided would be similar in nature to that which is recommended during the current project period for increasing project effectiveness, e.g., financing Burundian professionals as short-term technical consultants in key areas of the national family planning program. It is especially important that broad program management expertise be reinforced at both the central and provincial levels to ensure strong leadership at the national and peripheral levels.

Such "categorical" support for family planning should not extend to a separate family planning supervision system that would interfere with integrated supervision and service delivery at the health center level. Technical and material resources should be earmarked for family planning because it is intended that it become a far stronger service within a weak health care system. To the degree possible, however, the responsibility of supervisors and service providers for all health services needs to be recognized. Separate or "vertical" supervision and services delivery for each health program would be an unwise use of scarce resources as well as detrimental to health center clients.

Training in supervision and service delivery should therefore include as many generic skills as possible, but the training program should demonstrate their applicability in the family planning context. Furthermore, professional expertise in family planning should be available at the central and provincial levels but should be offered to service providers in close coordination with the supervision activities of the health sector chiefs. A family planning project within the context of a health sector support grant would help to avoid vertical supervision and service delivery.

With respect to the management level at which support should be provided, the health sector is a critical link in the health care delivery system, a general outlook shared by the recent USAID/Burundi Health Sector Assessment. The health sector is essential to supervision and assurance of quality health services. This level must be furnished with the resources necessary to fulfill this function, such as supervisory skills and tools, essential drugs and clinic supplies, and transportation.

The Health Sector Assessment did not precisely define the health sector role, however, and therefore overlooked the equally critical role of the provincial medical chief in health systems management. Planning, programming, evaluation, training, and mobilization of multi-sectoral resources for IEC activities, are essential functions that are far more effectively and efficiently fulfilled at the provincial level. A family planning project must include resources at the provincial level to carry out these functions, or health sectors will not have the support and leadership they need to carry out their own tasks.

A disadvantage of an intensive family planning program as opposed to a project to strengthen the health delivery structure as a whole, is that it raises the question whether the government can sustain the program when donor funding is reduced. Future sustainability of efforts by the government will become less important once the demand is there, however. If public facilities cannot meet their need, people will turn to alternative distribution channels which will have been developed in the interim. Furthermore, many components of the program will have become institutionalized and self-sustaining, e.g., family planning training in medical and paramedical schools and logistics systems. Finally, Burundian project staff, whose salaries cannot subsequently be absorbed by the government, will be part of the skilled labor pool needed to operate alternative distribution channels.

Another disadvantage of this approach is that it may neglect other important health determinants of fertility, such as child mortality. In Burundi, however, pre-natal and immunization coverage is very high, and it is more affordable to sustain and expand this area than is true in countries with much lower coverage.

An alternative approach is to strengthen the entire health delivery structure in order to improve all health services in a balanced manner. One advantage of this approach is that it includes activities aimed at building institutional capabilities and other efforts of a self-sustaining nature. Another advantage is that as the health status of mothers and children improve, women will seek out family planning. A disadvantage of this approach is that it takes much longer to develop family planning

services because no preference or priority is placed on any particular service. Training, IEC, information systems and transport would be strengthened to support all services equally. Thus, the creation of contraceptive demand would be approached only from the perspective of health, even though determinants of fertility are also greatly influenced by personal, social, and economic reasons.

Ideally the two approaches could be combined. Problems would still arise, however, as the more heavily funded family planning program would continue to outweigh other service program demands for support or cooperation of central MOPH systems.

Whichever strategy is ultimately adopted, the USAID mission must be large enough to provide proper oversight and coordination with the growing donor efforts in the health and family planning sector. Mission staff have put forth much effort in the absence of health and family planning staff, but the return on investment in health and family planning will be greatly enhanced with sufficient staff.

4.1.3 Recommendations

47. To build on the success to date in the family planning program in Burundi, USAID should include a major family planning project in its future country strategy, and should expand the size of the mission staff to provide oversight and donor coordination.
48. USAID should speed up the movement of the family planning program toward the stage of critical mass with expanded support for family planning, including recurrent costs if necessary, preferably within the context of a health sector support program. USAID should reduce the risk of non-sustainability by investing in program activities that emphasize institution-building, and should simultaneously develop alternative distribution channels that should help to sustain efforts in the future.

Support would include financing needed Burundian professional expertise at the central and provincial levels; providing adequate transportation resources such as training, gas, and resources for vehicle maintenance and repair, and even vehicles; and providing training and material resources at the level of health sectors, communities, and health centers to ensure that family planning information, clinic services, and supervision is firmly integrated into existing services. This approach should not bypass health sector chief responsibilities for supervision of all health services. By the time recurrent cost support is phased out, alternative distribution channels will be sufficiently developed to help sustain future efforts.

4.2 Population Planning

4.2.1 Context

In view of the low contraceptive prevalence rate in Burundi after eight and a half years of family planning efforts, and the very high density of population (532 people per square kilometer of

cultivable land), it is highly desirable that long-range social and economic development planning be directed toward lower fertility rates. For instance, purposeful actions by the sectors of agriculture, health, labor, and education can have a profound impact on the status of women, who are the primary focus of all efforts to slow population growth. This goal can only be achieved with a detailed population planning strategy, and the expertise to develop and carry it out. Each sector needs the expertise to predict and plan for future demographic variables and to design appropriate strategies for influencing the behavior and characteristics of the growing population.

In preparing the Sixth National Five Year Plan (1993-1997), ministries were asked to provide sector strategies that would take into account the population variables affecting their areas of responsibility. The small staff of the Unit of Population Planning⁵ provided demographic analyses to each sector to assist them in their planning. The UPP reported that staff of the ministries are not sufficiently trained, however, to incorporate the data into their activities, either for purposes of projecting the size and characteristics of the population they serve in order to more appropriately meet their needs, or to develop strategies for encouraging lower fertility.

The RAPID IV project will provide resources to Burundi's population planning activities, primarily by orienting mid-level professionals to the use of population data. The UPP staff, who are familiar with RAPID, believe that RAPID will only touch on the need, and that a longer-range and more intensive training effort is required before national plans can have an effective impact on the population.

As mentioned in Section 1.2.1, a series of conferences has been initiated as part of an effort to produce a detailed population policy. The conferences provide a forum for multiple sectors to focus on long-range options in social and economic development which can affect population growth.

During 1995-96, ministries will begin to evaluate the current national plan in order to establish objectives for the Seventh National Five Year Plan (1998-2002). The UPP believes that for the national plan to be effective it is essential that many more mid-level professionals be trained to deal with the complexities of demographic variables, and be able to translate them into proposals for action. They particularly cite the need to develop an array of development interventions that will ultimately have an impact on the status of women, who are the central focus of all efforts to reduce fertility.

Donors have been supportive of population policy development by providing assistance in research, evaluation, and information collection systems. UNFPA supported the creation of the UPP. The USAID project paper (August 1988) noted the absence of a population policy component in the USAID-Pathfinder Population Project, but expressed the intention of USAID to identify other options for technical assistance for the government in policy development and initial implementation. Some support has been available from RAPID and the U.S. Bureau of the Census. Certain USAID project assistance, such as that provided to the MOPH health information system, help to develop planning expertise within different ministries.

⁵The UPP is responsible for assisting the government to develop the population policy and presently has only two staff, one of whom is an expatriate consultant.

4.2.2 Recommendations

- 49. USAID should develop and finance a five-year training strategy (1993-1997), with the goal of equipping planners in Burundi to prepare a Seventh National Five Year Plan (1998-2002) that provides concrete social and economic strategies for slowing population growth and improving the quality of life.**
- 50. Training should include bringing outside experts into the country; sending staff to countries where long-term development plans have had an impact on the population, such as Mauritius; sending staff abroad for short- and medium-term training, e.g., to Boston University and the Dakar Institute of Population Development.**

Appendices

Appendix A
Statement of Work

Appendix A

Statement of Work

Burundi Population and Family Planning Project Mid-Term Evaluation

BACKGROUND

The Burundi Population and Family Planning Project was designed in 1987-88 to address Burundi's high fertility rate, estimated at 6.5, and high population growth rate estimated at 2.8-3.0 % per annum. Burundi is already the second most densely populated on the continent and is encountering increasing pressures on its limited land resources. A Demographic and Health Survey conducted in 1987 revealed a high level of acceptance for the concept of family planning (89%); approximately 23.6% of those surveyed wanted no more children and 53% wanted to space their births, but only 1.6 % were actually using a modern method of contraception.

A number of family planning activities were initiated in the early 1980s. The United Nations Population Fund (UNFPA) assisted the Ministry of Health to integrate family planning into MCH services in one province. JHPIEGO provided training to some physicians and nurses. RAPID presentations were used to raise Government of the Republic of Burundi (GRB) awareness of the impact of population growth rates and their impact on the GRB's efforts to provide schools, health and other services. In 1983 the GRB promulgated a policy which endorsed voluntary family planning and called for its availability nationwide.

At present, the donors active in supporting family planning services and population policy efforts include: the World Bank through its Population and Health project (\$14 million over a five-year period); UNFPA which funds contraceptives, training, development of teaching materials, as well as clinic rehabilitation; and UNICEF which supports family planning through its support to IEC, health information systems, and improved managerial procedures at the Ministry of Health.

The Burundi family planning program is at a "pre-emergent" stage. While services are available in principle at most Ministry of Health facilities, access remains problematic for many women and couples, support systems such as IEC, logistics, and training and supervision are still rudimentary, and actual use remains very low. (The Burundi Population and Family Planning Project was designed to address these deficiencies through the strengthening of training, IEC, logistics, supervision, and other support systems in the Ministry of Health service delivery network, and to identify and test family planning services delivery through alternative delivery channels; Pathfinder is the implementing

agent under the oversight of USAID/Burundi. By the end of the 5-year project, contraceptive prevalence was to increase to 7.6 % with approximately 90,000 active users of modern methods of family planning. (See Attachment A for a complete listing of project objectives.)

ARTICLE I - TITLE

Burundi Population and Family Planning Project- Mid-term Evaluation (695-0123)

ARTICLE II - OBJECTIVE

The purpose of this PIO/T is to provide funding for the fielding of a team to conduct the mid-term evaluation of the Burundi Population and Family Planning Project and prepare a final report. The evaluation exercise is seen as an opportunity to look not only at the effectiveness of this project, but also to re-assess the development of the family planning program in Burundi and the most appropriate type and level of assistance from USAID/Burundi. The contractor will provide a three person team comprised of the following skills:

- Family Planning Program Analyst/Team Leader
- Clinic Services Specialist
- IEC/Training Specialist

ARTICLE III - STATEMENT OF WORK

A. **General:** The evaluation has four principal objectives:

- 1) To assess progress made in meeting the objectives of the project; identify barriers and constraints as well as facilitating factors to progress at mid-term; and, likelihood of project meeting its objectives by the end of the project period;
- 2) to assess the appropriateness of the project design and its implementation (proposed and actual inputs, outputs, and overall strategy) to achieving the project's purpose of increasing modern contraceptive availability and prevalence;
- 3) to make recommendations regarding continuation of the project as designed and implemented or changes in project design (inputs, outputs, and strategy) and its implementation; and

4) to assess the appropriateness of the project's objectives and USAID's role in the family planning sector vis-a-vis the GRB, other donors, and the general socio-cultural environment, and to make recommendations for USAID's long-term strategic role in the family planning sector.

B. Methodology:

The evaluation is expected to last approximately four (4) weeks. The team will assess the Burundi Population and Family Planning Project by means of:

1. field visits in at least three provinces to assess in-clinic (and out-of-clinic) delivery of family planning services, levels of service coverage, and adequacy of referrals; through interviews with clients, clinic staff, supervisors and provincial managers, and observation of service delivery;
2. interviews with Ministry of Health staff at the central level, and other ministry, government and non-government staff, as appropriate;
3. interviews with Pathfinder personnel in Burundi and from the regional office;
4. interviews with USAID personnel and representatives of other donors and USAID cooperating agencies as appropriate;
5. review of relevant documentation and statistics related to service delivery and coverage.

C. Specific: The individual scopes of work for the team are as follows:

1. The tasks of the **Family Planning Program Analyst/Team Leader** will include an analysis of the following:
 - (a) Appropriateness of the service delivery approaches and strategies to achieving the contraceptive prevalence targets of the project and assuring availability and accessibility of family planning services.
 - (b) Potential alternative approaches to delivery of family planning services in the context of Burundi (political,

technical, and organizational).

- (c) Appropriateness of the project components and support provided to achieving the project outputs; effectiveness of support services such as logistics, information systems, etc.
- (d) Effectiveness of implementation of the project elements and quality of outputs.
- (e) Appropriateness of technical assistance provided, commodities furnished, and other inputs to project and program needs (assess in terms of quality, timing, quantity, and effectiveness of delivery).
- (f) Given other donor inputs into the sector, appropriateness of USAID assistance and mechanisms for coordination and management.
- (g) Linkages of family planning services with other development programs and activities, and relationships with other Ministries.

The team leader will also be responsible for coordinating and guiding the activities and inputs of the other team members, preparing the outline of the report, and assuring high quality draft and final reports.

- 2. The tasks of the Clinic Services Specialist will include an analysis of the following:
 - (a) Quality of family planning services being provided with project assistance (and in program overall).
 - (b) Appropriateness of training manuals, supervision guidelines, service delivery policies and guidelines for the delivery of quality clinical services and high levels of access.
 - (c) Appropriateness of equipment, contraceptives and other supplies available to the delivery of quality family planning services.
 - (d) Effectiveness of integration of family planning services into the delivery of MCH, preventive and other health services.

- (e) Effectiveness of the referral system for handling problems and complications.
 - (f) Effectiveness of family planning program management and support from the central, regional, and local levels.
 - (g) Utilization of family planning and related health information systems to assess service access and quality and make corrections.
 - (h) Availability and accessibility of family planning services in MOH clinics to populations in need and at risk.
 - (i) Accessibility to a wide range of family planning methods.
3. The tasks of the IEC/Training Specialist include and analysis of the following:
- (a) Access to accurate information about family planning services, methods, etc.
 - (b) Effectiveness of mass media programs, print materials and alternative communication strategies (e.g. folk media) in reaching target audiences and conveying relevant information.
 - (c) Effectiveness of family planning and other health personnel in conveying information and counselling clients on family planning.
 - (d) Effectiveness and appropriateness of training for IEC and clinical services delivery.
 - (e) Appropriateness of structure and materials for delivery of effective family planning training, e.g. training of trainers, availability of teams, sites, clinical practice when needed.
 - (f) Effectiveness of training follow-up and supervision.
 - (g) Adequacy of project inputs to address family planning training needs (skills, numbers); training needs which still need addressing.
 - (h) Effectiveness of pre-service training and linkages with in- service.

ARTICLE IV - REPORTS AND DELIVERABLES

<u>Deliverable</u>	<u>Due Date</u>
Work Plan and Schedule	2-3 days after arrival in Burundi
De-briefing with USAID	2-3 days prior to departure from Burundi
Draft Evaluation Report (with principal findings and recommendations)	4 days prior to departure from Burundi
Final Evaluation Report	2 weeks after USAID transmits comments on draft report

The draft report should include a section which summarizes the key findings and recommendations which can be translated into French for review by Ministry of Health officials. The final report will include recommendations that clearly describe the implications for funding levels, actions required by USAID/Burundi, Pathfinder, and the Government of Burundi, and for short- and long-term follow-up. The recommendations should also include proposals on the most appropriate linkage of the family planning and population activities/interventions to USAID/Burundi's other activities/interventions in the health sector as a whole, specifically the proposed Burundi Health Systems Support Project.

The Evaluation Report should follow standard USAID evaluation format as outlined in Handbook 3 Chapter 12, and Handbook 3 Supplement: AID Program Design and Evaluation Methodology, Report 7, April 1987.

V. Roles and Responsibilities.

The contractor is responsible for: identifying the potential team members for USAID approval; developing an overall evaluation guide for use during field visits; conducting the field visits, interviews, etc. to collect the data needed to evaluate the project; develop and present findings, conclusions and recommendations; de-brief personnel at USAID/Burundi and the officials at the Ministry of Health; write and finalize the report. The contractor will be responsible for all international and in-country travel arrangements, logistical support, and finalizing and distribution of the final report to USAID/Burundi.

USAID/Burundi is responsible for: approving final selection of team members; selecting with Pathfinder and the Ministry of Health the sites for field visits and helping with logistical arrangements; collecting and providing supporting documentation to the evaluation team as necessary; and reviewing and providing comments on the draft evaluation report.

Pathfinder is responsible for: making available all relevant documentation on the project and its implementation; assisting in the selection of sites for field visits and with logistical arrangements; making staff available for interviews and data available as requested by the evaluation team; and reviewing and providing comments on the draft evaluation report.

The Ministry of Health is responsible for: designating a senior level official as counterpart to the evaluation team leader; assisting in selecting sites for field visits and with logistical arrangements; making available relevant documents and individuals for interviews to assure the team members full knowledge of all aspects of family planning program implementation; assisting in any other ways needed to assure a successful data-gathering and analysis effort; and comments on the recommendations of the team.

VI. WORK DAYS ORDERED

The evaluation will be conducted during the month of February 1992. A total number of 84 workdays is ordered under this PIO/T (78 workdays total plus two workdays/consultant for travel). The work days are divided as follows:

<u>Position</u> <u>Dates</u>	<u>Work Days</u>	<u>Requested</u>
Family Planning Program Analyst/Team Leader	30	2/ /92-3/ /92
Clinical Services Specialist	24	2/ /92-2/ /92
IEC/Training Specialist	24	2/ /92-2/ /92
Total Number of Workdays:	78	
Travel Days:	6	
Total Number of Workdays Ordered:	84	

VIII. Qualifications

Family Planning Program Analyst/Team Leader. At least a masters level degree in public health, public administration, or other relevant field. At least 10 years of relevant experience in planning, designing, managing, and evaluating family planning programs in developing countries; at least 5 years experience in

design and implementation of non-clinical family planning program activities. Experience in sub-Saharan and francophone Africa highly desired. Must have French language capability at FSI 3+/3+ level.

Clinical Services Specialist. Advanced clinical degree, M.D. preferred; at minimum R.N./Midwife (or equivalent). M.P.H. preferred. At least 10 years experience in delivery, management, and/or supervision of family planning services in clinical setting with at least 5 years experience in clinics with limited equipment and other facilities, such as those found in least developed countries. 3-5 years experience developing and using quality control tools appropriate to developing countries with limited health infrastructure. Experience in sub-Saharan Africa highly desired. French language capability at the FSI 3/3 level.

IEC/Training Specialist. Masters level degree in communications, adult education, public health or related, relevant field. At least 10 years experience in the development of and training in IEC and training materials for family planning and/or health interventions in developing countries, with experience in all aspects of IEC development, e.g. needs assessments and pre-testing. Experience in the evaluation of IEC and training programs in developing countries. Experience in sub-Saharan Africa highly desired. French language capability at the FSI 3+/3+ level.

All consultants must be able to write English well.

ARTICLE IX - SPECIAL PROVISIONS

- A. Duty Post: Work will be undertaken primarily in Bujumbura with site visits to the interior of the country as needed.
- B. Language Requirements and Other Required Qualifications: All team members should be fluent in written and spoken French. In addition, previous experience in Burundi is preferred.
- C. Logistical Support: The mission will make every attempt to provide vehicle and computer support on an as needed basis to the team. However, insofar as resources are sometimes strained, the team should be prepared to use local taxis from time to time (and claim reimbursement later), as well as use their own (or rented lap top computers). USAID has the capacity to handle Wang, Word Perfect 5.1, as well as Lotus 123 (Rel 2.3).
- D. Work Week: A six day work week is authorized.

Appendix B
List of Persons Contacted

Appendix B

List of Persons Contacted

USAID/Burundi

Mr. Glenn G. Slocum, Director
Mr. David Leong, Project Development Officer
Mme. Antoinette Ferrara, Program Officer
Mme. Nancy Rosen, PSC, PDO/HPN Office
Mme. Janis Timberlake, PSC, PDO/HPN Office

USAID/REDSO/NAIROBI

Mme. Margaret A. Neuse, Regional Health/Population Development Officer

Ministry of Public Health

Dr. Norbert Ngendabanyikwa, Minister of Public Health
Dr. Jean Rirangira, Director, Bureau of Coordination of National Family Planning Program (CPPF)
Mme. Mariam Kalala, Assistant Director, Administration and Finance, CPPF
Mme. Leoncie Barengayabo, Social Worker, IEC Unit, CPPF
Dr. Claire Ryanguyenabi, Assistant Director, Technical Services, CPPF
Dr. Nestor Ndayimirisje, Technical Counselor to Minister of Health
Dr. Charles Nfafitiro, Director, Provincial Hospital, Ngozi
Dr. Theobald Hategekimana, Provincial Medical Officer, Cankuzo
Dr. Patrice Ngendakumana, Director, Provincial Hospital, Cankuzo
Mme. Cassilde Ntamamiro, Health Sector Officer, Cankuzo
Mr. Christophe Karisabiye, Health Sector Officer, Butezi
Dr. Damien Nimpagaritse, Provincial Medical Officer, Ruyigi
Dr. Antoine Barutwanayo, Director, Provincial Hospital, Ruyigi
Mr. Pamphile Vyizigiro, Health Sector Officer, Gitega
Dr. Janvier Rwamwego, OB-GYN, Provincial Hospital, Gitega
Dr. Tharcisse Ndayizeye, OB-GYN, Provincial Hospital, Gitega
Dr. Roger Rushingabigwi, Provincial Medical Officer, Karuzi
Dr. Innocent Ntaganira, Assistant Director, Department of Hygiene and Preventive Medicine
Dr. Fidele Karabagega, Director, National Institute of Public Health

Ministry of Plan

Mr. Gaspard Gapiya, Director, Population Planning Unit
Mr. Laurent Assogba, Technical Expert, Population Planning Unit

Ministry of Primary and Secondary Education

Mr. Ignace Sanwidi, Technical Advisor, Unesco Family Planning Project
Mme. Marie-Therese Rutahe, Director, Population Education Project
Mme. Rose Nahimana, Trainer, Population Education Project
Mr. Augustin Hayifayi, Trainer, Population Education Project

Ministry of Communication, Sports and Culture

Mr. Emmanuel Bizimana, Assistant Director of Population IEC Project
Mme. Rose Mukabirasa, Director of Research and Training, Population IEC Project

Mme. Rosette Mpfunyigabo, Trainer, Population IEC Project
Mr. Sadiki Ruvano, Trainer, Population IEC Project
Mme. Modeste Oyduwimama, Provincial Coordinator of Social Action, Cibitoke

Ministry of Promotion of Women and Social Protection

Mme. Agathe Lawson, Director of Women's Support Project
Mr. Raphael Bindariye, Social Worker, Department of the Family

Paramedical School of Ngozi

Mr. Emile Sempabwa, Professor

Paramedical School of Gitega

Dr. Lazare Nyagahene, Director

UNFPA

Dr. Abdul Karim Diop, Resident Director

Family Action Program of Catholic Church

Mr. Gaspard Kirombo, Director

CARITAS

Dr. Christien Hupin, Medical Director
Sr. Agnes Mushatsi

Faculty of Medicine, University of Burundi

Dr. Jean-Baptiste Sindyigwanya, Deputy of the Dean
Dr. Gervais Ninteretse, Professor, Department OB-GYN

German Embassy

Dr. Heike Peitsch, First Secretary

Pathfinder International

Mr. Melesse Tewodros, Assistant Director, Regional Office, Nairobi
Dr. Marcelle Chevallier, Resident Advisor, USAID Population Project

Appendix C

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Appendix C

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Appendix D
Project Goal and Objectives

Appendix D

Project Goal and Objectives

Goal: Promote economic and social development in Burundi through the implementation of an effective family planning program that will improve the health and well being of mothers and children.

Purpose: Expand the availability and use of family planning information and services by men and women in Burundi. By the end of the project period in 1993, CPR will have increased from the current 1.2% to 7.6%.

General objectives: By the end of the project period (1993):

1. A capacity will be established for planning, conducting, managing and evaluating effective regional-level clinical family planning training.
2. A capacity will be established for planning, conducting, managing and evaluating an effective nationwide family planning IEC program.
3. High-quality, culturally appropriate family planning information and services will be widely available in government facilities and in selected private sector facilities throughout Burundi.
4. There will be approximately 90,000 active users of family planning services provided by trained personnel.

Specific objectives (expressed as Project outputs in the Technical Proposal). By the end of the project period (1993):

- 1.1 There will be developed training curricula for clinical in-service family planning training.
- 1.2 27 trainers of the 4 Regional Training Teams will have the skills necessary to train clinical family planning service providers.
- 1.3 Two long-term fellowships for MPH degrees with specialization in family planning, and twelve short-term grants for IEC, service delivery and program management training, will be provided.
- 1.4 Member of MOPH and LPPF staff will be able to plan and manage training activities based on current training needs assessments.
- 2.1 There will be developed training curricula for family planning IEC training.
- 2.2 12 trainers will have the skills necessary to train community agents in family planning IEC techniques.
- 2.3 350 IEC extension agents from the public sector and from the political party will be trained in family planning IEC.
- 2.4 The following will be developed, pre-tested and disseminated: 4 posters, 7 handouts, 2 flipcharts, 6 radio messages and 3 radio talk shows.
- 2.5 Members of the Health Education Unit of the MOH will have developed skills to conduct formative research and evaluation of IEC activities.
- 3.1 Service standards and protocols will be developed in order to strengthen service delivery.

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- 3.2 450 health personnel will be trained in the delivery of family planning services (each will have participated in an initial family planning training program and later in a FP update refresher program).
- 3.3 20 family planning service providers will be trained in voluntary surgical contraceptive service delivery.
- 3.4 15 provincial medical officers will be trained in family planning program management.
- 3.5 A management information system and a contraceptive supply system will be developed and implemented.
- 3.6 Family planning services offered in facilities of the MOH and the private sector by trained personnel will be provided according to quality standards of care.
- 4.1 Family planning services will be provided to 170,000 new users.
- 4.2 Pilot alternative contraceptive distribution channels will be developed.

Appendix E
Recommendations

Appendix E

Recommendations

Training

Training of Clinical Trainers

1. The project should provide regional trainers with 1) a one-week TOT in family planning motivation in the context of socio-cultural values, interpersonal communication and group IEC skills, and quality of care issues in the delivery of family planning services, and 2) additional reference materials to support the teaching of these concepts.
2. Once the logistics, record keeping and reporting policies have been finalized by the CPPF, the regional trainers should receive one week of training in these areas to enable them to effectively train service providers in these skills during refresher training.

Standardized Training Curriculum (Clinical In-Service Training)

3. The project should assist the CPPF with the elaboration of a concise reference document for health workers on existing rumors and how to respond to each one. Information for such a document could be gathered from the KAP studies and from the experiences of the trainers.
4. Once family planning service delivery standards and protocols are adopted, they should be incorporated in the training curriculum for supervisors and providers.
5. Once the contraceptive supply/logistics, record keeping, and reporting systems have been finally worked out, the project should ensure that a curriculum is developed for the training of trainers and service providers in these areas.
6. At the end of the training of service providers in 1992, the project should assist regional trainers in the review and update of the family planning service provider curriculum in order to produce a comprehensive training manual in family planning.

This review should focus on a) the completeness and clarity of the curriculum, b) new family planning methods and/or information available since the elaboration of the initial curriculum, c) time frames and methodologies for various training sessions to ensure adequate application of concepts, d) necessary support documents, and e) other subjects that may need to be added and/or reinforced, including rumors about family planning and how to respond to them, quality of care issues in the organization of family planning services, strategies for follow-up of family planning drop-outs, STDs and AIDs, logistics (contraceptive supply management), and record keeping and reporting. (The last two topics will need to be developed separately, by the CPPF assistant director for administration and finance and an outside consultant with experience in these areas.)

The curriculum revision will require a period of one week and will require outside consultation. It will provide the MOPH with a solid family planning curriculum based on two years experience, and will strengthen MOPH staff skills in needs assessment and curriculum development. These skills are essential if the MOPH is to develop a strong institutional capability to sustain the family planning program.

The curriculum revision could be conducted independently or be combined with one or both of the activities in Recommendations 1 and 2 above. In either case, it is essential that a week be reserved for each activity.

Training of Service Providers

7. The project should postpone the refresher/contraceptive update training originally planned for project year 3 until project years 4 and 5 to allow for completion of the initial series of training which is scheduled to finish in September 1992. The content for refresher training should be based upon training needs defined during supervisory visits, taking into consideration the possible training needs referred to under Section 2.1.2. This training should be planned for a period of up to a week as necessary to respond effectively to priority training needs. In order to facilitate application of skills, a maximum of 15 participants should be trained at a time, with close monitoring by trainers skilled in the subject areas.

Training in Voluntary Surgical Contraception (VSC)

8. The project should pursue with the CPPF the steps that remain to make the VSC unit in the Prince Regent Charles Hospital functional, and with the CPPF and AVSC the programming of VSC training as originally planned.

Management Training for Provincial Medical Officers

9. The project should support the CPPF in a) assessing the training, technical assistance, and material support needs of provincial-level coordinators and health sector chiefs in the area of supervision; and b) providing training, technical assistance, and material support as needed to the above personnel in order to reinforce the competencies needed to effectively fulfill their roles.

Long-Term Fellowships and Short-Term Grants

10. The remaining funds available for short-term external training should be used to help upgrade the skills of two new CPPF staff — an assistant director for technical services and an additional person in the IEC unit.

IEC Training Curriculum

11. Once the results of the KAP studies are available, the project should assist the IEC unit in reviewing the training curriculum to ensure that it responds to socio-cultural values and perceptions of family planning identified in the KAP studies.

12. A concise reference document for health workers on existing rumors and how to respond to each one, as recommended in Section 2.1.2, should be adapted for use by IEC agents.

13. The project should assist the IEC unit in reviewing the reference guide for IEC agents which is being elaborated by the IEC project and assist in its modification so that it responds to the information needs of IEC agents.

14. The project should pursue production of several series of visual aides (in the form of flip charts) adapted to the socio-cultural context of priority themes of IEC sessions. For IEC agents already trained, the use of these visual aides will have to be introduced in the course of local group supervisory visits.

Training of IEC Agents

15. Once supervision of agents is improved (see Section 2.2.2), feedback should be used to strengthen training and refresher courses.

16. For future IEC training, group size should be limited to 15 in order to allow maximum participation and practice.

Information, Education, and Communication

Materials Production/IEC Skills Development

17. In light of the need for IEC materials to promote family planning, the project should utilize the private sector as necessary to ensure the timely production of these materials. The project should also proceed with hiring a local IEC specialist as planned to strengthen the management of the CPPF IEC unit.
18. The project should support the development of at least three simple flip charts for IEC agents, each with a different orientation to the promotion of family planning. Messages would be based on the results of the KAP studies regarding the population's concerns and attitudes relative to family planning.

Deployment of IEC Agents

19. The project should support the option being discussed by the CPPF/MOPH to decentralize the support and supervision of IEC agents.

Service Delivery

Service Protocols

20. The project should continue to support the CPPF in the further development and refinement of standards and protocols for family planning service delivery. This support might be provided through direct technical assistance or through financing of a workshop to bring together managers, providers, and other professionals. The project's support should ensure that the final product is responsive to client needs, and should take the following into account:
 - All standards and protocols should be sensitive to any possible impact that recommended practices might have on relative degree of access to family planning services. Standards and protocols should be developed within the context of, and with an emphasis on, increasing access to services.
 - Standards and protocols should be developed with service provider input and should be tested before being introduced in health centers.
 - Standards and protocols should be included in the second volume of the Maternal and Child Health Manual that is being prepared by the EPI/CCCD program. Toward this end, all necessary activity required to develop a final version of the guidelines should be pursued as expeditiously as possible.

Management Information System (MIS)

21. The project should continue to provide technical assistance to the CPPF in order to improve its reporting system and to build CPPF analysis capabilities.
22. The project should assist the CPPF in working with EPISTAT to develop tables of organization of family planning data to assure routine and timely data analysis.
23. Given the high drop-out rate, the project should assist the CPPF in working with EPISTAT to institute a routine calculation of drop-outs.
24. A section on record keeping and reporting should be included in the training curriculum. The project should also discuss with the CPPF the possibility of training health care providers in data use, particularly if

they are permitted to have input into the elaboration of objectives, so that the significance of the data they collect could be fully understood.

25. The project should assist in training a specialist on data analysis at the national level.

Contraceptive Logistics Management and Supply

26. The project should continue to provide technical assistance to the CPPF to improve the contraceptive supply system, exploring mechanisms to improve distribution of supplies on a quarterly basis. Efforts to streamline reporting should continue. Once the logistical, record keeping and reporting systems are firmly established, health workers will need training in all of these areas. Such training could logically be included in the refresher training planned for project years 4 and 5.

27. The project should continue to provide whatever assistance it can to the CPPF in the resolution of the contraceptive procurement problem, particularly the immediate problem created by the lack of approval of the UNFPA 1992 budget.

28. The project should encourage CPPF to take an active role in seeking a long-term solution to the transportation problem (see Section 4.1.2).

Pilot Alternative Contraceptive Distribution Channels

29. It is essential that the follow-up team being brought in by the project to develop a more concrete proposal also propose a phase-in of the pilot projects so that the amount of work required by the MOPH is in line with its capacity for high-level management and oversight.

30. To phase in the pilot projects as practically as possible, the team needs to work closely with those who are likely to be designated by the MOPH to oversee the projects.

31. The selection of Muyinga as a site for the CBD pilot project should be reviewed even if concerns about the current UNICEF-supported activities are addressed. Before finally deciding to use the Muyinga site, consideration should be given to the following alternatives sites: a) the Gitega model clinic, if it proceeds in a timely fashion; and b) a demonstration program, as recommended in Section 3.4.2, which would be developed for the purpose of strengthening health center services. (The latter alternative was also suggested in the feasibility study.)

Project Management

32. To strengthen the capacity of the CPPF to participate in the management and coordination of project activities, the project should proceed as planned to fill the approved long-term IEC position, and other such positions should be considered for funding in those areas which are critical to achieving specific project objectives.

33. USAID should increase its health and population presence in order to fulfill its role in project management and donor coordination, and should take immediate steps to forge a closer working relationship with the UNFPA.

34. The selection of the next resident advisor should be heavily weighted toward someone with strong management experience.

35. The project should participate in all financing required to finalize a population policy in 1992.

Recommendations for Increasing Project Impact

Accelerated Pace of Current Activities

36. The project should identify and finance specific items which, with additional resources, would increase the speed at which current activities are being carried out. For example, to accelerate the pace at which service providers are being trained, and to train in smaller groups, the project should hire additional training professionals on a consulting basis, and should finance gas and vehicle repair or rental; to speed up availability of VSC services, the project should finance equipment and renovation of an additional VSC unit and training.

Resources for Managing the National Program

37. The project should discuss with the CPPF options for using its resources to increase professional staff. This might include paying Burundian professionals to serve as long-term technical consultants, and in that case the project should obtain a commitment from the MOPH to sustain as many of these positions as possible at the end of the project period. To improve the chances for future sustainability, these consultants should be used to develop permanent program components. For example, the MIS, an annual planning and programming process for overall operations as well as IEC and training, and a quality assurance system are all aspects of a national program that require intensive resources and expertise to develop. They require fewer high-level professionals to maintain them, however. Another option would be to increase project staff, as is already being done for IEC activities.

38. The project should offer to finance a management needs assessment of the national family planning program, clearly defining the minimal organizational requirements of the CPPF. This should include preparing functional job descriptions in key management areas including training, IEC, supervision, and management information; and making recommendations for the most effective use of existing human resources. This should preferably be conducted by someone already closely involved with the MOPH or the project, who is in a position to carry it out effectively with minimal disruption to operations, and by someone who will be available to participate in follow-up assistance.

39. The project should propose to CPPF that project financing be used to conduct a narrowly focused assessment of vehicle support at the central level, as well as at the supervisory level recommended below, and the project should consider additional resources to strengthen central staff mobility appropriate to the findings of the assessment.

Supervision and Follow-Up of Trained Personnel

40. The project should finance an intensive, one- to two-year program of supervisory training for the 25 health sector chiefs which includes supervisory visits to health centers with trained personnel, thereby combining on-the-job training in supervision with needed follow-up of trained personnel. Training should be conducted with as small a group as possible in different regions of the country to permit maximum coverage of health centers. Supervisory skills should be generic, but demonstration of specific application of skills should be in family planning.

41. The project should offer to finance a needs assessment and should identify budget items for additional resources to increase mobility of health sector chiefs: analyze underlying problem of mobility; identify non-recurrent cost obstacles (maintenance/repair capability, motor pool management skills, driver training and supervision); review allocation of resources (gas budget, vehicle use); assess usefulness of alternatives (mobilettes, bicycles); and propose coordinated donor support in selected, non-recurrent cost areas. Items for increased funding might be narrowly confined to transport during supervisory training with field visits to health centers, for health sector chiefs, or support for repair and maintenance to put more vehicles into operation for routine supervision.

IEC Strategy

42. The project should continue to support and seek ways to speed up the IEC strategy contained in the medium-term plan of the CPPF, including support for additional professional staff during the planning and early implementation stages of the strategy.

Services Delivery System

43. The project should consider expanding support for its proposed model clinics (for IUD and other clinic training) to include a project to demonstrate various approaches for improving clinic-based services, as follows:

- a) develop and test general delivery polices for promoting access and high-quality services;
- b) implement the delivery of a wide range of contraceptive methods including the IUD, VSC, and Norplant to follow up and measure clients' satisfaction and side effects;
- c) provide opportunities for clinical training, particularly for IUD insertion and VSC;
- d) introduce new channels of contraceptive distribution to ease access for women living far from health centers;
- e) try innovative management models such as the participation of health care providers in the elaboration and monitoring of objectives;
- f) integrate effectively family planning activities with MCH;
- g) conduct operations research to investigate women's satisfaction with the delivery of services, culturally appropriate ways of delivering services, and causes of service discontinuation;
- h) try different approaches for client follow-up and outreach to drop-out cases;
- i) try different approaches for supervision that reflect needs as well as health sector capabilities; and
- j) use patient flow analysis to improve organization of services, use of space, etc.

44. Guidelines should be developed for staff to systematically use child health and well-baby clinics as sources of referrals for family planning services. Efforts should be made to monitor the effectiveness of such recruitment, perhaps within the context of the demonstration project.

45. Efforts should be made to expand the range of contraceptive methods currently available:

- a) As soon as the Gitega, Ngozi, and two other model clinics are operational, priority should be given to providing IUD training to personnel of health centers attached to hospitals. IUD training should then be made available to staff of health centers who are highly motivated and where the health center can be properly equipped to offer IUD services.
- b) Although the current status of Norplant is still not certain, the project should collaborate with UNFPA in following up studies of current users and collaborating with the Population Council when it begins working in Burundi.

- c) The project should work with the CPPF and AVSC to complete the site for VSC and expand services as quickly as possible.

46. The feasibility of developing a separate outreach component in the health care delivery system should be assessed during the evolution of both the CBD pilot alternative and the expanded IEC campaign. If it is determined that such a component is feasible, results of the study should be presented to the MOPH.

Family Planning and Health Sector Support

47. To build on the success to date in the family planning program in Burundi, USAID should include a major family planning project in its future country strategy, and should expand the size of the mission staff to provide oversight and donor coordination.

48. USAID should speed up the movement of the family planning program toward the stage of critical mass with expanded support for family planning, including recurrent costs if necessary, preferably within the context of a health sector support program. USAID should reduce the risk of non-sustainability by investing in program activities that emphasize institution-building, and should simultaneously develop alternative distribution channels that should help to sustain efforts in the future.

Support would include financing needed Burundian professional expertise at the central and provincial levels; providing adequate transportation resources such as training, gas, and resources for vehicle maintenance and repair, and even vehicles; and providing training and material resources at the level of health sectors, communities, and health centers to ensure that family planning information, clinic services, and supervision is firmly integrated into existing services. This approach should not bypass health sector chief responsibilities for supervision of all health services. By the time recurrent cost support is phased out, alternative distribution channels will be sufficiently developed to help sustain future efforts.

Population Planning

49. USAID should develop and finance a five-year training strategy (1993-97), with the goal of equipping planners in Burundi to prepare a Seventh National Five Year Plan (1998-2002) that provides concrete social and economic strategies for slowing population growth and improving the quality of life.

50. Training should include bringing outside experts into the country; sending staff to countries where long-term development plans have had an impact on the population, such as Mauritius; sending staff abroad for short- and medium-term training, e.g., to Boston University and the Dakar Institute of Population Development.