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**BURKINA FASO
FAMILY HEALTH AND HEALTH FINANCING PROJECT
(Project Number: 686-0275)**

MID-TERM EVALUATION

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ACRONYMS

AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
AID/W	Agency for International Development/Washington
CA	Cooperating Agency
CERPOD	Center for Research on Population and Development
CHW	Community Health Worker
CM	Medical Center
CSM	Condom Social Marketing
CSPS	Center for Health and Social Promotion
DDC	Diarrheal Disease Control
DEP	Directorate of Studies and Planning
DESA	Directorate of Health and Sanitation
DICSS	Directorate of Central Inspection of Health Services
DHS	Demographic and Health Survey
DMP	Directorate for Preventive Medicine
DPF	Directorate for Family Promotion
DPSP	Provincial Directorate for Public Health
DSF	Directorate of Family Health
FHHF	Family Health and Health Financing Project
FP	Family Planning
FP/MCH	Family Planning/Maternal Child Health
FPMD	Family Planning Management Development
FPMT	Family Planning Management Training
FPS	Family Planning Support Project
GOB	Government of Burkina Faso
GTZ	Gesellschaft Technische Zusammenarbeit
HIS	Health Information System
IEC	Information, Education and Communication
INTRAH	Program for International Training in Health
IUD	Intrauterine Device
KAP	Knowledge, Attitudes and Practices
KFW	Kreditanstalt für Wiederaufbau
MCH	Maternal and Child Health
MIS	Management Information System
MOH	Ministry of Health

MSH	Management Sciences for Health
NACP	National AIDS Control Program
NTT	National Training Team
NUTCOM	Nutrition Communication
OAR/B	Office of the AID Representative/Burkina Faso
OR	Operations Research
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OR/TA	Africa Operations Research/Technical Assistance Project
OST	Office of Workers Health
PACD	Project Activity Completion Date
PCS	Population Communication Services
PEV	Enlarged Program of Vaccination
PIL	Project Implementation Letter
PIO/T	Project Implementation Order/Technical
PIR	Project Implementation Review
PP	Project Paper
PSI	Population Services International
PTT	Provincial Training Team
SEATS	Family Planning Service Expansion and Technical Support
SHPC	Strengthening Health Planning Capacity Project
STD	Sexually Transmitted Disease
TA	Technical Assistance
TOT	Training of Trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank

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I. EXECUTIVE SUMMARY

A. Project Performance

The Family Health and Health Financing (FHHF) project, a six-year, \$10 Million project consists of three discrete but linked subprojects. Two of the subprojects, Child Survival and Maternal Health and Strengthening Health Planning, were subject of a mid-term review in late 1993; the third, health financing, experienced delays in start-up, and will be reviewed separately later in the project period. Overall the FHHF project has performed well and has met most mid-term objectives set out in the amended project design, despite a complex administrative structure and a high rate of organizational change within the Ministry of Health (MOH).

The continuation of project activities under the bilateral umbrella with most of the same contractors who had worked in Burkina Faso prior to implementing the FHHF project allowed steady project progress with the development of known local strengths and amelioration of weaknesses. While this created some problems in coordinating timing of interrelated activities carried out by different contractors, inconveniences were offset by the facts that OAR/Burkina was able to access the best talent available in the relevant project domains, and virtually all of the cooperating agencies increased available resources by drawing on central funds to complement project activities.

Subproject 1, Child Survival and Maternal Health, evidenced complementarity and coordination among its component activities: family planning, nutrition, diarrheal disease control, and condom social marketing. There has been functional integration at the level of service delivery, and supervisors are being trained to monitor FP/Child Survival activities as a set, rather than as discrete functions. Only the social marketing of condoms remains somewhat out of this loop, as it is oriented to the private rather than the public sector; nevertheless its introduction has been coordinated with appropriate directorates of the MOH.

Subproject 3, Strengthening Health Planning, has provided support to the Directorate for Studies and Planning (DEP) to increase its health planning capabilities for the MOH, and to increase its budget from non-USAID sources. DEP is now involved in all the planning and evaluation functions of the MOH. However, DEP needs to improve the quality of its documents needed for planning purposes such as the annual health statistics report. DEP can also make better use of the annual donor coordination conference to address policy related issues such as financial sustainability of MOH programs.

B. Major Project Achievements

While the separate subprojects of the FHHF project have been oriented to specific goals, the project as a whole has striven to promote fundamental change at the central and provincial levels of health service provision. An important effect of the project is the adoption and acceptance by the Government of Burkina Faso of a multi-pronged approach to the delivery of family planning services. Contraceptive supplies are being offered through

the public sector, the private sector, social marketing, and, on an experimental basis, through community based distribution. This represents a real opening of service delivery systems, and is particularly significant in the West African context, long known for the medicalization of health care services.

The adoption of training materials and curricula, policy and standards, protocols, and IEC materials developed under the project as national norms is another major success of the project. This adoption of documents as national standards has assured common training, service provision, and targets for all health sites throughout the country.

The FHFF project has been successful in fully engaging the MOH in project planning and implementation. While the MOH had identified these programs as being important prior to the development of the FHFF project, it now is completely committed to achieving the project goals, especially for family planning and MCH.

The Burkina Faso Demographic and Health Survey, carried out in 1992-1993 found that among women in union, the contraceptive prevalence rate (CPR) for all methods is 7.9 Percent, with 4.2 Percent using modern methods. In 1987, the CPR for modern methods was less than 1 percent. As OAR/Burkina has been the lead donor agency supporting family planning since 1985, much of the increased use of contraceptives can be attributed to project activities, and their predecessors funded by USAID.

Finally, the saturation strategy of the condom social marketing program yielded a remarkably rapid and successful insertion of condoms into the private sector. The result has been widespread product identification throughout the entire country. Now, the focus of this subproject must be on securing product position, increasing demand, and developing more retail sales. The marketing efforts have worked well to define a product image and its market niche; much remains to be done to raise knowledge and awareness about condoms both as a protective measure against both disease and pregnancy.

C. Lessons Learned

The strong support of the MOH to accept activities as integral to its goals and not only as isolated, donor-driven projects facilitates the adoption of documents and protocols as national standards, and has assured common training, service provision, and targets for quality at health sites throughout the country, regardless of variations in donor support for different provinces.

Marrying the diverse activities included in maternal and child health, family planning, and health financing subprojects can be a sensible strategy to use in situations of limited human resource capacity and infrastructure constraints, particularly when efforts are made to ensure acceptance and adoption of project outputs by all relevant participants.

The design of a bilateral project as a compilation of activities supported by different contractors and cooperating agencies fostered some trade-offs. While efficiencies were realized at the outset in preparing only one set of A.I.D. Project documents, and in continuing work already begun by centrally-funded projects, subsequent demands on USAID and MOH personnel were heavy as they prepared separate subcontracts for each activity, and worked with consultants from different organizations under different timelines.

The presence of local technical counsellors and easy access by regional contractor staff ensured routine monitoring of project progress, reducing the need for direct USAID intervention in project activities.

D. Recommendations for Second half of Project

No major changes in project design are required for the second half of this project. Close technical oversight of subproject activities continues to be warranted, and the continuation of contractor technical assistance, provided by local technical counsellors or contractor regional offices, is encouraged.

The project should continue its support of MOH efforts to adapt training, management and supervisory practices, information, education and communication activities, and related service delivery skills to the strengthening of integrated service delivery systems.

In view of the likely phase-out of USAID activities in Burkina Faso, OAR/Burkina bears a responsibility to coordinate with other donors to ensure the continued support and development of successful health and family planning interventions and strategies. Efforts are already being made by OHP staff to lobby for the inclusion of activities previously supported by OAR/Burkina in projects to be developed and funded by other donors, lenders, and non-governmental organizations.

E. Future Directions

The activities introduced under the FHMF do not appear to be sustainable without continued donor support. The core of trained staff needs expansion, and regular retraining. The staff at the provincial administrative level is stretched thin, carrying out their own tasks, supervising lower level health staff, and in some cases bearing clinical responsibilities as well. Staff mobility is a problem, with frequent reassignments interrupting reinforcement of local sites, and necessitating continual reestablishment of priorities and procedures based on local needs. There is also a lack of general management skills among health care professionals working in the field.

Efforts must be sustained in the remaining period of the project to continue support for strengthening and expanding skills and services developed under the auspices of this project.

II. PROJECT DESCRIPTION

A. Introduction and Project Background

This mid-term evaluation report begins with a brief description of the Burkina Faso Family Health and Health Financing project, and the evaluation methodology. A discussion of the achievements of subprojects and elements follows, with an analysis of the impact of the project as a whole. The final sections include a discussion of the appropriateness of the project design, and thoughts on how USAID might continue to support Burkina Faso in the health and population sectors in the future.

The Burkina Faso Family Health and Health Financing (FHHF) Project is a six-year \$10 million bilateral grant signed in 1990. The project includes three subprojects, which taken together have the goal of improving the health of the Burkinabè population, particularly women and children. This will be accomplished by expanding Family Planning and Maternal and Child Health (FP/MCH) services, improving its quality and financing, and strengthening the planning capacity of the Ministry of Health (MOH).

The project represents a continuation and expansion of activities begun under two previous bilateral health grants and several centrally-funded projects. Sub-project 1, Child Survival and Maternal Health, builds on the experience of the Family Planning Support Project (FPS) (1986-1990), and several centrally-funded projects. The Health Financing Subproject (Sub-project 2), is an expansion of the operations research project undertaken by OAR/Burkina and the World Bank during 1987-1990. Finally, the third sub-project, Health Planning Support, is a continuation of support to the MOH begun under the bilateral Strengthening Health Planning Capacity (SHPC) Project (1982-1990).

B. Project Objectives

The focus of sub-project 1, Child Survival and Maternal Health, is to strengthen and expand preventive health services for mothers and children. The sub-project consists of four discrete, yet related, components. They include: Family Planning and Maternal and Child Health (FP/MCH); Diarrheal Disease Control (DDC); Nutrition Communication; and AIDS prevention through Condom Social Marketing. This sub-project finances the training of service providers; purchase and distribution of contraceptives, clinical equipment and other commodities; production and dissemination of Information, Education, and Communication (IEC) materials; operations research; short- and long-term Technical Assistance (TA); and local costs related to project activities.

The focus of the Health Financing sub-project 2 is on improvement of services offered by primary health care facilities, in a financially sustainable way. Pharmacies at the village level will be established to stock and sell essential drugs which will both improve health treatment and generate revenue for primary health care services. Diagnostic tests will be introduced, diagnosis and treatment will be improved, supervision and management will

be strengthened, and user fees introduced as a way to partially recover recurrent costs. Health facilities will retain part of the revenue generated to support recurrent costs. (While this description of sub-project 2 is included to provide a complete picture of the FHHF project, the Health Financing sub-project has not been included in the current evaluation because it has only been active for one year; its mid-term evaluation is scheduled for 1994.)

Finally, the objective of the Health Planning sub-project 3 is to assist the Directorate of Studies and Planning (DEP) of the MOH in developing permanent sources of financing for the recurrent costs of important periodic health planning activities. This sub-project provides financing for recurrent health planning activities, while working to increase the MOH contribution to the DEP budget. Steps will be taken to develop sources of revenue from DEP activities and to reduce recurrent costs.

C. Project Components Description

1. Sub-Project 1: Child Survival and Maternal Health

The activities carried out under sub-project 1, Child Survival and Maternal Health, are being implemented by the MOH with technical assistance from several US-based contractors. The sub-project consists of four components: Family Planning and Maternal and Child Health; Nutrition Communication; Diarrheal Disease Control; and Condom Social Marketing for AIDS prevention.

a. Component 1 - Family Planning/Maternal and Child Health

Objective:

To strengthen and expand FP\MCH services by improving information and services in 52 old sites and 32 new sites in 15 provinces.

Activities:

Building upon the work begun by the Directorate of Family Health (DSF) FP service under the bilateral Family Planning Support (FPS) Project, the main activities supported under the component are:

1) Training

The National Training Team (NTT) receives MCH refresher training. In addition, Provincial Training Team (PTT) members, DSF staff and supervisors are trained in training of trainers techniques, performance evaluation, clinical preceptor skills, FP management, and supervision/evaluation techniques.

All service providers not previously trained will attend a basic FP course. The NTT, will utilize the FP training manual developed under the FPS project to conduct the course. The course will entail two weeks of theoretical training followed by four weeks of practical training. The practical training will be held at clinics with sufficient caseload to permit participants to complete training objectives, including the required number of supervised IUD insertions.

The MOH will develop two MCH in-service training curricula (one for midwives/nurses, one for assistant midwives). These curricula will cover all aspects of MCH including prenatal care, post-natal care, health education, nutrition counseling, and birthing, as well as having a specific module on principles, practices and procedures for integrated service delivery. They will be used as a guide for refresher training of midwives/nurses and assistant midwives. The two-week refresher course in MCH/FP will be conducted at the provincial level by the PTT, with guidance and technical assistance provided under the project and by the NTT, as necessary.

The NTT will conduct training in FP information, education and communication (FP/IEC) for front-line workers from the MOH and other government institutions. The four-week course will concentrate equally on modern FP methods and communication techniques. PTTs, with assistance as necessary from the NTT, will conduct refresher training in FP/IEC for social educators and monitors. These three-day sessions will include use of audio-visual equipment, GRAAP methodology, management and supervision techniques.

Finally, key staff of the MOH will benefit from short-term training and attendance at FP/MCH conferences in the U.S. or a third country. In addition, one study tour of MCH/FP programs in other African countries will be organized.

2) Information, Education and Communication (IEC)

The project will develop IEC strategies and materials to improve knowledge and awareness of FP services and methods. The DSF will organize a workshop for participants from all organizations implementing FP/IEC activities. Following this workshop, the DSF will organize various activities in the field, including brief FP informational conferences for opinion leaders and national and provincial IEC campaigns targeting the general public.

Print materials developed under the FPS project (brochures, posters, decals, cloth) will be reproduced under this project. In addition, new materials will be developed including posters, FP fliers, informational brochures on modern methods, and comic books with FP themes for adolescents. A distribution plan for all print products will be elaborated at the beginning of the project. In addition, the project will fund the production and recording of a FP play, a seminar for the media to improve reporting skills on FP issues, and on an experimental basis, portable FP information kiosks which will be placed in strategic locations in the provinces in an effort to make FP information more accessible.

The project will also provide a limited quantity of IEC equipment and supplies and reference materials for the DSF and MOH field agents.

3) Strengthening Service Delivery

The project will provide the contraceptives necessary for the program (pills, IUDs, spermicide, condoms). Contraceptive orders will be based on distribution statistics and will be coordinated with those of other donors, including UNFPA. The MOH and USAID will jointly program the proceeds of contraceptive sales.

The project will provide new project sites with essential FP/MCH equipment. Orders will be based on the findings of the needs assessment study conducted at the beginning of the project.

The project will provide financial and technical assistance to the Office of Workers' Health (OST) to strengthen FP services currently provided to OST's occupational health care service network, and to extend services to other OST dispensaries in Ouagadougou, Bobo-Dioulasso, Koudougou, Poura and Banfora.

4) Strengthening Program Management and Supervision

The project will assist the DSF to improve its management information system through the provision of technical assistance, computer equipment and training.

In addition, the project will fund the printing of record keeping documents essential for the management of FP/MCH/Nutrition programs. Management tools to strengthen supervision will be developed. The project will also develop a family register to be used for integrated service delivery.

Finally, the project will provide DSF and provincial FP/MCH and FP/IEC supervisors with the means to conduct periodic supervision visits to the project sites.

5) FP/MCH Operations Research and Evaluation

Studies to be funded under the project will include: 1) a needs assessment study in the 15 provinces at the beginning of the project to evaluate staff knowledge and skills in FP, and to conduct an inventory of FP/MCH equipment and supplies; 2) a situation analysis of the national FP program at the beginning and the end of the project; and 3) a study to test the use of trained village birth attendants as FP educators and service providers. In addition, each component will include evaluation activities such as KAP studies, pre-post surveys, focus groups etc.

Additional studies to be funded will be identified during the life of the project.

b. Component 2 - Nutrition Communication

Objective:

To modify the behavior of Burkinabe families in order to improve their nutritional status. Mothers and children will constitute the primary target group within the general population in eight provinces.

Activities:

This component will continue work funded under pilot nutrition communication activities with the DSF.

1) Training

The staff of the MOH Nutrition Service, with technical assistance provided by the project, will train the provincial training teams in the principal nutrition themes to be developed under the project. Under the Directorate of the Provincial Health Directors (DPS), the provincial training teams will conduct the training and refresher training of service providers in 8 provinces.

2) Information, Education and Communication (IEC)

A national level technical workshop will be held to review results of the baseline KAP study and develop the communication strategy to be implemented under the project. With technical assistance from the contractor, the Directorate of Family Health (DSF) and the Directorate "de l'Education pour la Santé et Assainissement" (DESA) will develop and carry out a coordinated educational campaign which will effectively communicate and reinforce key nutritional messages on three themes: 1) maternal nutrition; 2) infant feeding and growth; monitoring/promotion; and 3) recuperative feeding of children after episodes of diarrhea and other illness.

3) Program Management and Supervision

The project will provide funds for the DSF and provincial supervisors to undertake periodic supervision visits to project sites. Supervision and observation visits by MOH and contractor staff will provide qualitative information on efficacy of project training and training materials provided to provincial health workers.

4) Operations Research and Evaluation

Baseline and post-project KAP studies will be undertaken to permit observation of changes in knowledge, attitude and practices in the project zone. Focus group activity may be carried out as necessary to more clearly identify targets selected. Follow-up monitoring of the IEC materials and radio spots developed and disseminated will test comprehension and knowledge on the part of target audiences.

c. **Component 3 - Diarrheal Disease Control**

Objective:

To promote the appropriate treatment of diarrheal cases in health facilities and the community and to improve supervision of DDC activities at the central and provincial level in eight provinces.

Activities:

1) **Training**

The project will provide in-service training in DDC to health agents and community primary health workers in the eight project provinces. The national DDC training team will train provincial health trainers in DDC. In turn, the provincial trainers will train all the professional health agents (doctors, nurses, midwives and other paramedical staff) and a significant number of the community health workers in each province. The project will utilize the DDC training manual and animation booklet for health agents and community health workers developed under the USAID/PRITECH Pilot DDC project. Provincial trainers will conduct integrated refresher training workshops on DDC for health agents and community health workers on a bi-annual basis and will train the pharmacists in the project area in the principles of oral rehydration therapy (ORT) and the limitations of anti-diarrheal drugs. DDC training modules will be provided to the national school of public health, and DDC didactic materials will be provided to the national medical school.

2) **Community Education**

The project will conduct community sensitization activities to influence the behavior of mothers who have limited or no contact with health personnel or community health workers.

3) **Strengthening Service Delivery**

The project will strengthen DDC service delivery by procuring the materials and equipment necessary to establish oral rehydration therapy corners in the health facilities of the project provinces. Health agents and community health workers will be provided with the DDC animation booklets and technical guides which were developed under the USAID/PRITECH Pilot DDC project. The project will fund annual supervision visits by the national DDC coordinator to each of the project provinces and will fund integrated supervision activities at the provincial level.

4) **Operations Research and Evaluation**

KAP studies will be conducted to measure the knowledge, attitudes and practices of mothers concerning diarrhea; and periodic studies will be conducted to assess case management of diarrhea by health workers. Other operations research activities will be undertaken as appropriate.

d. **Component 4 - Condom Social Marketing (CSM) Program**

Objective:

To prevent the spread of AIDS and other sexually transmitted diseases in Burkina by increasing the use, acceptability, and availability of condoms to high risk and other target population.

Activities:

1) **Condom Sales**

The project will establish a condom distribution network through support to an independent company to overpackage AID-procured condoms; to train sales staff; to establish a wholesale and retail distribution network in major towns, border towns and mining areas; and to monitor overall sales by province.

2) **Community Education**

The project will support product mass media promotion activities in accordance with local tastes and perceptions to improve consumer knowledge of the benefits associated with condom use and to stimulate demand for the product. In addition, the project will train community retailers in appropriate storage and proper use of condoms.

3) **Operations Research and Evaluation**

The project will support research activities to monitor condom use, surveys of consumer acceptance and retailer studies to discern consumer satisfaction and product acceptance, studies on the return on investment and likelihood of self-financing, and studies on the prevalence of sexually transmitted diseases.

4) **Program Management**

The project will strengthen private sector management capacity to distribute and monitor condom sales. In addition, the project will establish a management information system and train staff in this aspect of project management and monitoring.

2. **Sub-Project 3: Strengthening Health Planning**

Objective:

To assist the DEP to develop permanent sources of financing for the recurrent costs of important periodic health planning activities.

Activities:

a. Health Planning

The DEP will analyze MIS data for including in the MOH technical reports, evaluations and health plans.

b. Donors Coordination Conferences

The DEP will annually initiate, organize and conduct annual Donor's Conferences. The purpose of these conferences is to encourage donors' coordination and to discuss broad health sector issues.

c. Financial Sustainability

By developing its annual budgets, DEP should initiate and encourage a recurrent costs sharing system with its partners and obtain more national budget support for its activities and/or develop activities to generate funds.

d. Reports

The DEP will produce an annual report of service statistics for MOH planning and program evaluation purposes.

e. Training Support

The DEP will develop and implement a training plan for health technicians at Central, Provincial and/or Departmental levels on health data gathering, analyzing and reporting.

f. Research/Studies

The DEP will conduct and/or collaborate on, as decided between USAID and DEP, selected studies to improve the MIS system and/or MOH program performance.

D. Other Donor Activities

USAID is one of three major international donors providing support for health and family planning activities in Burkina Faso. The United Nations Fund for Population (UNFPA) supports all health sites in 9 provinces not covered by USAID, and with USAID shares support for activities in Kadiogo, the province in which Ouagadougou is located. UNFPA supports the reinforcement of integrated FP/MCH services carried out by the DSF, social welfare activities in rural areas and family life education carried out by the Directorate

for Family Promotion (DPF), population education in secondary schools, and support for the National Population Council in the Ministry of Finance and Plan. A new project will emphasize the strengthening and continued decentralization of FP/MCH services.

The World Bank is funding the Development of Health Services project, which includes a FP/MCH component launched in 1989. The project provides support for the remaining 6 provinces in the country. Activities include initial and refresher training for health personnel in FP/MCH and in family planning IEC; provision of technical and audio-visual equipment to health facilities; repair and construction of health facilities; and awareness raising among decision makers on the significance of FP/MCH. A new Population and AIDS Prevention Project is being planned; it is scheduled for approval consideration in July 1994. Its objectives are to reduce the rate of population growth by enhancing fertility decline, and slowing the spread of HIV/AIDS by promoting behavioral change.

Other donors, notably UNICEF, the German aid organization Deutsche Gesellschaft Technische Zusammenarbeit (GTZ) and a variety of non-governmental organizations working mainly in rural areas provide additional support for maternal and child health and some family planning activities.

The level of coordination among the principal donors is high. Planning for project activities has taken into account work being carried out by other agencies. The National Training Team developed under the earlier USAID project conducts training for UNFPA and World Bank projects. Curricula, IEC materials, service policies, standards and protocols, and supervision protocols developed under the FHHF project and the earlier FPS project have been adopted as national standards and are used throughout the country, regardless of source of donor support. USAID and UNFPA also consult each other to ensure timely acquisition of contraceptive commodities, with the UNFPA mainly assuming responsibility for importation of injectable contraceptives, and USAID having the major responsibility for the other methods.

III. MID-TERM EVALUATION PROCESS

A. Objectives and Scope of Work

The purpose of this mid-term evaluation is to assess the effectiveness of two of the three sub-projects of the Burkina Faso Family Health and Health Financing Project. The Child Survival/Maternal Health sub-project and the Health Planning sub-project are being evaluated at this time, but the Health Financing sub-project was delayed in its start so its mid-term evaluation will not be conducted until late 1994.

For the Child Survival/Maternal Health and the Health Planning sub-projects, sub-projects 1 and 3 respectively, this mid-term evaluation includes assessment of project design, management, implementation of the planned range of activities, impact upon the Burkina Faso health sector systems, and attainment of outputs objectives. It also attempts to evaluate the sustainability of the project's achievements, to identify the lessons learned which can be applied to the remainder of this project and to USAID's future project design work, and to formulate specific recommendations concerning USAID health sector assistance in Burkina Faso, both during the life of the project and beyond.

The full text of the Scope of Work that OAR/Burkina prepared for this mid-term evaluation is attached as Annex C. It should be noted, however, that this Scope of Work was drafted before the intention of USAID to close the OAR in Burkina and possibly terminate the continued use of bilateral projects was known. With these and related consequences of the Agency's reorganization now better understood, this evaluation does not include recommendations for a follow-on project but concentrates instead on management of the remainder of the project.

B. Team Composition

The mid-term evaluation was undertaken by a team of three health sector development professionals as follows:

Team Leader - Program Planning and Design Specialist

Albert E. Henn, MD MPH FACPM

Public Health and Demography Specialist

Susan E. Adamchak, MA

AIDS Prevention and Control Specialist

Souleymane Barry, MD

Both the Team Leader and the Demographer were supplied through an IQC by Devres, Inc., and the AIDS Specialist was provided by REDSO/WCA.

C. Methodology and Schedule

The Devres-provided consultants arrived in Ouagadougou on October 27, 1993, and worked in Burkina Faso for approximately three weeks. Due to conflicting commitments, the team member from REDSO/WCA had to complete his portion of the evaluation by October 30. However, he was able to meet with the other members of the evaluation team and brief them, USAID and PROMACO staff on his findings before his departure, and he left a comprehensive draft report with the team leader to be incorporated into the final report. His complete final report is attached as Annex J.

In gathering information for the mid-term evaluation, the evaluation team reviewed all available relevant documents including, inter alia: the Project Paper, Grant Agreements, PIO/Ts, Accords between Contractors and the MOH, PIRs, PILs, progress reports, study reports, IEC materials produced, trip reports and other documents kept in the OAR Health Office files. In addition, team members interviewed MOH officials, OAR/Burkina staff and Contractor personnel, both in Ouagadougou and in connection with site visits made while on trips into the provinces assisted by the project. In all, 11 of the 30 provinces were visited by the team.

A map of Burkina Faso indicating which components of the project are active in which provinces is attached as Annex D; a chart showing which Contractors are associated with which project components is presented as Annex I; the schedule of activities of the evaluation team is attached as Annex E; a list of important documents consulted is attached as Annex G; and a list of the persons contacted by the team is attached as Annex F.

IV. PROJECT PROGRESS AND EFFECTIVENESS

Overall the FHHF project appears to have been productive in its efforts to expand quality maternal and child health services. The performance of the project's sub-projects and components is discussed below.

A. Sub-project 1: Child Survival and Maternal Health

1. Family Planning & Maternal and Child Health

The Family Planning and Maternal and Child Health component of sub-project 1 includes a wide spectrum of activities, and is the largest element of the FHHF project. Taken as a whole, the activities constitute a logical follow-on to those started under earlier bilateral agreements and central projects, and have provided the means to gradually expand FP and MCH services in Burkina Faso.

a. Training

Implicit throughout the FHHF agreement is the reinforcement of the Burkinabe health infrastructure, including its human resource base, at all levels of implementation. It is particularly notable in the focus of FP/MCH training.

A key benefit of the training carried out under the project with technical support from INTRAH was the development of an MCH training curriculum, and revision of the family planning curriculum. Both have been adopted as national standards, and are now being used in training new nurses and midwives at the school of public health, as well as in clinical training and retraining of health care personnel.

A second significant result of the training component of the subproject is the development and subsequent adoption of the Politique et Standards des Services SMI/PF au Burkina Faso, and the related service delivery protocols. Again, these have been adopted as official documents of the MOH, and will be used in training and refresher courses for all health personnel, as well as serving as reference guides at all service delivery sites.

National adoption of these documents assures consistent training and service delivery standards at all service delivery sites throughout the country, regardless of donor funding source. Thus, although nominally USAID is responsible for FP/MCH activities in 15 provinces, in fact health staff in all 30 provinces are benefitting from these project products.

The documents were developed in a series of collaborative workshops, and their preparation and use is an indicator of the level of commitment of the MOH to improving the quality of service delivery.

A further important benefit of the training component of the project is the reinforcement of the National Training Team (NTT), development and strengthening of Provincial Training Teams (PTT), and identification of regional training sites. This contributes to a further strengthening of local capacity to plan, conduct, monitor and evaluate training activities in Burkina Faso, enhancing human resources and program sustainability.

The INTRAH project, responsible for the training activities, effectively combined the skills of a resident technical advisor with continuity in the short-term advisors sent to Burkina Faso. Working closely with the MOH and USAID, INTRAH developed a comprehensive training plan that details 80 separate activities to be undertaken during the project. These include needs assessments, curriculum development, training of trainers, MCH and FP skills training, policy development, protocol development, study tours and conferences. The plan describes activities, and provides dates, participants, trainers, and funds for each, thus serving as a common reference for INTRAH, the Ministry, and USAID.

Training is proceeding according to the schedule proposed in the training plan. Numerous courses have been held, including: training of trainers; clinical family planning; clinical preceptor; performance evaluation; and family planning refresher courses.

Lessons Learned

The full and collaborative participation of MOH staff in identifying training needs, developing curricula, and carrying out training was extremely important in developing common national training and performance standards. In addition to fully imbedding FP/MCH training in the national program, this has led to a wider project impact, affecting the entire country rather than only the USAID project provinces.

With inclusion of family planning and maternal and child health training curriculum in the professional training programs, all newly graduated health personnel will enter their posts familiar with basic FP/MCH concepts and practices. In the not-too-distant future, training needs will shift from providing basic training, to an emphasis on clinical updates, improved management, and better quality of care.

The detailed and comprehensive training plan developed by MOH, INTRAH and USAID has proved to be an effective planning and monitoring document used by all parties. It provides a model that can be fruitfully emulated by other project components in future project planning.

Recommendations

Project activities should be continued according to schedule. A greater effort should be made to reproduce training materials and related documents such as the Politique et Standards and service protocols, and to disseminate them widely to Medical Centers (CM) and Centers for Health and Social Promotion (CSPS) for use as references in service delivery.

b. Information, Education and Communication (IEC)

With slight modifications, the IEC activities are proceeding according to plan, although requiring calendar adjustments to accommodate some delays in implementation. The project supports an extensive mix of media to promote family planning messages, including posters, bumper stickers, leaflets (both general and one targeting youth), leaflets, signs, flip charts, flannel boards, fabric printed with the family planning program logo, a radio series and paid advertisements, and a video of a play having a family planning theme, to be used as a television broadcast. As with the training component, the project built on work that had been accomplished earlier with USAID funding and technical assistance from the Johns Hopkins University Population Communication Services, dating from 1985.

Three issues of a newsletter have been produced, and distributed to the provinces. Clinic signs are being refurbished to indicate that family planning services are available every day, and new ones are to be constructed; it appears that 40 of the 100 planned are done. Family planning badges and bumper stickers are being printed in the U.S.; DSF staff believe that a PCS consultant will bring those on a TA visit planned for the month following this evaluation. Three old family planning posters were to be reprinted, and three new ones designed. The reprinting is behind schedule. Pretesting the new ones is evidently underway now, slightly delayed, and distribution is planned for the first quarter of 1994. Four hundred poster frames were made and distributed. The model for a family planning cloth is prepared, and was recently approved; it will be printed soon, and available for sale early in 1994.

A general family planning brochure has been printed, and a leaflet for targeting youth is underway about 8 months late. About 8 episodes of a radio series (of a projected 40) have been completed and are broadcast weekly; production on other episodes will begin once response to the first set has been evaluated. Several advertising spots were also prepared, and are aired around the time of the series. The radio series is one change from the initially planned activities, and is being carried out in lieu of proposed training for social agents.

Production of a play with a family planning theme, "Fatoumata, the Baby Machine", will be the subject of the December 1993 TA visit. It is planned to video tape the play, and distribute copies to each province. It will also be aired on national television. The airing of the program will be timed to coincide with the planned national information campaign. Finally, IEC campaigns are being carried out with provincial opinion leaders. Three have been done, and the remainder are scheduled for the duration of the project. One hundred FP flip charts were purchased by the project, and are being distributed now. Two of three planned IEC training sessions (a reduced number from that originally planned) for social agents have been held, the remaining is scheduled for 1994. Three of 7 refresher courses for agents already trained have taken place. Retraining of the National Training Team is also scheduled for January 1994.

The materials that were reviewed by the evaluation team are attractive, and carry appropriate messages. However, with the exception of a few posters, few IEC materials were in evidence at the CMs and CSPSs in the five provinces visited by the team. If they had received posters, often they were not hanging, with local staff citing the difficulty of mounting the posters on the stucco walls. Although frames were made to address this problem, they have not yet made their way to the health facilities visited. Distribution of items from the central to the provinces was found to be a problem. In Seno province, the Provincial Medical Office was manufacturing their own frames for provincial sites. Overall, provincial health staff have few IEC resources available to use for client motivation and education activities.

Also, health staff who have received IEC training are using their skills only intermittently to conduct "causeries", or discussion groups. One medical center visited had a monthly calendar of talks posted, with the staff responsible for conducting each clearly indicated. Two other CSPSs stated that they scheduled one theme each month, with one reporting that they had presentations weekly, the other two times during the month. Some staff remarked that with the practice of now providing integrated services, they no longer had a predetermined idea of who would come to the clinic each day, a situation that had previously facilitated their planning IEC activities. Nevertheless, most of the health sites visited have very low IEC activity levels. The CM or CSPS could plan a weekly rotation of topics, and present one subject several times each week.

The preparation and availability of IEC materials is lagging behind the other activities mainly due to the re-organization at the MOH level during the past three years and the IEC unit was affected by it the most. It lost some of its trained people to other units.

It is clear that increased awareness and knowledge of family planning methods is key to increasing contraceptive use in Burkina Faso. The preliminary results of the Burkina Faso Demographic and Health Survey, carried out in 1992-1993, show that 63 percent of women know about modern contraceptive methods, and fewer than 30 percent know a source for a method. About half the women surveyed knew of the pill or condom, but far fewer were familiar with other methods.

Lessons Learned

Frequent staff mobility and turnover at both central and provincial levels seem to affect those components most where there are no resident technical counsellors provided under the project, such as the IEC component. Project implementation continues to require close follow-up on part of the USAID office.

Integration of health services complicates efforts to provide regular IEC messages and requires rethinking about how to schedule causeries in an integrated manner and what to discuss when IEC presentations are made.

Recommendations

IEC activities should be reinforced and intensified during the second part of the FHHF project if a real increase in contraceptive use is to be realized.

Greater effort should be made to have regular IEC presentations at provincial health service sites. This may require shifting to more individual counselling of health clients, or developing weekly schedules of presentations on different topics.

Materials must be made available to staff at service delivery sites for better counselling.

c. Strengthening Service Delivery

The preliminary results of the 1992-1993 Burkina Faso Demographic and Health Survey show a contraceptive prevalence rate for all methods of 7.9 percent among women in union, and a rate of 4.2 percent for modern methods. While not a direct measure of the impact of USAID's intervention in the family planning, to the extent that USAID has been the major supporter of family planning activities, and the major importer of contraceptive commodities as well as expanding services to a total of 84 clinics, this rate can be considered as an indicator of program performance.

Although improving skills through training and increasing awareness through IEC activities, providing contraceptives and supplies for new clinics, as discussed above will have effects on service delivery, in this section we focus on two elements of changes made in the actual delivery system under the project: the support for service expansion in the private sector; and the integration of FP/MCH services throughout all levels of service delivery in the public sector.

Private Sector

Through the FHHF the MOH Office of Workers Health (OST) with technical support from the SEATS project has expanded the availability of clinical family planning services to 18 industrial clinics in five cities. This is a follow-on of a project begun in four sites by the Enterprise Project, a precursor to SEATS. The sites are monitored by the OST and the MOH, and are subject to the same standards of quality of service provided elsewhere. Expansion into the network of the enterprise clinics serves to increase FP/MCH accessibility for workers and their families.

Thirty-eight clinical service providers were trained, and their work sites provided with appropriate clinical equipment. Almost 200 volunteer motivators were trained in family planning IEC, and then charged with motivating their fellow workers to use family planning, and selling condoms. It was projected that each motivator would contact at least 100 people, reaching 20,000 workers, and that about 5000 would be served by the clinics.

IEC materials developed for the project were imported from the U.S., and were delayed upon arrival which resulted in some delay in project progress.

Project supervision has been inadequate. Some supervisory visits have taken place in Ouagadougou, but they do not occur monthly as was planned. They occur much less frequently in other cities where the project relies on provincial training specialists to join the project director to supervise implementation. There were complaints of inadequate resources for gas, and SEATS allocated a special amount for this purpose. The project director recently identified a midwife to administer the project in Bobo-Dioulasso and Banfora; she will supervise project sites and assist with data collection and reporting. This step may alleviate some of the problems realized to date.

Related Private Sector Initiatives

The activities introduced under the FHHF bilateral grant have been complemented and enhanced by related activities provided through central funding. In some cases, central support permitted an expansion of planned activities, such as an increased number of persons to be trained, or more copies of documents to be printed. In other cases, particularly vis-a-vis the private sector, entirely different activities were started, with the result of expanding the scope of family planning activities.

Three private sector activities are among those supported by central funds of the SEATS project. SEATS has expanded and enlarged prior support to the Burkinabe Midwives Association (ABSF) to train satisfied users as motivators, visiting women in their homes to tell them about ABSF clinic services in general, and family planning in particular. They are carrying out visits in 15 neighborhoods in Ouagadougou, and in 19 in Bobo-Dioulasso. In addition to motivating possible contraceptors, the animators are distributing non-prescription methods, and are referring women to ABSF clinics for other methods.

SEATS is also working with the Burkina Association for Family Well Being (ABBEF) to provide services for youth through youth centers, clubs and clinics in Ouagadougou and Bobo-Dioulasso. They are providing IEC activities in secondary schools, and have targeted 10,000 youth in the informal sector, to teach them about family planning, AIDS, STDs, and family life.

Finally, a project was developed with the Ministry of Health Directorate for Central Inspection of Health Services (DICSS), to provide clinical training for service providers who are in private practice. Twenty providers in Ouagadougou received an initial training, and ten were selected for more in-depth training. Also, their clinics are being upgraded with appropriate equipment so that they can successfully offer family planning services.

Taken together, these projects reflect a very important opening of the private sector, and a small but significant increase in its role in providing family planning services. This is particularly notable given the strong history of medicalization of health care in Burkina Faso, and its virtual total reliance on the public sector for service provision.

Lessons Learned

All of these projects propose new and interesting ways of bringing family planning services to women and men in Burkina Faso. But, they are being carried out on small scales, and will require follow-up if they are to become fully operational and sustainable.

As in the public sector, as private sector FP/MCH activities are introduced, there needs to be regular monitoring and supervision.

While there may be a latent demand for FP/MCH services, most programs, including those implemented through the private sector, will benefit from IEC efforts to inform potential users and compel them to meet their demands.

Recommendations

Supervisory visits should be made more regularly, and used to increase the motivation of project animators and clinicians.

Motivators and animators in the private sector projects could be trained in AIDS IEC. This would be appropriate if the project continues and funding can be secured. Many men may be more interested in protecting themselves from AIDS and STDs than in using condoms for family planning; the opportunity should not be missed to address both issues.

Little has been done to alert other enterprises affiliated with the OST of this project, and its potential impact. The project director and local technical advisor should undertake this effort, perhaps scheduling a luncheon or seminar for managing or personnel directors of other companies to share experience to date. This strategy has resulted in significant "spin off" effects in other countries.

FP/MCH Integrated Services

The MOH has made a policy decision to integrate family planning and maternal and child health services at all levels of the health care system. USAID supported this effort with TA from SEATS central funds through the development of a curriculum and training in the management of integrated programs. Five training sessions have been held in four cities around the country; 138 people have been trained. Again, training included people from the entire country, not only those working in USAID-supported provinces ensuring standard practices throughout the country.

In order to encourage actual application of newly learned management skills and to ensure the decentralized follow-up of the integration process, the project calls for preparation of individual provincial action plans to be prepared by training participants once they return to their post. These are to be submitted to the DSF for consideration, and funding is available for implementation of the plans through training, renovation, supplies, and technical

material. Slightly more than half of the provinces have submitted plans to date, and DSF has begun the review process for those available. This is an important component of this project, providing the opportunity for immediate, tangible results from the application of newly learned planning and integration skills.

The evaluation team saw mixed evidence of integration during their field visits. In principle, all but two of the sites visited offered integrated services, although in practice many found that they continued to serve clients seeking specific services on the days previously devoted to that service. That is, while the clinic staff was willing to provide a full range of FP/MCH services every day, the women seeking them continued to come according to the old program. Furthermore, few of the centers had developed action plans. The follow-up process will require continued intervention during the life of the project, as is planned. It should be noted that the effort to provide integrated services is still quite new, and patients naturally will adhere to the old schedule until the new one is institutionalized. It may help get the announcement of integrated service delivery out to the communities if all patients coming to health facilities are asked to tell their neighbors that all services are now offered every day the facilities are open.

Recommendation

Provinces not yet submitting proposals for integration should be followed up with letters, telephone call, or visit (perhaps piggy-backed with another team going to that location) in order to encourage and aid proposal preparation.

Commodity and Equipment Procurement

USAID has procured contraceptive commodities for the FP/MCH elements of this subproject. For the most part this has proceeded well, although there continues to be problems with the MOH logistics and distribution system. For example, while the evaluation team was in Burkina Faso, service delivery sites were experiencing stock-outs of oral contraceptives, due to a shipment being held up in customs in Abidjan. While this was the direct result of AID/Washington having changed shippers, the situation nevertheless points to problems with either the level of reserve stocks held in Burkina Faso, or, if national supplies are adequate, with the internal distribution system. Steps are being taken to resolve this problem under the current project, but more attention must be focused here.

d. Strengthening Program Management and Supervision

Under this topic we present findings from two activities, training in supervision, and improvement of the MOH health information system. With technical support from the Family Planning Management Development (FPMD) project, the MOH did a baseline study of the existing supervisory system. They then developed a training curriculum and supervision protocols and trained provincial staff who have now returned to their posts to use the new tools. Field visits showed that there is some use of the protocols,

or adaptation of them to better meet local needs. Some supervisors have programmed their visits throughout the year so that health sites know when to expect visits. Nevertheless, there are still problems concerning transportation, funds for gas, and impassable roads during the rainy season, causing delays and interruptions in programmed visits. Also, some supervisors are not doing integrated supervision, necessitating multiple trips to the same health center by several different people. A guide to supervision was also developed.

A well-functioning Health Information System (HIS) serves as an important tool in managing FP/MCH programs. Under FHFF, the SEATS project was requested to assist DSF and DEP in improving their HIS, to be better able to plan, implement and evaluate the national family planning program, and to coordinate with private sector FP activities. Technical assistance was provided by the Center for Research on Population and Development (CERPOD), a regional demographic center located in Bamako, Mali.

CERPOD carried out a review and assessment of the existing system, and recommended changes. New software was developed and installed at central MOH offices, and the DEP has successfully cut their turnaround time in preparing their annual health statistics report. However, the utility of this report is minimized by poor data from the field. USAID has conducted a study to look at the problems of data collection and quality of the data being collected at the field level. The project is now working to revise forms and to rationalize data collection efforts in order to have consistency between data needs and information sent from provinces.

Lessons Learned

Improvements to the health care delivery system cannot be undertaken at the central level without being aware of the contributing factors and resulting effects at the provincial level, although doing so may help identify problems or unanticipated results. Comprehensive measures to ameliorate problems need to be introduced systematically through all levels of the program.

Recommendations

Work should continue on improving the health information system. Efforts should be made to ensure that staff at the provincial level understand the importance of submitting accurate data to the central MOH. A feedback mechanism should be developed, and carried out in a timely way, to inform provincial staff of data findings.

e. Operations Research and Evaluation

Operations research (OR) has played, and continues to play, an important role in the development of family planning activities in Burkina Faso. For example, the current emphasis on integrating maternal and child health and family planning services has roots in an OR pilot project carried out during the mid-1980s.

Three operations research studies were carried out with direct support from the FHHF project, and several other related studies were conducted with support from AID central funds. Perhaps the most important of the studies was the FP Situation Analysis carried out in 1991-1992¹. This study served to assess the functioning of services and the quality of service delivery at a sample of approximately 50 sites throughout the country. Eighteen recommendations were made following analysis of the study results, and virtually all have been acted upon by the Ministry.

The two remaining studies focused on innovative service delivery systems. One was an evaluation of a project using traditional birth attendants as contraceptive distributors. Based on the positive findings, funding for the TBA project has been offered by UNFPA, and it will be expanded to encompass five provinces. This may be an important test of the utility of community based distribution in Burkina Faso. If the government wants to meet its target of achieving 30 percent contraceptive prevalence by 2005, as indicated in the Family Planning Strategy, it will need to make services as widely available and as easily accessible as possible.

Finally, the ABSF study of using satisfied users as motivators for family planning promotion and referral mentioned above was first carried out on a smaller scale as an Operations Research study in Ouagadougou. Based on the findings of the study, the project was modified, enlarged, and extended to sites in both Ouagadougou and Bobo-Dioulasso.

Since gaining the experience of conducting OR, the unit at the DSF has gone on to carry out other studies with support from different donors. Provincial medical staff adapted the family planning Situation Analysis methodology for MCH services, and carried out analyses at the provincial level with local support. The DSF has gone from reluctant acceptance of OR, at first not being convinced of its utility to a service-oriented unit, to being truly appreciative of the value of research in orienting and prioritizing field activities. Discussions are ongoing to further institutionalize the local OR capacity by installing a unit formally charged with research and research training, perhaps at the University of Burkina Faso.

Like other units in the MOH, the human resource base of the OR unit is small, with much of the responsibility for the basic research resting with the local technical advisor. The Ministry faces the possible loss of this advisor, as he may be charged with other responsibilities by the contractor under the new, follow-on OR project. If this is the case, he will have less time to dedicate to work in Burkina Faso.

¹. The Situation Analysis (SA) combined the objectives of the needs assessment and the SA mentioned in the project description, section II.A.5.

Lessons Learned

It is clear that Ministry staff have become convinced of the utility of OR as a planning and testing tool for service provision. The efforts funded under FHHF have shown the importance of developing a local capacity to carry out OR, enabling OR to be undertaken as an integral component of a comprehensive service delivery system.

Recommendations

Activities programmed under this component of the FHHF are completed. The contractor (Population Council) is in the process of identifying new research opportunities in Burkina Faso to be carried out under the follow-on to the centrally funded Africa Operations Research and Technical Assistance project. USAID should encourage an ongoing presence of this project, and a further strengthening of the local research capacity.

2. Nutrition Communication

The Nutrition Communication component of sub-project 1 is impressive because it has been largely managed by Ministry personnel who, with the assistance of contractor technical assistance, have continued to monitor, readjust and stimulate program activities to the extent that project objectives in terms of studies, training and materials development have been met or surpassed in spite of the usual constraints faced by the Ministry. It is a good example of the development of management skills in Ministry staff as a result of their taking responsibility for a program's operation.

a. Training

A recent evaluation of this component of the project, undertaken by the Ministry in April of 1993, showed that training was well ahead of schedule. 98% of the target trainees have already received training in the three emphasis themes, and 87% of those trained are still working in the health sector. 80% of the 500 targeted community health workers have already received nutrition communication training.

Among those trained were representatives from other ministries who had been named to provincial multisectoral nutrition coordination committees.

The same evaluation assessed the impact of project training upon the field performance of health workers and found that they were engaging in nutrition communication activities at health centers and that they were making use of the nutrition IEC materials they had.

The evaluation also drew attention to the difficulty inherent in trying to use the "causerie" approach to nutrition communication where the new integrated approach to services delivery had been adopted, and this observation resulted in the Nutrition Service changing its training emphasis from the "causerie" approach to individual counselling.

b. Information, Education and Communication (IEC)

Of the numerous different IEC materials to be developed, 75% have already been produced including, inter alia: 2 posters, 5 flip charts, one slide series, 2 songs, 18 episodes of a radio play and new health cards. These materials have been developed and modified based upon information gathered from pre-program KAP studies, and many of them are being translated into local languages.

The Ministry's own evaluation, cited above, showed that IEC materials had been distributed to 76% of the sites visited and 100% of these sites were using the materials to undertake nutrition communication activities. Our evaluation team's field visits did not find materials in use.

c. Program Management and Supervision

Program management and supervision is strong from the Ministry level to the provinces, but although the provinces have Nutrition Communication Coordinators, these individuals are impeded in their ability to provide effective management and supervision to the health centers in the provinces due to the widespread lack of resources for travel. To the extent possible the provincial Nutrition Coordinators try to take advantage of travel funded by other programs, eg. by accompanying the PEV Coordinator on his travels.

At the Ministry's Nutrition Service, management of the nutrition communication project has been solid and can be credited with much of the achievement of this component of the project, even though there has been a significant input of competent long and short term technical assistance. Examples of this management accomplishment include the formulation of a draft strategy for nutrition communication which is under review and the initiation and completion of the April 1993 component evaluation without its being a formal requirement of the project

d. Operations Research and Evaluation

The project undertook a pre-program KAP study to provide guidance for nutrition communication message development and has used focus groups and other field testing techniques to evaluate the effectiveness of IEC materials before going into their production. The Nutrition Service conducted a formal evaluation of the nutrition communication component in April 1993 in which 7 of the 8 project provinces were visited by the evaluation teams. This led to a published report of findings and recommendations. The latter included, inter alia: undertaking focused in-service training to correct weaknesses in nutrition communication techniques, more attention to the development of local IEC action plans and further attempts to stimulate activity by the provincial multisectoral nutrition communication coordination teams.

The Nutrition Service plans to continue its testing of IEC materials developed and monitoring of the nutrition communication activities at provincial, health center and community levels, and it plans to carry out another KAP study later in the project to evaluate the impact of nutrition communication activities upon the knowledge, attitudes and behavior of the target audience, Burkinabe mothers.

3. Diarrheal Disease Control

The Diarrheal Disease Control component of sub-project 1 was able to start without delay, building directly upon the previous work of PRITECH in Burkina Faso without the loss of momentum. This component of Subproject 1 has also been successful in achieving its outputs objectives ahead of schedule, and in the case of establishing ORT corners, has already established 150% of the end-of-project target.

This said, this evaluation team found that at the health center level there are serious problems of ORS stockouts (it must be remembered that this project is not responsible for furnishing ORS.), absence of DDC IEC materials and little evidence of any effort at DDC IEC. Many of these shortcomings were due to the absence for more than 18 months of a National DDC coordinator at the MOH.

The National DDC Policy was formulated (including the Action Plan for Cholera) and a Five Year Workplan was defined for the '94-'98 period. The national DDC Technical Committee has been named. Yearly DDC planning meetings are conducted with DPS reps, and all 30 provincial DDC plans have been prepared.

a. Training

The Diarrheal Disease Control component of the project has very ambitious training targets for the training of Ministry staff, community health workers and pharmacists, and these targets are already 70% met; training of Ministry staff is ahead of schedule, but CHW training has been hampered by the travel constraints faced by the provincial trainers. Both of the planned TOT courses have been held, and these courses were used to train trainers for all 30 provinces, and not just the eight project provinces as originally planned.

The distribution of teaching manuals and the animated guide has continued in all eight project provinces. The training manual for depot managers ("pharmacists") has been completed, and distribution will be undertaken soon.

DDC curriculum development is also on schedule, and the new modules are already in use in the Nursing School. Diarrheal Disease Control is one of the best examples of the benefits of the FHHF project being felt well beyond the geographic impact area designated for the project. DDC training materials and treatment protocols developed by the project are used throughout the country, irrespective of which donor is supporting the population/ health

sector development in the areas. This was also observed for training and protocol materials for the FP/MCH component.

b. Community Education

Although IEC activities are included in the draft national DDC policy/strategy, this document focuses upon case management. DDC themes are sometimes scheduled in the rotation of themes planned by those health centers undertaking regular IEC activities, but this evaluation team was not able to find any evidence of DDC IEC materials, except for UN case management posters, when it visited field health centers. When asked about community DDC IEC activity, health center workers replied that only those engaged in the immunization program had resources for travelling into the communities, so little community contact was being realized.

DDC IEC activities also undertaken by the project include the organization of films, theater and a concert for "Nurse International Day" and the support of students in Bazega who have organized and presented a theater drama which has been effective in teaching the audience proper ORS preparation.

c. Strengthening Service Delivery

Case management training has been extensive with 5574 health workers already having received training and improved case management being worked into the basic training of all physicians and nurses. ORT corners have been established in 129 sites, and an August 1993 field evaluation showed active ORT use with good diagnosis and treatment and some ability to adapt treatment protocols to specific patient needs. This same evaluation noted that little IEC or ORS preparation demonstration was being done at the health centers visited.

A technical card to help health workers diagnose diarrheal disease and plan treatment has been produced and distributed, and demonstration materials have been distributed to 162 health centers.

d. Operations Research and Evaluation

Four of the six planned operations research studies have been completed including a dysentery study, a liter measurement study, a household study and an evaluation of the Animated Guide. The Ministry conducted a site visit/evaluation shortly before this evaluation in which it visited seven of the eight project provinces.

4. Condom Social Marketing²

Condom Social Marketing (CSM) plays an important role in expanding the availability of condoms, both for disease prevention and contraceptive use. It greatly enlarges the number of sites at which contraceptive or STD prophylactic supplies can be obtained. An important secondary effect that is sometimes accorded insufficient attention is the role CSM plays in making it more acceptable to speak openly about contraception, pregnancy, sex, and STDs, including AIDS. Through these open discussions, people learn and become empowered to make decisions that may improve their health and quality of life.

The FHHF project has supported the development of CSM in Burkina Faso through PROMACO, the Burkina Faso National Condom Distribution and Promotion project which is implemented by Population Communications International. The project markets condoms under the brand name Prudence. The goal of this activity is to limit the spread of HIV/AIDS and other sexually transmitted diseases in Burkina Faso through an increase in condom use nationwide. Specific objectives include:

- increase the availability of affordable condoms in all 30 provinces, selling at least 250,000 per month in year 1 and 333,000 per month in year 2 through at least 2,000 outlets;
- recover project costs to the maximum extent possible; and
- transfer social marketing technology to an indigenous non-governmental organization or commercial firm.

The approach used to achieve these goals combines the development of a widespread, reliable private sector distribution network emphasizing repeated follow-up of wholesalers and retailers with the sustained promotion of Prudence condoms using both formal and informal gatherings.

a. Condom Sales

Prudence is distributed through a network of 81 wholesalers, 2290 small shops, and 496 stallholders, located throughout the entire country. The database maintained by the project lists 3,450 points of purchase, far exceeding the 2,000 specified in the cooperative agreement. Rather than relying on an existing distribution network, PROMACO developed a new, independent system of supplying wholesalers and initially, using the sales agents to restock the networks. As consumer demand is established, sales representatives have been able to reduce their contacts with retailers. This approach seems to have been successful, and with reasonable modifications after a shake-down period is now functioning smoothly.

². This discussion of contraceptive social marketing summarizes the findings of a comprehensive evaluation of this project component. A full list of lessons learned and recommendations are included in the evaluation report, attached as Annex J.

Analysis of sales records shows an apparent variation by season, with sales dropping during the rainy season months, and increasing during the cool months. Stock records indicate sales of approximately 250,000 per month to wholesalers, the level projected for year 1, but data are not yet available to estimate consumer purchases.

Sales through wholesalers are moving well, particularly in Ouagadougou and Bobo-Dioulasso. Smaller cities such as provincial capitals are showing good sales in densely populated areas and at sites near hotels, bars, and military camps. Stock-outs are rare in the urban areas, but occur more frequently in rural areas. There, it appears that vendors are not making a special trip to their wholesaler when condom stock is depleted, preferring to delay until they need to replenish several items, or until the PROMACO Representative next visits.

Sales vary by location, with some sites in Ouagadougou selling as many as 110 packets per week, while others sell as few as 22 per week. In less populated areas, this figure (22 per week) represents high sales, with other outlets in semi-urban centers reporting sales of only 22 packets per month.

An unanticipated outcome of the project was PROMACO's impact on the sale of condoms through MOH facilities. Following the launch of Prudence, sales of condoms in health facilities declined from about 1.2 million per year in 1990 and 1991 to about 150,000 per year in 1992 and 1993. The Ministry, health agents began to purchase Prudence condoms for resale, because they were able to retain the small profit made at the health center level. Also, as Prudence condoms became more widely available, people no longer needed to travel to the health center for their purchase, further reducing demand at the health centers. This and the fact that the MOH had large stocks at hand which were not moving very fast, USAID has stopped the procurement of condoms for the public sector.

Preliminary results of the Burkina Faso Demographic and Health Survey show 6.8 percent of men and 0.9 percent of women using condoms. Interviews with retailers show that the vast majority of purchasers are young men, generally reporting that condom use is for protection against AIDS and other sexually transmitted diseases. This information, coupled with the discrepancy in use between males and females reported in the DHS, implies that married men are not using condoms with their regular partners. Use of condoms as a contraceptive appears to be low.

The level of PROMACO sales per capita is comparable to that of other social marketing programs at similar stages of development, in part due to efforts made to maximize cost recovery. Project staff have made a concerted effort to keep costs low through a number of ways, including: using Yamaha 350 dirt bikes for transportation rather than cars; providing flamboyant clothing and bike gear for sales representatives, in effect making them mobile Prudence advertisements; training chauffeurs as animators, eliminating the cost of additional staff; reusing internal shipping cartons as condom dispensers; charging sales reps with administrative tasks, again reducing staff costs (although also reducing sales time); and eliminating middlemen between wholesaler and retailer, increasing wholesaler commodity price.

b. Community Education

A variety of formal and informal marketing and IEC activities have been undertaken throughout the PROMACO project, including conferences, dances, discussion groups, mass media advertising, and product promotions using tee-shirts, hats, and bumper stickers. Two vehicles are equipped with sound systems for promotional use, and PROMACO representatives and drivers give demonstrations of correct condom use. These activities appear to have created a high awareness of Prudence condoms, and of their benefits in protecting against AIDS. An estimated 250,000 people have been exposed to IEC efforts. The DHS results show a high level of awareness of AIDS among the Burkinabe population, but knowledge of condoms is still relatively low (77.4 percent among men, 49.3 percent among women).

While efforts have been made to link PROMACO promotion and IEC efforts with those carried out by the MOH at the provincial level, linkages have been hampered by lack of resources, and by limited activities carried out by the MOH and others. Lack of funds for the MOH available for per diems, promotion, and supervision under the project initially affected project progress, however, after the program agreement was amended in 1992, all parties had a better understanding of their roles and responsibilities. Furthermore, the sales representatives have not had formal training on HIV/AIDS or basic IEC techniques, nor do they have a detailed information package on condoms available.

Recommendation

Training in HIV/AIDS, FP, and basic IEC techniques and the provision of information to keep on hand relating to AIDS, STDs, and condom use would improve the quality of information offered and promotion activities.

IEC activities should be strengthened in order to increase motivation to purchase and use condoms.

c. Operations Research and Evaluation

Knowledge, Attitudes and Practices (KAP) studies were undertaken at the outset of the project; these provided baseline data for project activities. Other research carried out included a study on condom distribution in three cities; a marketing study to aid development of a youth strategy; a study of sales of Burkina condoms in Cote d'Ivoire; an analysis of the attitudes about AIDS and condom use among young people; and an opinion survey of government officials, condom distributors and consumers.

Also, the computerized management information system is well functioning, with thorough information on sales, finances, and stock movement. These data should be exploited fully to improve, rationalize and streamline PROMACO project operations, and to develop performance targets for the sales representatives.

Recommendations

PROMACO should maximize the utility of its ongoing data collection, and conduct some market research to better understand the client and market distribution systems and permit verification of key assumptions made by the sales team.

If resources are available, the FHFF project should undertake market research to reposition Prudence as a contraceptive as well as a prophylactic against AIDS and STDs.

d. Program Management

Links with MOH

The MOH had been the implementing agency for the pilot condom distribution activity funded under the AIDSTECH project in 1989-1990. When the bilateral FHFF project was signed in 1990, it included a buy-in to AIDSTECH, which was subcontracted to Population Services International (PSI) for implementation, through the AIDSTECH end-of-project in August 1992. A subsequent agreement was signed directly with PSI to continue activities through May 1994.

Even though PSI assigned a full-time representative to the project in September 1991, the Ministry official charged with the pilot project wished to continue direct control. When an amendment to the bilateral project agreement was made in June 1992, the project agreement was amended to clarify the PROMACO-MOH interactions. The amendment specified that PROMACO was to work under the general policy guidance of the National AIDS Control Program, while reporting directly to USAID on project implementation. In turn, USAID maintained direct liaison with the government, reporting on project progress.

In the last 2 years of the project, the National AIDS Control Program has given the project more flexibility and increased support. The improved collaborative relationship has allowed the team to focus more on sales and promotion.

Routine Program Management

Five sales representatives, all university graduates, are each assigned responsibility for six provinces. Each month, they spend about three weeks visiting their territory, and one week writing reports and planning the following month's activities in collaboration with the project director. A marketing plan developed by the entire staff after the first year of project implementation sets overall targets and objectives to be achieved, and serves as a guide for activity planning. However, individual targets and objectives have not been set for each sales representative, nor is there daily or weekly planning of outlets to be contacted. Therefore, it is difficult to assess the performance of individual sales representatives.

That being said, it should be noted that the PROMACO director deliberately recruited young, enthusiastic and well-trained sales representatives, and gave them significant responsibilities for the day to day operation of the project. They have developed and updated the marketing plan, designed and implemented marketing studies, completed income statements, managed finances, and prepared reports. As was evident in the engagement of MOH in the other phases of the MCH/FP component of the bilateral, this strategy has facilitated the development and reinforcement of expertise among Burkinabe professionals.

Transfer of Social Marketing Technology to a Local Firm

In an effort to ensure the sustainability of contraceptive social marketing in Burkina Faso, the project design calls for the transfer of social marketing skills to an indigenous firm or NGO by the conclusion of the project. In view of the intent of the German development bank Kreditanstalt für Wiederaufbau (KfW) to finance a follow-on project and their stated reluctance to change the management configuration and form a PVO during their takeover, USAID has dropped this requirement from their project agreement with PSI. KfW has pointed out that the envisioned expansion of the CSM project (increasing to 32 sales staff in 1994) will itself present such a management burden it does not want to be diverted by the development and immaturity of a new NGO. The National AIDS Committee also feels that transfer of CSM operation to an NGO would be premature.

Recommendations

The new social marketing expertise of project staff should be fostered and strengthened through ongoing supervision and training in skills such as planning, proposal writing, fund raising, and communication techniques.

Job descriptions should include annual performance or achievement indicators.

The project should encourage the use of sales clerks by wholesalers to support and develop the distribution system by offering incentives, basic training, and perhaps travel allowances. This would reduce time spent by sales representatives in doing routine tasks, and free them for more marketing and network activities.

Acknowledging that with the change of donor support there is less reason to transfer social marketing technology to a local firm or develop NGO status for the project, the manager should continue to look into the requirements to make such a transition. Considering the long-term sustainability and viability of CSM activities in Burkina Faso, this is likely to remain a long term goal, and feasible alternatives should be prepared.

B. Sub-project 3: Strengthening Health Planning

On the whole this sub-project has performed as expected; the DEP has been able to increase its level of responsibilities and related activities, and the budget of the DEP has continued to increase even though USAID is paying a progressively smaller proportion each year.

1. Health Planning

The DEP plays a critical role in providing much of the information upon which health planning depends and is becoming involved in the MOH annual plans, budget process and evaluations. However, the impact of DEP's input in the MOH's planning process is unclear. It appeared to the evaluation team that the DEP has been so engaged in the demanding work of establishing the MIS for the health sector in Burkina Faso and of generating the required reports that it has not had much time to devote to analysis of the information being generated.

It would seem that the DEP could contribute more to the health planning process if it were to include more analysis of the data in its reports. It is recommended that the DEP be aided to enhance its analytic capacity, possibly through TA, study tours to neighboring countries in which ministry data reports include a commentary on the significance of the figures presented and their implications for future planning, and/or short term training on health sector analysis.

2. Donors Coordination Conferences

The DEP has conducted annual donor coordination conferences, and they are used to discuss health topics of relevance to Burkina Faso. Although these conferences are carried out as planned and is present a rare opportunity for all donors to meet and address some of the most important donor-related issue confronting the Ministry, the success of this conference is questionable. Often topics addressed are programmatic rather than policy.

Donor coordination with respect to specific programs is sometimes attempted through special meetings, and the Ministry customarily meets with donors on an individual basis when it negotiates levels of donor assistance. It is unlikely that these practices will change, so it is recommended that the OAR/Burkina Faso and the Ministry reconsider whether the resources now invested in initiating, organizing and conducting annual donor coordination conferences could be better invested in performing more analysis on the information coming from the MIS and sharing this analysis with the rest of the Ministry.

3. Financial Sustainability

An analysis of the annual budgets of the DEP shows that, although the total DEP budget may jump up or down from year to year, depending upon its level of activity, the percentage of the budget contributed by USAID has steadily decreased. In fact, due to the DEP's being unable to spend all of the USAID funds available each year, the percentage of the budget provided by USAID has dropped much more rapidly than called for. For example, the project design calls for the USAID contribution to have fallen to 70% of the total budget by 1993; however, it has fallen to only 30%.

The decrease in USAID funding to the DEP was to have been offset by increases in the funds provided by the Government of Burkina and by the funds attracted from other donors. The budgets for 1990 - 1993 clearly show steady increases in both government and other donor funding.

4. Reports

The annual budgets and expenditure reports are being completed as planned, donor coordination meetings are held, and provincial level MIS training is on schedule. Weaker areas are the Annual Statistical Report which, although definite progress is being made in reducing the delay in producing the report, the presentation of data could be made more useful, and the reports do not yet contain any analysis or recommendations. Other forms of information feedback to the provinces and health centers, such as the Epidemiologic Bulletin, are very delinquent in production and are not formatted to provide much real feedback of analysis of provincial and health center or community data. Again, it is recommended that the DEP be helped to modify the process of preparing its reports so that they include of an analysis of the information being presented.

5. Training Support

Much of the work of the DEP in establishing the MIS for the health sector has been in the development of MIS training curricula and in the conducting of MIS training at the provincial level. The training at the provincial level has proceeded on schedule, but there has been some delay in the MIS training at the central Ministry level due to the difficulty of assembling senior health officials who must deal with many competing demands upon their time.

6. Research/Studies

Although only one of the five operations research studies scheduled to be undertaken by the DEP during the life of the project has been completed, three others are now in progress. Some computer and software problems observed by the team could have affected the research activity.

BEST AVAILABLE DOCUMENT

V. PROJECT IMPACT

For this mid-term evaluation project impact issues considered include the degree to which the impact of the project exceeded that which was financed through bilateral funds alone, an assessment of the appropriateness of the achievement indicators presented in the Project Paper and in the design amendment defined by Project Implementation Letter (PIL) 15, and a brief summary of the project impact to date.

A. Program Impact vs Project Impact

As this report has already described, the Family Health and Health Financing Project was designed as a "bilateral" project although its management plan called for project goods and services to be accessed through a "buy-in" mechanism which would engage several different centrally-funded projects in undertaking the project's many activities. While this management approach resulted in a much more complicated and burdensome responsibility for the OAR Health Office, it had many advantages which were presented in the discussion above.

In addition to these advantages, such as the ability to conduct project design and evaluation with single teams and sets of documents and the forced integration of a wide array of activity objectives into a single strategy, there is also the advantage which derives from being able to use USAID mission bilateral funds to leverage more funds from the core budgets of the centrally-funded projects to be invested in population/health sector development in Burkina Faso.

By supporting the continuing involvement of selected centrally-funded population and health projects in Burkina Faso, the OAR Health Office was able to get these centrally-funded projects to contribute over \$5 million in additional funding from their core budgets to the \$10 million committed from bilateral funds. The most remarkable example of this leveraging use of bilateral funds is the case of the SEATS project in which the investment of approximately \$250 thousand of bilateral funds is associated with the commitment of approximately \$2.5 million of core SEATS project funds, a multiplier effect of ten!

This ability of the FHFF project to attract core funding from centrally-funded projects has resulted in an increased flow of technical assistance, training, commodities and other costs to support Ministry efforts which are closely related to the objectives of the project. This has accounted for the fact that many of the project's original achievement targets have been exceeded and many of the project-supported activities are reaching far beyond the geographic area defined as the target for the project.

B. Appropriateness of Project Indicators

Whether or not the identified project achievement indicators were appropriately selected in the first place, the USAID Health Office should be credited for taking the initiative to modify them somewhat in PIL 15 after two years of project management experience. This design amendment provided some more definite and realizable targets in terms of training objectives and the number of target sites to be affected by the project.

Apart from calling for an unquantified reduction in infant, child and maternal mortality rates in the Project Paper, the remainder of the project indicators presented in either the PP or PIL 15 are process or output measures. These targets, when quantified, appear to be reasonable, and they were somewhat modified/clarified in the 1992 (PIL 15) design updating to account for the project's experience to date.

From the fact that almost all of these process/output targets have been met or exceeded, it can be inferred that the targets were not excessive. The fact that their having been met is not necessarily reflected in better services delivery at the interface between the health system and the population suggests that there may be additional indicators which would better measure the application of project outputs to improved services delivery. It may be appropriate during the second half of the project to undertake a special study to identify the determinants of the impact of such outputs as training upon service delivery and IEC materials development upon active population/health promotion.

At the project goal level, the PP calls for an unspecified degree of reduction in infant, child and maternal mortality rates. These indicators were not altered by PIL 15. At the outset of the project, infant mortality was estimated at 134/1000 and maternal mortality was estimated at 3 - 6 / 1000 (based upon the 1985 census). The 1991 Annual Statistical Report of the Ministry presents the same figures: 134/1000 and 6.1/1000, respectively (although the data within the body of the report shows a lower maternal mortality rate of only 2.8/1000). The preliminary report of the 1992 DHS does not include mortality estimates. Mortality reductions are not inappropriate objectives for a five year project like FHMF, but significant reductions should not be expected within such a short time period, even if project-supported interventions are effective, nor could projects claim responsibility for mortality changes in the absence of multivariate analysis.

At the project purpose level, the PP lists 13 End of Project Status indicators; 8 for Sub-project 1, 4 for Sub-project 2, and 1 for Sub-project 3. Of these only 23% are strictly quantified. These are an increase in CPR (presumably for modern methods) from less than 1% to 8%, having 50% of mothers in the project area responding to the three nutrition improvement themes, and increasing PHC facility utilization by 50%. The remainder of the PP project purpose level indicators call for making services and information available in the project areas or unspecified increases in positive indicators such as the use of ORT and decreases in negative indicators such as STD rates. PIL 15 does not alter these indicators except to clarify the objective of increasing FP services and information in 15 provinces by defining the numbers of old and new sites to be aided by the project.

The Annual Statistical Report gives an estimate of 6.3% for Total CPR in 1991 but does not give a figure for modern methods. The DHS preliminary report gives 7.9% as the 1992 figure for Total CPR and 4.2% for modern methods. This latter figure is impressive when compared with an estimate of less than 1% only five years earlier. The project has not yet undertaken the second nutrition KAP study, so there are no estimates of mothers' response to nutrition communication. The Annual Statistics Report shows an actual reduction of 27% in the utilization of PHC facilities between 1986 and 1991. For the remainder of the qualitative objectives, it can be argued that there has been some change in the desired direction.

Again, for the level of USAID investment in the FHHF project it is probably warranted to make a greater effort to quantify the objectives more at the project purpose level and to ensure that the Ministry, with project assistance, monitors the agreed upon indicators so that current information on them is routinely available. The indicators selected during project design appear appropriate, but they could have had more quantified targets. For the purpose of routine project evaluations, one should hope to demonstrate positive associations between project efforts and indicator changes rather than causal relationship since so many determining factors lie outside the influence of the project.

As would be expected, there is much more quantification of indicators at the outputs and inputs levels of project design. The indicators presented in the PP appear to have been appropriate at the time of project design, and these indicators are the ones which were clarified or changed in the 1992 PIL to reflect project implementation experience to date. The fact that the project has surpassed the target figures for most of these achievement indicators suggests that the targets could have been set somewhat higher, but the original and modified targets appear reasonable and most of the "over achievement" by the project has been in the areas of numbers of people trained and ORT corners established.

C. Summary of Project Impact to Date

At the time of this mid-term project evaluation, it is clear that the project has had a profound impact in terms of national policies formulated and adopted, training curricula developed and placed into official use at national and provincial levels, the establishment of national standards for services delivery and supervision, the establishment of national and provincial training teams, the training of large numbers of health workers at all levels, the development of a wide array of IEC materials for each of the project's focus areas, and the supplying of equipment, supplies and some operating costs support to selected service delivery and supervision activities of the Ministry. These figures have been cited above, and in sheer numbers they are an impressive accomplishment.

Whether or not these input, output and process achievements can be credited with sustainable impact at the level of the vital statistics of population of Burkina Faso is, of necessity, debatable. There are too many variables outside the influence of the project which

contribute to vital statistics such as morbidity, mortality and contraceptive prevalence rate for the project to either take credit for positive changes or be blamed for negative changes. However, the project is a major contributor to the aggregate efforts to improve

population/health services delivery in Burkina Faso, and it can reasonably be inferred that positive changes in vital statistics occurring during the life of the project are at least partially the result of project-supported activities.

1. Development of Multiple Service Delivery Channels

An important effect of the project is the adoption and acceptance of a multi-pronged approach to the delivery of family planning services by the Government of Burkina Faso. That is, contraceptive supplies and services are being offered through the public sector, the private sector, social marketing, and, on an experimental basis, through community based distribution. This represents a real opening of service delivery systems, and is particularly significant in the context of West Africa, long known for its medicalization of health care services.

In its Population Policy Declaration (June 1991), Burkina Faso set a target contraceptive prevalence rate of 60 percent to be achieved by the year 2005. During discussions with the MOH, this was referred to as a "policy goal", while the Ministry focused on a "strategic goal" of 30 percent CPR to be reached by the same date. The DHS found prevalence of all methods to be 7.9 percent in early 1993, and 4.2 percent for modern methods. Although there has been remarkable progress from the 1985 estimate of less than 1% for modern methods, much more needs to be done if Burkina is to reach its stated goal within 12 years. Utilizing all possible channels of service and supply delivery is one means to approach the desired prevalence levels.

2. Engagement of the Ministry of Health

Another important effect of the FHHF project has been its successful engagement of the MOH in family planning and maternal and child health activities. While the Ministry had identified these programs as being important prior to the development of the FHHF project, it has continually demonstrated its full commitment to the project goals throughout the first years of implementation. This has been indicated by the devotion of staff to project activities and their full participation in developing work plans and materials, including curricula, protocols, manuals, training plans, and IEC materials.

The institutionalization of FP/MCH skills is further evidenced by the adoption of curricula and training materials developed during this and prior AID projects by the medical professional schools in Burkina Faso. FP/MCH subjects are given full recognition, and the improved and expanded training of health care professionals will contribute to the improved health status of Burkinabe women and children.

3. Increased Contraceptive Prevalence Rate

As noted above the modern CPR represents an increase from less than one percent of women in union reporting modern contraceptive use in 1985-1986. (The modern CPR among married men is 7 percent, probably explained by condom use with women other than their wives.) Virtually no family planning services were available in Burkina Faso until 1985. As USAID has been the leading donor agency supporting family planning in Burkina since that time, much of the increased use of contraception can probably be attributed to USAID assistance, including FHFF project activities.

It is expected that the FHFF project will continue to contribute to increases in CPR as more personnel are trained to provide family planning, as more service sites are established, and as improvements in the logistics system make contraceptive supplies routinely available.

Fertility is also showing some small declines. The total fertility rate (TFR) was estimated to be 7.2 children per woman in 1985; the DHS found a rate of 6.9. In a pattern typical of many developing countries, fertility is showing greater change in urban areas where women report having only five children.

4. Opening of the Private Sector

The saturation strategy of the condom social marketing program has yielded a remarkably rapid and successful insertion of condoms into the private sector. The result has been widespread product identification, throughout the entire country. Now, the focus of the project must be on securing the product position, increasing demand, and developing greater retail sales. The marketing efforts have worked well to define a project image and its market niche. Much remains to be done, however, in raising knowledge and awareness about condoms as both a disease and a pregnancy prophylaxis.

VI. PROJECT DESIGN

A. Relationship between Three Subprojects

The Family Health and Health Financing project consists of three discrete, vertical subprojects, one of which includes four internal elements that are themselves quite discrete. A question posed in the evaluation scope of work asks whether vertical project design is an effective and efficient way to increase access to quality preventive health care services. Relative efficiency is difficult to measure in this case, as we lack a comparison case with a different design. The FHHF project has been effective in increasing the number of people trained to provide services and in greatly increasing the number of outlets where people can obtain services.

In theory, linking the three separate subprojects (Child Survival and Maternal Health, Health Financing, and Health Planning) in a single project forces consideration of the inter-relationship of the public and private sectors, project sustainability, and of the dynamics of planning integrated and comprehensive activities, while at the same time budgeting for them and developing the sources of revenue and human resources needed to sustain them both at the MOH and USAID. It is less evident whether this happened in actuality, in part because the subprojects followed different timelines, were implemented with different government Directorates, and used technical support from different contractors and cooperating agencies. At the same time, there is no evidence that project implementation suffered due to its vertical characteristics.

This design does reflect a very sensible development of the programs previously undertaken in Burkina Faso with USAID support. The continuation of activities with most of the same contractors allowed steady project progress for the most part, with development of current strengths and amelioration of weaknesses. Contractors and USAID staff were both aware of the absorptive capacity and human resource constraints of the MOH, and were able to develop project activities taking these into account.

In addition to the logical continuity, there are two additional advantages to continuing the bilateral activities with multiple contractors. First, virtually all of the contractors working in Burkina are known for their functional expertise in particular areas. For example, PCS is renowned for its skills in IEC; and INTRAH is well known for its training programs. Choosing this route for the bilateral program gave USAID access to the best contractor talent available in the various project components.

A second advantage to buying in to centrally funded contracts to execute portions of the bilateral project is the leveraging effect. As noted earlier, virtually all of the CAs increased the resources available to Burkina Faso by drawing upon core funds to support complementary program activities.

A disadvantage to using multiple executing agencies arises from the varying timelines and project completion dates of the different central projects. Adapting to these additional deadlines, external to the bilateral time frame, may cause some activities to be completed at a stage when they might fruitfully continue interaction with other project activities. Such is the case, for example, with the FP/MCH operations research element.

A second disadvantage occurs when trying to evaluate the bilateral program, as the number of activities to assess, documents to read, staff to interview, sites to visit all increase proportionately, complicating the evaluation process.

B. Integration of Four Subproject 1 Components

At first glance, there appears to be limited integration among the four components of Subproject 1 (Child Survival and Maternal Health) at the implementation level. Component activities were carried out with different coordinating units both within the MOH (DSF for MCH/FP and NUTCOM; DMP for CDD) and outside the MOH (condom social marketing), with technical support from different contractors and cooperating agencies. Nevertheless, a closer look reveals complementarity and coordination among the components.

There has been some functional integration at the level of service delivery, where health sites down to the level of the CSPS provide MCH/FP, nutrition and CDD services. Also, supervisors are being trained to monitor all FP/MCH activities as a complementary set of activities, rather than as discrete functions, and staff have been trained to manage and plan integrated programs. AIDS prevention through condom social marketing remains outside this loop, although its activities are certainly complementary to the role played by public sector health services and are important for their impact on sensitizing the population to condom use.

The best evidence of integration and complementarity is seen among the constituent elements of the MCH/FP component of Subproject 1 (i.e., research, training, IEC, service delivery, management, and supervision), bolstered by services and technical assistance provided through core funds of centrally funded projects (logistics support, integration, FP in the private sector).

These elements hang together as a reasonable system of activities, suitable for the needs of the FP/MCH program at the present time. The scope of activities is reasonable, given the human resource capacity of the MOH; and their pace of implementation is appropriate, given infrastructure constraints and the historical development of FP in Burkina Faso.

A particular strength of the project has been the adoption of FP/MCH and CDD training materials and curricula, policies and standards, protocols, and IEC materials as national norms. Materials developed under one component of the project, for example the curriculum and protocols developed with INTRAH support, are often subsequently used by other subproject elements, i.e., private sector training undertaken by SEATS.

Beyond direct project applications, the adoption of documents as national standards has assured common training, service provision and targets for quality at all health sites throughout the country, regardless of variations in donor support for different provinces. That is, although USAID, UNFPA and the World Bank provide support for 15, 10 and 6 provinces respectively, the content of training, types of services provided, and IEC materials available are consistent throughout the entire country. Using the documents as national standards also underscores the collaborative effort through which the materials were prepared, and indicates the seriousness with which the project activities were accepted by the MOH and the government of Burkina Faso.

Also, the ongoing reinforcement of the National Training Team and the Provincial Training Teams has contributed to institutionalization of local training skills, and to the provision of common training to all relevant health personnel.

A second type of integration is apparent in the subsequent expansion and development of project activities undertaken by one subproject by another subproject or another donor. That is, if early results prove favorable, they are built upon and developed on a larger scale rather than being shelved once the original subproject activities have been completed. For example, following the favorable evaluation of the use of traditional midwives as family planning motivators and service providers (a pilot project carried out by the American College of Nurse Midwives and evaluated under the FP/MCH operations research component), an expanded project is being funded by UNFPA. Also, following the evaluation of satisfied user volunteers as animators by the OR component, the project was modified and expanded to include the larger area of Ouagadougou and Bobo-Dioulasso (SEATS support of ABSF).

Finally, an important aspect of designing a project that capitalizes on the input of centrally-funded contractors is that OAR/Burkina has been successful in inviting additional activities from the same contractors, for which central or core funds are used. This was the case with virtually all the contractors implementing the Child Survival and Maternal Health subproject, and in some cases the additional core funds were substantial. For example, INTRAH included additional funds at 40 percent of the bilateral amount. The input from SEATS, at approximately \$2.2 million, dwarfs the \$250,000 provided from bilateral funds.

That being said, a possible problem in preparing a bilateral agreement that assumes support from existing projects and contractors is the lack of consistency in project completion dates across projects. For example, the SEATS project is scheduled to end in June 1994, implying that local activities must be finished by that time. Local staff are confident that the work programmed will be completed, but there is much that remains to be done in the various activities being undertaken with SEATS support. For example, the private sector activities under way with the Office of Workers' Health are at a nascent enough stage that they would benefit from ongoing USAID support through the end of the FHHF project.

C. Management/Monitoring/Coordination Issues

1. Management

The design of the bilateral agreement as a compilation of activities supported by different contractors and cooperating agencies fostered a trade-off between the initial efficiencies gained in preparing only one set of USAID project documents (PID, PP, etc.) and in continuing work already begun by centrally-funded projects, and subsequent demands on USAID staff and MOH personnel in preparing separate subcontracts and PIO/Ts and in working with consultants from so many different contractors and Cas.

The latter problem (numerous consultants) was in some degree alleviated by the presence of resident local advisors (Population Council, INTRAH, SEATS, PSI, PRITECH), and by West African regional offices often ensuring consistent use of the same staff members and consultants over time.

Management was also smoothed by having USAID staff fully engaged in overall program management. Two foreign service national works virtually full time on the bilateral project, and a TAACs advisor devoting at least fifty percent of her time on the project. The Population/Health/Nutrition officer provides regular oversight to the staff. The USAID staff was able to maintain perspective on the "big picture" of the program, and to facilitate communication and coordination among the various organizations and individuals involved.

2. Monitoring

The presence of resident local advisors and easy access by regional office staff also ensures more routine monitoring of project progress by contractor staff, reducing the need for direct USAID intervention in project activities. Using local advisors appears to have fostered closer collaboration on project activities than sometimes occurs with intermittent consultant visits, and a more rigorous adherence to project schedules.

The only complaint from USAID regarding individual project monitoring concerned JHU/PCS. Work was slowed in IEC activities due to staff turnover at the DSF. Having invested much in building the capacity of the unit under previous project activities, it appears the contractor incorrectly assumed an ongoing strength and capacity to work independently with limited monitoring from the central office. This situation has now been resolved.

Most of the contractors involved in subproject implementation appear to have had regular contact with local counterparts. Revised subproject workplans were sent to USAID regularly, with several, notably that of INTRAH, being particularly well designed to ensure common understanding of the type and pace of activities, and to facilitate rapid assessment of subproject progress.

3. Coordination

Coordination of subproject activities to enhance complementarity and avoid duplication of effort seems to have been reasonably effective. Much possible redundancy was avoided at the early stage of project design by using contractors with unique areas of expertise. At the debut of the project, a kick-off conference was held with participation from all the contractors, in order to introduce the various project elements as a complete package.

Once the project was underway, particular care was taken to link training materials and the development of supervisory skills necessary to monitor integrated programs. Ongoing use and reinforcement of the National Training Team, and development of Provincial Training Teams by the various subprojects was also important.

Links with other donors and coordination with their activities are also evident, both formally and informally. The DSF and DEP coordinate annual donors meetings on health and family planning, discussing particular themes, and there are quarterly meetings among the donors to assess project progress. Actual budget and program planning takes place in individual meetings with various donors. As the World Bank, UNICEF and UNFPA have developed new health projects during the past few years, they have regularly contacted USAID to be briefed on FHHF activities and progress. Similarly, USAID contractor teams have frequently met with other donor resident representatives concerning their respective portfolios.

4. Sustainability

The evaluation scope of work poses the question "Does the MOH have the institutional capacity (staff, resources) to sustain sector-based activities after the end of the project?". We conclude that it does not. A core of trained staff is established, but this core needs expansion and regular retraining. The staff at the provincial administrative level is stretched thin, carrying out their own tasks, supervising CSPA and CM staff, and in some cases, carrying clinical responsibilities as well.

Staff mobility is also a problem, for while staff can carry their training and knowledge base with them, frequent reassignments interrupt reinforcement of local sites and necessitate continual reestablishment of priorities and procedures based on local needs. This will be lessened in the future as health sites begin to achieve parity in resources and a uniform standard of services and care, and as more staff participate in common training and retraining, but it is a process that will be ongoing for years to come. (The addition of clinical family planning training to the curriculum of Nurses and Midwives training is an important step in improving the skills of the MOH human resource base.)

There is also a lack of general management skills among the health care professionals working in provincial health sites. Many reported feeling that they lacked the competence and the confidence to run the programs at their respective sites. Often, state nurses or

midwives are assigned responsibility for a facility immediately upon finishing their formal training, or after only one previous assignment. They have no management courses included in their clinical skills training, and thus must learn by doing how to prepare reports, meet data reporting requirements, do planning, requisition supplies and equipment, etc.

Regarding fiscal resources, USAID stands as one of the leading donors in Burkina Faso supporting FP/MCH. Some additional monies will be coming in under the auspices of a new World Bank Population and AIDS Prevention project now under development and negotiation (estimated \$25.1 million, of which \$13.5 million is for population), but it is not clear whether this will be adequate to compensate for the loss of funds if USAID support is not continued in the future. Virtually every health site visited during this evaluation (n=8) identified inadequate financial resources as a serious constraint to providing high quality preventive health care, and supervisors were unanimous in citing resource constraints as an impediment to routine staff monitoring. More can be done with the resources that are available; this is in part a function of staff drive and motivation and making better use of time and local resources. However, there is a need for ongoing support.

While the health care financing subproject is being implemented to ameliorate this situation, it is too early in its activities to assess its potential impact. For the time being the MOH program is donor driven.

5. Gender Issues

A brief analysis of women in development issues was included in the project paper. It refers to improved access to health care as a means of reducing the burden of rural life on women; the inclusion of women health care professionals as a contribution to their improved status; and the collection of statistics such that project impact can be desegregated by gender. These are very general references, for the most part reflecting the inherent nature of family planning projects in particular and MCH activities more generally to directly impinge on the lives of women, hopefully in a positive way. A more specific consideration of the role of women emerges in the discussion of the health financing subproject, and the efforts that will be made to encourage or ensure the participation of women on the village health committees that will run the pharmacies and determine distribution of profits. The mobilization of the village committees was underway at the time of the evaluation, and so it is too early to determine if the project is successful in recruiting women, and if so, how active is their participation.

To truly change their status and position in Burkina society, women will have to become more knowledgeable in the domains of health and family planning, to understand that control of health, nutrition, and contraception is within their power. They must have knowledge of health, nutrition, and family planning practices, know where services are available, and be able to discuss these subjects with their spouse, if necessary. Women must be a key target for IEC efforts, and those efforts must be intensified. The health and

population program needs a much broader use of print materials, such as informative posters, media coverage of health and family planning topics, and more intensive community outreach efforts through group meetings, mobile teams, market kiosks, etc.. The efforts of this project, both through formal IEC activities and through the desensitizing role added by promotion of condoms through social marketing, are a move in this direction. These activities, coupled with increased levels of formal education and more widely available sources of services, will affect the status of women.

VII. FUTURE USAID ROLE IN POPULATION/HEALTH IN BURKINA FASO

There has been considerable progress in the Government of Burkina Faso's ability to ensure family planning and maternal and child health services to its people during the first half of the Family Health and Health Financing Project. Much of this progress has resulted from USAID support received through the FHHF project and its predecessors. However, it is clear to the evaluation team that the sustainability of the progress realized to date is anything but assured. There continue to be stock outages in critical supplies such as contraceptives and ORS, there are insufficient funds available for the implementation of basic supervision on a regular basis, and the government is only just embarking on an effort to restructure the financing of the population/health sector.

Continued donor assistance is clearly needed for the Government of Burkina Faso to be able to maintain progress in the strengthening of government services, its encouragement of private sector services delivery, and its efforts to address specific threats to health such as high fertility, malnutrition, diarrheal disease and AIDS. The United States has developed an ability to provide high quality technical assistance in the areas of institutional development, operational research, private sector mobilization, population and health promotion and the introduction of cost-sharing into public sector programs. USAID should continue to participate with other donors in working with the increasingly stronger Burkina Faso Ministry of Health and Social Welfare to sustain the progress toward the establishment of a sustainable population/health services delivery system.

Irrespective of the outcome of the on-going USAID reorganization, the Agency will still have a range of options open to it for continuing assistance to the population/health sector in Burkina Faso. Whether the Burkina Faso USAID program of the future will be managed from Washington, Abidjan or a closer regional site, it will still be possible to program future assistance through centrally-funded projects, bilateral projects or a combination of the two. If USAID moves, as expected, to make centrally-funded projects less dependent upon "buy-ins" from bilateral funds by fully funding the core funds of these projects, then they will be in a much better situation to provide development services to countries which do not have a USAID mission.

In any event, it will be critical for USAID to maintain enough in-house technical expertise to ensure that the Agency is able to work closely with the authorities of beneficiary governments and other donors to assess needs and plan the collaborative assistance efforts of USAID. Without such in-house expertise, the Agency will find itself in the dark, dependent upon contractor experts to tell it what to do and then having to hire the same contractors to carry out its programs.

Annex A.

Mid-Term Evaluation Scope of Work

ARTICLE I - TITLE

The Family Health and Health Financing (FHFF) Project
Project Number: 686-0275

ARTICLE II - OBJECTIVE

To undertake the mid-term evaluation of the child survival/maternal health and the health planning sub-projects of the FHFF Project in health and the health planning sub-projects of the FHFF Project in Burkina.

ARTICLE III SCOPE OF WORK

The purpose of the mid-term evaluation is to review the child survival/maternal health and the health planning sub-projects of the FHFF Project in Burkina. Overall, this evaluation will assess project effectiveness in achieving its objectives to date; recommend changes in the design, focus and/or strategy for the remaining period of the project; and make recommendations for a follow-on project. The evaluation team shall also examine the centrally-funded activities to assess how they complement the bilateral project. The health financing sub-project will not be evaluated at this time. A separate evaluation will address this sub-project in late 1994.

The Contractor's team shall access the following elements:

A. Progress of Project Activities

Ascertain the extent to which project is progressing towards achieving project objectives (quantitative and qualitative outputs). For the child survival/maternal health sub-project, the evaluation team shall respond to the following questions:

1. Are the training and IEC activities in the FP/MCM, DDC, and nutrition components being implemented efficiently?
2. To what extent are the training activities improving the performance of health service providers and changing client behavior?
3. Are the management and monitoring systems in place and resulting in improved service delivery?

4. What efforts have been made under the project to extend the clinic-based preventive health care services to the community level? How successful are these efforts?

5. What are the strengths and weaknesses of the PROMACO approach to promotion, distribution and sales (i.e., using the PROMACO sales staff to establish an independent sales network for the condom, PRUDENCE, rather than working through an existing commercial distributor)?

6. What have been the lessons learned about the conflicts and problems inherent in the establishment of a private sector activity under the auspices of a public sector bilateral agreement? Suggest ways to avoid such conflicts when setting up other social marketing projects which target the private sector.

For health planning sub-project the evaluation will address the following questions:

1. Is the DEP conducting its activities according to the workplan to ensure that the activities are not declining with the yearly reduction of USAID's contribution?

2. What efforts are being made by the DEP to identify and obtain other sources of funding per USAID/MOH agreement? Is the MOH contribution increasing to compensate for the declining USAID funding?

B. Review of Impact Indicators

During the course of project implementation, a number of changes have been made to the original project paper. These changes are reflected in the grant agreement amending and the sub-agreements prepared between the MOH and the contractors providing technical assistance. The evaluation team will review the appropriate documents and assess:

1. If the original indicators in the logframe are appropriate and achievable in light of project inputs and changes in the program design. If not, provide recommendations for an alternative set of indicators to measure project impact.

2. The potential for end-of-project sustainability of the DEP. At the end of the FHFF project, it is expected that DEP will be sustainable as a result of inputs provided under the health planning sub-project. The Contractor's team shall reexamine the sustainability issue in light of the resources available from the MOH and other donors and make recommendations regarding the criteria to use for assessing impact for this sub-project.

C. Project Design and Management

The Contractor's team shall review the project design, MOH capacity, other donor involvement and make recommendations for changing, refocusing or modifying the project strategy which was to group health, family planning, child survival, AIDS and health financing activities under one project.

The design of the FHFF project was based on ongoing health and family planning activities in Burkina Faso implemented under a number of different arrangements including those centrally-funded through AID/W and those funded through two separate AID/Burkina bilateral projects. While the concept to group all assistance under one bilateral project was valid, the project requires technical assistance from numerous AID/W contractors. For example, for family planning alone there are five contractors with separate sub-agreements with one department of the MOH with limited staff. Understanding this environment the evaluation team will assess the questions:

1. Is a project design where each activity is planned and implemented vertically an effective and efficient way to increase access to quality preventive health care services? What are the lessons learned that can benefit the remaining life of the project?
2. How successful are the mission and the MOW in ensuring that activities of the contractors are effectively coordinated to avoid duplication of resources?
3. Does the MOH have the institutional capacity (staff, resources) to sustain sector-based activities after the end of the project? What lessons can be learned for the future?
4. Are gender issues adequately addressed in the design? If not, provide recommendations for design modification.

D. Future Directions

The LOP of the FHFF project is July 1996, however, the majority of the activities in the child survival/maternal health sub-project for the AIDS prevention, family planning, and nutrition will be completed by September 1994. The team will review MOH priorities, other donor assistance, USAID's comparative advantage and make recommendations regarding:

1. What continued role, if any, USAID should play in these areas during the remaining life of the current project.
2. The need and/or desirability of a follow-on project giving priority areas taking into consideration lessons learned during the current project and USAID/Burkina's decreasing resources.

Annex B.
Logical Framework

SUBPROJECT 1
CHILD SURVIVAL AND MATERNAL HEALTH

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>PROJECT GOAL</p> <p>TO IMPROVE THE HEALTH STATUS OF THE PEOPLE OF BURKINA FASO, ESPECIALLY WOMEN AND CHILDREN.</p>	<p>MEASURES OF GOAL ACHIEVEMENT:</p> <ul style="list-style-type: none"> - REDUCED INFANT, CHILD AND MATERNAL MORTALITY RATES. 	<ul style="list-style-type: none"> - 1985 AND 1995 CENSUS - DEMOGRAPHIC AND HEALTH SURVEY - SPECIAL STUDIES - HEALTH STATISTICS REPORTS 	<ul style="list-style-type: none"> - GOB HUMAN AND FINANCIAL RESOURCES AVAILABLE TO MEET OBLIGATIONS AND ASSURE SERVICES. - GOB FAVORABLE POLICIES IN HEALTH SECTOR REMAIN UNCHANGED. - COMPLEMENTARY EFFORTS BY OTHER DONORS AND INPUT PROVISION TAKE PLACE AT AN ADEQUATE LEVEL. - GOB IS COMMITTED TO IDENTIFYING AND ADDRESSING BROADER ECONOMIC POLICY AND INSTITUTIONAL CONSTRAINTS WHICH AFFECT RESOURCE FLOW AVAILABILITY TO HEALTH SECTOR.
<p>SUB-PROJECT PURPOSE</p> <p>MAXIMIZE MATERNAL AND CHILD HEALTH BY INSTITUTING IMPROVED PROGRAMS OF FAMILY PLANNING, DIARRHEAL DISEASE CONTROL AND NUTRITION.</p>	<p>END OF PROJECT STATUS</p> <ul style="list-style-type: none"> - CONTRACEPTIVE PREVALENCE RATE INCREASED TO 8%. - FAMILY PLANNING SERVICES AND INFORMATION AVAILABLE AT MCH CNTRS & M/D'S IN 15 PROVINCES. - DDC INFORMATION AVAILABLE IN ALL HEALTH FACILITIES IN 8 PROVINCES. - REDUCED USAGE OF ANTI-DIARRHEAL DRUGS. - INCREASED USAGE OF ORT AT HEALTH CENTERS AND IN HOMES. - 50% OF THE MOTHERS IN THE PROJECT AREA WILL BE: CONSUMING A MORE BALANCED DIET; FEEDING THEIR CHILDREN A MORE BALANCED DIET; FEEDING THEIR RECUPERATING CHILDREN A BETTER DIET. - NUTRITION SERVICES AND INFORMATION AVAILABLE IN MEDICAL CENTERS IN 8 PROVINCES. - EVIDENCE OF DECREASED RATES OF STD'S. 	<ul style="list-style-type: none"> - HEALTH STATISTICS REPORTS - KAP SURVEYS - SPECIAL STUDIES 	<ul style="list-style-type: none"> - POLITICAL AND FINANCIAL SUPPORT FOR PROJECT ACTIVITIES FROM PUBLIC SECTOR CONTINUES. - SUPPORT FOR ACCEPTANCE OF SERVICE BY INDIVIDUAL COUPLES AND PARENTS CONTINUES.

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FAMILY HEALTH AND HEALTH FINANCING (686-0275)
LOGICAL FRAMEWORK

SUBPROJECT 1

CHILD SURVIVAL AND MATERNAL HEALTH

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>OUTPUTS</p> <p>A. FAMILY PLANNING</p> <p>1. FP SERVICES WIDELY AVAILABLE IN 15 PROVINCES.</p>	<p>MAGNITUDE OF OUTPUTS</p> <p>- 84 SERVICES SITES EQUIPPED AND SUPPLIED WITH CONTRACEPTIVES.</p> <p>- APPR. 453 MOHSA SERVICE PERSONNEL TRAINED OR RETRAINED.</p> <p>- 84 PUBLIC FACILITIES WITH FP SERVICES AND INFORMATION AVAILABLE.</p> <p>- MANAGEMENT, SUPERVISORY AND LOGISTICS SYSTEMS IN PLACE.</p>	<p>- ON-SITE VERIFICATION</p> <p>- SERVICE STATISTICS REPORTS</p> <p>- MANAGEMENT INFORMATION SYSTEM REPORTS</p> <p>- MOHSA REPORTS</p> <p>- SURVEY AND STUDY REPORTS</p> <p>- TRAINING CURRICULA</p> <p>- TRAINING REPORTS</p> <p>- CONTRACTOR REPORTS</p> <p>- EVALUATION REPORTS</p> <p>- PROTOCOLS & PROCEDURE MANUALS</p> <p>- ASSIGNMENT OF TRAINED PERSONNEL TO APPROPRIATE POSITIONS</p> <p>- INTER-INSTITUTIONAL COORDINATION ARRANGEMENTS</p> <p>- MEETINGS AND PATTERNS OF COMMUNICATION</p>	<p>- QUALIFIED CANDIDATES FOR TRAINING ARE AVAILABLE.</p> <p>- EXPERIENCED MOHSA HEALTH SECTOR PERSONNEL INCLUDING SUPERVISORS AND MANAGERS ARE IDENTIFIED, REMAIN IN PRESENT JOBS OR ARE ASSIGNED TO APPROPRIATE POSTS WHICH UTILIZE THEIR TRAINING.</p> <p>- PERSONNEL WILL BE RELEASED FOR TRAINING.</p> <p>- PUBLIC HEALTH FACILITIES CAN ACCOMMODATE INCREASED ACTIVITIES.</p> <p>- PEOPLE ARE WILLING TO PURCHASE CONTRACEPTIVES.</p> <p>- PEOPLE ARE WILLING TO ADOPT INTERVENTIONS ONCE INFORMED.</p> <p>- GOB WILLING TO ACCEPT POLICY RECOMMENDATIONS.</p> <p>- INTER-INSTITUTIONAL RELATIONSHIPS (PUBLIC AND PVO SECTORS) WILL GROW AND DEVELOP IN A COOPERATIVE MANNER.</p>
<p>2. CONDOM SOCIAL MARKETING PROGRAM ESTABLISHED.</p>	<p>- 350 OUTLETS FOR CONDOMS.</p> <p>- 20 PROMOTIONAL CAMPAIGNS ON CONDOMS FOR AIDS CONTROL.</p>		
<p>3. FP IEC PROGRAM IMPROVED AND EXPANDED.</p>	<p>- 3 VIDEO PROGRAMS AND IEC PRINT MATERIALS PRODUCED AND DISTRIBUTED.</p> <p>- 30 AWARENESS RAISING CAMPAIGNS CONDUCTED IN 15 PROVINCES.</p> <p>- IEC EQUIPMENT SUPPLIES TO APPR. 385 TRAINED SOCIAL WORKERS.</p> <p>- APPR. 385 SOCIAL EDUCATORS TRAINED OR RETRAINED.</p>		
<p>4. PROGRAM DATA COLLECTION AND RESEARCH CONDUCTED.</p>	<p>- 2 OPERATIONS RESEARCH STUDIES CONDUCTED.</p>		
<p>B. DIARRHEAL DISEASE CONTROL</p> <p>A FUNCTIONING DDC PROGRAM IN 8 PROVINCES.</p>	<p>- APPR. 3620 PERSONS TRAINED TO PROVIDE DDC SERVICES.</p> <p>- 76 HEALTH FACILITIES WHERE ORT SERVICES AVAILABLE.</p> <p>- IEC ACTIVITIES IMPLEMENTED.</p> <p>- ORS DISTRIBUTION IMPROVED.</p> <p>- 1 OPERATIONS RESEARCH STUDY</p>		

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SUBPROJECT 1 CHILD SURVIVAL AND MATERNAL HEALTH		
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
C. NUTRITION	- 240 PERSONNEL TRAINED IN EACH OF THREE NUTRITIONAL THEMES. - PRE AND POST KAP STUDIES CONDUCTED.	- A.I.D. REPORTS - CONTRACTOR REPORTS - PROJECT EVALUATIONS AND AUDITS - SITE VISITS - GOB REPORTS - TRAINING CURRICULA - TRAINING REPORTS - KAP STUDIES
1. A NUTRITION IEC PROGRAM IMPEMENTED IN 8 PROVINCES.	- 240 PERSONNEL TRAINED IN 3 IEC THEMES AND USE OF MATERIALS PRODUCED. - APPROX. SIX POSTERS, 3 BROCHURES, SIX SONGS, 3 SLIDE SHOWS, 9 RADIO PROGRAMS, 18 RADIO SPOTS, AND 3 PLAYS PRODUCED.	IMPORTANT ASSUMPTIONS - GOB AND A.I.D. INPUTS WILL BE AVAILABLE ON SCHEDULE. - BUY-IN CONTRACTORS WILL BE ABLE TO RESPOND TO REQUESTS FOR ASSISTANCE. - BENEFICIARIES ARE CLOSELY INVOLVED IN PROJECT IMPLEMENTATION - QUALIFIED CANDIDATES FOR TRAINING ARE AVAILABLE AND APPROPRIATELY ASSIGNED.
INPUTS - A.I.D.	MAGNITUDE	
TECHNICAL ASSISTANCE (BUY-INS)	\$3,975,000	
FAMILY PLANNING		A.I.D. REPORTS, VOUCHERS - CONTRACTOR REPORTS - PROJECT EVALUATIONS AND AUDITS - SITE VISITS - GOB REPORTS AND ADMINISTRATIVE RECORDS - PROJECT MANAGER RECORDS AND REPORTS
- PAC 11 B	\$446,000	GOB AND A.I.D. INPUTS WILL BE AVAILABLE ON SCHEDULE. - BUY-IN CONTRACTORS WILL BE ABLE TO RESPOND TO REQUESTS FOR ASSISTANCE.
- FPMT	\$135,000	
- SEATS	\$300,000	
- JHU/PCS	\$546,000	
- OR	\$150,000	
- CSM - AIDSTECH	\$1,165,000	
- DDC - PRITECH	\$472,000	
- NUTRITION	\$761,000	
COMMODITIES		
- CONTRACEPTIVES	\$641,000	
- CLINICAL EQUIPMENT AND SUPPLIES	\$454,000	
- VEHICLES	\$100,000	
OTHER COSTS	\$87,000	
- PSC - SUBPROJECT MANAGER	\$1,102,000	
- DDC LOCAL COST	\$825,000	
SUB-PROJECT TOTAL	\$277,000	
GOB CONTRIBUTION	\$5,718,000	
PERSONNEL		
HEALTH FACILITIES		
SUB-PROJECT TOTAL	CFA 220,788,871 CFA 128,147,661 CFA 348,936,532	

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FAMILY HEALTH AND HEALTH FINANCING (686- 0275)
LOGICAL FRAMEWORK

SUB-PROJECT 2
HEALTH FINANCING

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>PROJECT GOAL</p> <p>TO IMPROVE THE HEALTH STATUS OF THE PEOPLE OF BURKINA FASO, ESPECIALLY WOMEN AND CHILDREN.</p>	<p>MEASURE OF GOAL ACHIEVEMENT</p> <ul style="list-style-type: none"> - REDUCED INFANT, CHILD AND MATERNAL MORTALITY RATES. 	<ul style="list-style-type: none"> - 1985 AND 1995 CENSUS - DEMOGRAPHIC AND HEALTH SURVEY - SPECIAL STUDIES - HEALTH STATISTICS REPORTS 	<ul style="list-style-type: none"> - GOB HUMAN AND FINANCIAL RESOURCES AVAILABLE TO MEET OBLIGATIONS AND ASSURE SERVICES. - GOB FAVORABLE POLICIES IN HEALTH SECTOR REMAIN UNCHANGED. - GOB POLICIES AND APPROVALS FOR MECHANISMS REQUIRED FOR OPERATION OF HEALTH COST RECOVERY ELEMENTS ARE IN PLACE. - COMPLEMENTARY EFFORTS BY OTHER DONORS AND INPUTS PROVISION TAKE PLACE AT AN ADEQUATE LEVEL. - GOB IS COMMITTED TO IDENTIFYING AND ADDRESSING BROADER ECONOMIC POLICY AND INSTITUTIONAL CONSTRAINTS WHICH AFFECT RESOURCE FLOW AVAILABILITY TO HEALTH SECTOR.
<p>SUB-PROJECT PURPOSE</p> <p>TO PROMOTE COMMUNITY PARTICIPATION IN THE HEALTH SYSTEM AND TO INSTITUTE COST RECOVERY ACTIVITIES AND EFFICIENT MANAGEMENT AND SUPERVISION PRACTICES DESIGNED TO IMPROVE HEALTH SERVICES AT THE MEDICAL CENTER AND HEALTH CENTER LEVELS IN 5 PROVINCES.</p>	<p>END OF PROJECT STATUS</p> <ul style="list-style-type: none"> - 50% INCREASE IN UTILIZATION OF PHC FACILITIES. - REDUCTION IN MEDICAL EVACUATIONS. - INCREASED NUMBERS OF PRENATAL CONSULTATIONS. - HIGHER IMPACT FOR EACH INDICATOR LISTED IN SUBPROJECT 1. 	<ul style="list-style-type: none"> - HEALTH STATISTICS REPORTS - SPECIAL STUDIES 	<ul style="list-style-type: none"> - PROGRAM AND FINANCIAL SUPPORT FOR PROJECT ACTIVITIES FROM GOB AND COMMUNITIES CONTINUES. - ECONOMIC CONDITIONS WHICH PERMIT PEOPLE TO PAY FOR HEALTH CARE CONTINUE. - OTHER DONORS CONTINUE TO SUPPORT COMPLEMENTARY ACTIVITIES - INTER-INSTITUTIONAL RELATIONSHIPS (PUBLIC & PVO SECTORS) WILL GROW AND DEVELOP IN A COOPERATIVE MANNER
<p>OUTPUTS</p> <ul style="list-style-type: none"> - COMMUNITY-OPERATED PHARMACIES SELLING ESSENTIAL DRUGS WHICH GENERATE SURPLUS INCOME. - IMPROVE PHC FACILITIES CAPABLE OF PROVIDING IMPROVED PRIMARY HEALTH CARE SERVICES. - IMPROVED DIAGNOSTIC AND DRUG TREATMENT PROCEDURES. - LOGISTICS, FINANCIAL AND SUPERVISION SYSTEMS FOR MANAGEMENT OF HEALTH COST RECOVERY MECHANISMS AND PHC SERVICES. - HEALTH COST RECOVERY MECHANISMS GENERATING SUFFICIENT INCOME TO COVER ALL RECURRENTS COSTS (OTHER THAN SALARIES OF PERMANENT STAFF) AT PHC FACILITIES. 	<p>MAGNITUDE OF OUTPUTS</p> <ul style="list-style-type: none"> - 3 PROVINCIAL DEPOTS, 10 ZONE DEPOTS, AND 84 PHARMACIES ESTABLISHED. - 84 FACILITIES - APPR. 233 HEALTH WORKERS TRAINED IN THE USE OF NEW DIAGNOSTIC AND TREATMENT PROCEDURES. - SYSTEMS INSTALLED IN TEN HEALTH ZONES. - HEALTH COST MECHANISMS IN ADDITION TO DRUGS STORES AT 84 PHC FACILITIES. 	<ul style="list-style-type: none"> - ON SITE VERIFICATION - HEALTH STATISTICS REPORTS - MANAGEMENT INFORMATION SYSTEM REPORTS - TRAINING CURRICULA AND REPORTS - PVO REPORTS - EVALUATION REPORTS - IMPROVED ESSENTIAL DRUGS PRACTICES 	<ul style="list-style-type: none"> - THE MOHSA MAINTAIN TRAINED HEALTH CARE PERSONNEL AT PHC FACILITIES. - APPROPRIATELY QUALIFIED PERSONNEL ARE AVAILABLE FOR EMPLOYMENT BY COMMUNITIES.

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NAARRATIVE SUMMARY

INPUTS - A.I.D.

U.S. PVO

GOB & COMMUNITY ORGANIZATIONS

PERSONNEL
HEALTH FACILITIES
OPERATING COSTS

SUB-PROJECT TOTAL

OBJECTIVELY VERIFIABLE INDICATORS

MAGNITUDE

\$3,435,000

CFA 96,111,444
CFA 144,000,000

FCFA 240,111,444

MEANS OF VERIFICATION

- A.I.D. REPORTS, VOUCHERS
- PVO REPORTS
- PROJECT EVALUATIONS AND AUDITS
- SITE VISITS
- GOB REPORTS AND ADMINISTRATIVE RECORDS.

IMPORTANT ASSUMPTIONS

- GOB, A.I.D. AND COMMUNITY RESOURCES ARE AVAILABLE ON SCHEDULE.

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FAMILY HEALTH AND HEALTH FINANCING (686-0275)
LOGICAL FRAMEWORK

SUB-PROJECT 3
HEALTH PLANNING

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>PROJECT GOAL</p> <p>TO IMPROVE THE HEALTH STATUS OF THE PEOPLE OF BURKINA FASO, ESPECIALLY WOMEN AND CHILDREN.</p>	<p>MEASURES OF GOAL ACHIEVEMENT</p> <ul style="list-style-type: none"> - REDUCED INFANT, CHILD AND MATERNAL MORTALITY RATES. 	<ul style="list-style-type: none"> - 1985 AND 1995 CENSUS - DEMOGRAPHIC AND HEALTH SURVEY - SPECIAL SURVEYS - HEALTH STATISTICS REPORTS 	<ul style="list-style-type: none"> - QUALIFIED CANDIDATES FOR TRAINING ARE AVAILABLE. - GOB HUMAN AND FINANCIAL RESOURCES AVAILABLE TO MEET OBLIGATIONS AND ASSURE SERVICES. - GOB FAVORABLE POLICIES IN HEALTH SECTOR REMAIN UNCHANGED. - COMPLEMENTARY EFFORTS BY OTHER DONORS AND INPUT PROVISION TAKE PLACE AT AN ADEQUATE LEVEL. - GOB IS COMMITTED TO IDENTIFYING AND ADDRESSING BROADER ECONOMIC POLICY AND INSTITUTIONAL CONSTRAINTS WHICH AFFECT RESOURCE FLOW AVAILABILITY TO HEALTH SECTOR.
<p>SUB-PROJECT PURPOSE</p> <p>TO COMPLETE THE PROCESS OF INSTITUTIONALIZING HEALTH PLANNING FUNCTIONS WITHIN THE MOHSA.</p>	<p>END OF PROJECT STATUS</p> <p>A FUNCTIONAL, SELF-SUSTAINING HEALTH PLANNING ORGANIZATION.</p>	<ul style="list-style-type: none"> - MOHSA BUDGETS - DEP REPORTS, PUBLICATIONS, CONFERENCES - SITE INSPECTIONS 	<ul style="list-style-type: none"> - THE MOHSA CONTINUES TO GIVE PRIORITY TO HEALTH PLANNING AND TO PROVIDE FINANCIAL AND HUMAN RESOURCES REQUIRED.
<p>OUTPUTS</p> <ul style="list-style-type: none"> - ANNUAL HEALTH PLANS - HEALTH PROGRAM EVALUATIONS - DONOR COORDINATION CONFERENCES - PLANNING CONFERENCES FOR MOHSA DIRECTORS, STATISTICIANS, ETC. - ANNUAL HEALTH REPORTS - QUARTERLY EPIDEMIOLOGICAL BULLETINS - ANNUAL STATISTICAL REPORTS - TRAINED PERSONNEL - COST RECOVERY MEASURES - INCREASED GOB MEETING OF DEP RECURRENT COSTS 	<p>MAGNITUDE OF OUTPUTS</p> <ul style="list-style-type: none"> 1 ANNUAL HEALTH PLAN/YR OVER LOP. 1 PROGRAM EVALUATION PER YEAR. 1 DONOR CONFERENCE/YR OVER LOP. 2 WORKSHOPS FOR STATISTICIANS/YR. 1 COORDINATION CONFERENCE FOR HEALTH DIRECTORS/YR OVER LOP. <ul style="list-style-type: none"> - USER FEES FOR PRODUCTS AND SERVICES. - HIGHER SHARE OF RECURRENT COSTS PROVIDED BY MOHSA AND DECREASING AMOUNT BY AID. 	<ul style="list-style-type: none"> - ON-SITE VERIFICATION - MOHSA BUDGETS - DEP REPORTS, PUBLICATIONS, CONFERENCES - TRAINING REPORTS - ANNUAL HEALTH DONORS CONFERENCE 	<ul style="list-style-type: none"> - DEP PERSONNEL REMAIN IN THEIR PRESENT POSITIONS OR IN OTHER APPROPRIATE POSITIONS WITHIN THE ORGANIZATION. - APPROPRIATE PERSONNEL ARE MADE AVAILABLE FOR TRAINING.
<p>INPUTS</p> <p>AID FUNDING FOR DEP ACTIVITIES GOB FUNDING FOR DEP</p> <p>AID INPUTS ALL COMPONENTS</p> <p>PARTICIPANT TRAINING AUDITS SHORT-TERM TA</p> <p>TOTAL PROJECT AID TOTAL PROJECT GOB</p>	<p>MAGNITUDE</p> <p>\$500,000 FCFA 352,268,700</p> <p>\$137,000 \$110,000 \$40,000</p> <p>\$10,000,000 FCFA 940,524,522</p>	<ul style="list-style-type: none"> - A.I.D. REPORTS, VOUCHERS - PROJECT AUDITS - SITE VISITS - GOB REPORTS, AND ADMINISTRATIVE RECORDS 	<ul style="list-style-type: none"> - COST CONTAINMENT WILL BE HONORED. - A.I.D. AND GOB RESOURCES ARE AVAILABLE ON SCHEDULE.

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Annex C.

Monitoring and Evaluation Plan

MONITORING AND EVALUATION PLAN

I. Users of the Information

The principal users of the information developed will be MOHSA managers at the central and provincial levels, private sector health organizations, and health donors active in Burkina who are impacting directly and indirectly in the areas of maternal and child health, family planning, AIDS control, health planning, and health financing. Information will also be used by USAID project and program officers.

II. Institutional Locus

The institutional locus for data collection and monitoring is the MOHSA's DEP and the provincial directorates of the MOHSA which are in the project area.

III. Project Goal, Purpose, Output Questions, Indicators and Data Collection Methodologies

The data collected during project implementation will examine the following questions. Indicators and methods are identified below.

A. Project Goal

The project goal is to improve the health status of the people of Burkina Faso, especially women and children.

Goal-Level Questions:

To what extent has the survivability of children under five and women of reproductive age improved.

Indicators: Infant, child, and maternal mortality rates.

Data Collection Methodology:

Nationwide surveys which specifically measure infant, child, and maternal mortality rates. Two such surveys are planned in the next five years: the 1995 National Population Census (to be funded by the national budget); and the Burkina Demographic and Health Survey (to be funded with mission PD&S funds).

B. Project Purpose (Three Sub-Projects)

1. Sub-Project 1 - Child Survival and Maternal Health

The purpose of this sub-project is to maximize maternal and child health by instituting improved programs of family planning, diarrheal disease control, and nutrition.

Indicators

Impact indicators for the FP/MCH activity will include the following: 1) contraceptive prevalence rates for women of reproductive age increasing from 2% to 8%; 2) 210,000 cumulative "Couple Years of Protection" 1990-1995; and 3) 80% of men and 60% of women in the project area will be able to name at least two FP methods and at least one FP service site.

Impact indicators for the DDC activity will include the following:

- * The percentage of cases of diarrhea in children under five years of age treated at health facilities with ORT will increase from an estimated 19% to 75%;
- * The percentage of mothers who have knowledge of ORS will increase from an estimated 31% to 50%;
- * The percentage of mothers who are able to demonstrate the correct use of ORT will increase from an estimated 19% to 40%;
- * The percentage of diarrhea cases which are treated with anti-diarrheal drugs at health facilities will decrease from 36% to 10%;
- * The percentage of cases which are treated by mothers at home with anti-diarrheal drugs will decrease from approximately 67% to 30%; and
- * The percentage of mothers in the project area who report having used ORT to treat diarrheal cases in children in the last two weeks will increase from approximately 16% to 40%.

Indicators for the Nutrition Communication activity will include the following:

- * Contribution to a reduction in low birth weight infants in the project from an estimated 11.2% to 10% of all newborns;
- * 10% reduction in the numbers of children (12-23 months) who have a weight for age less than that which is two standard deviations below the mean;
- * 20% of the mothers in the project area will have contact with one of the project's educational materials or programs relating to each of the three major nutritional themes targeted under the project;
- * 10% of the mothers in the project area be able to communicate the contents of: a balanced maternal diet consisting of locally available foods; a balanced diet for children aged 12-23 months consisting of locally available foods; and an appropriate diet for a recuperating child;

* 5% of the mothers in the project area will be: consuming a more balanced diet; feeding their children aged 12-23 months a more balanced diet; and feeding their recuperating children a more appropriate diet.

Indicators for the Condom Social Marketing activity will include evidence of a decrease in the transmission of STDs in Burkina and the financial sustainability of the program as measured by decreasing need for donor support over time.

Data Collection Methodologies

Data on the indicators listed above will be collected on a continual basis as part of the project's built-in data collection, monitoring and evaluation system. The methods used to generate this information will be the national health information system which is managed by the MOHSA's DEP; project-funded knowledge-attitude-practices (KAP) surveys; other special studies planned under the project such as diarrheal disease case management studies; and the ongoing MOHSA STD Epidemiologic Project which measures trends in STD incidence.

The data from the national health information system will be collected by the MOHSA's DEP. The data from the KAP and other special surveys will be collected by provincial staff members of the MOHSA in collaboration with the project's cooperating agencies. The Houet Provincial Health and Social Action Directorate will collect data on STD incidence.

B. Sub-Project 2 - Health Financing

The purpose of this sub-project is to promote community participation in the health system and to institute cost recovery activities and efficient management and supervision practices designed to improve and sustain health-related services at the medical center and health center levels in five provinces.

Indicators

- reduced numbers of medical evacuations in the subproject area;
- increased utilization of health facilities by a minimum of 50 percent;
- increased numbers of prenatal consultations; and
- higher impact for each indicator listed under subproject 1.

Data Collection Methodologies

Data on the indicators listed above will be collected on a continual basis as part of the project's built-in data collection, monitoring and evaluation system. The method used to generate this information will be the national health information system which is managed by the MOHSA's DEP. The information will be collected by the provincial agents of the MOHSA.

C. Sub-Project 3 - Health Planning

The purpose of this sub-project is to complete the process of institutionalizing health planning within the MOHSA by assisting the DEP to develop permanent sources of funding for the recurrent costs of important periodic health planning activities.

Indicators

- a sustainable DEP without need of USAID financial support;
- the continued effective functioning of the DEP.

Data Collection Methodologies

Data on the indicators listed above will be collected from MOHSA and DEP budgets, DEP reports and publications, and on-site verification of the DEP workplan. The information will be collected by staff members of the DEP and the USAID HPN Office. On-site verification will be conducted by staff members of the USAID HPN Office.

IV. Project Outputs (by three sub-projects)

A. Sub-project 1 - Child Survival and Maternal Health

The sub-project outputs will be modifications and improvements in existing maternal and child health services through better trained, supervised, managed, and equipped health workers and community-based programs.

Output Level Questions:

- To what extent have the subproject's training activities improved the performance of health service providers;
- To what extent have the improved project services been delivered in a fully integrated fashion;
- To what extent have clinic based preventive programs been extended to the community level;
- To what extent have improved management systems led to improved service delivery.

Indicators:

- Increased utilization of health services by the population.
- Positive supervision and monitoring visits of service providers.
- Positive supervision and monitoring visits of PHC workers.
- Integrated clinic schedules of services.
- Functioning management information systems for maternal and child health.
- The specific output indicators listed in the project paper.

Data Collection Methodology:

Examine supervision reports for health workers and PHC workers. Examine results of the national health information system and the MCH management information system. Examine clinic schedules and conduct site visits. Reports of cooperating agencies.

B. Sub-Project 2 - Health Financing

Output Level Questions

- To what extent have pharmacies contributed to the income and reduced the recurrent cost burden of the health centers in the project area;
- To what extent have the fee for service cost recovery measures contributed to the income and reduced the recurrent cost burden of health centers in the project area;
- To what extent has the training provided to health workers led to improved diagnosis and treatment of common diseases.

Indicators:

- Profitability of community pharmacies;
- Yield from fee for service cost recovery mechanisms;
- Percent of recurrent costs of health facilities recovered from pharmacy profits and from fee for service mechanisms;
- Appropriateness of drugs prescribed by service providers.
- Specific output indicators listed in the project paper.

Data Collection Methodology:

Data will be collected by examining financial records from pharmacies and health clinics in the project area, drug prescription records at pharmacies, and reports from the health information system.

C. Sub-Project 3 - Health Planning:

Output Level Questions:

- To what extent has the DEP continued to conduct the periodic activities in its annual workplan;
- To what extent has the DEP executed cost containment practices;
- To what extent has the MOHSA allocated additional resources to the DEP;
- To what extent has the MOHSA identified other donors to assist the DEP in the short term;
- To what extent has the DEP instituted improved cost recovery mechanisms.

Indicators:

- DEP's implementation of its annual workplan;
- The reduced costs of conducting periodic activities;
- Increased yields from cost recovery mechanisms;

- Increased MOHSA budgets for the DEP;
- Increased numbers of other health donors funding DEP activities in the short term.

Data Collection Methodology

- The DEP's annual and activity specific reports;
- On-site verification by USAID project officers;
- Examination of DEP and MOHSA budgets.

6. Budget:

Approximately one percent (\$110,000) of the \$10.0 million of the total AID funding for this project has been set aside for data collection and analysis, an interim and a final project evaluation. Funding and in-kind contributions will be provided by the GOB and AID as follows:

- GOB: Staff, office space and use of ADP facilities. Data generated and available from DEP and other GOB agencies.
- AID: Contract personnel to conduct external evaluations and to assist, as needed, in training and data collection tasks.

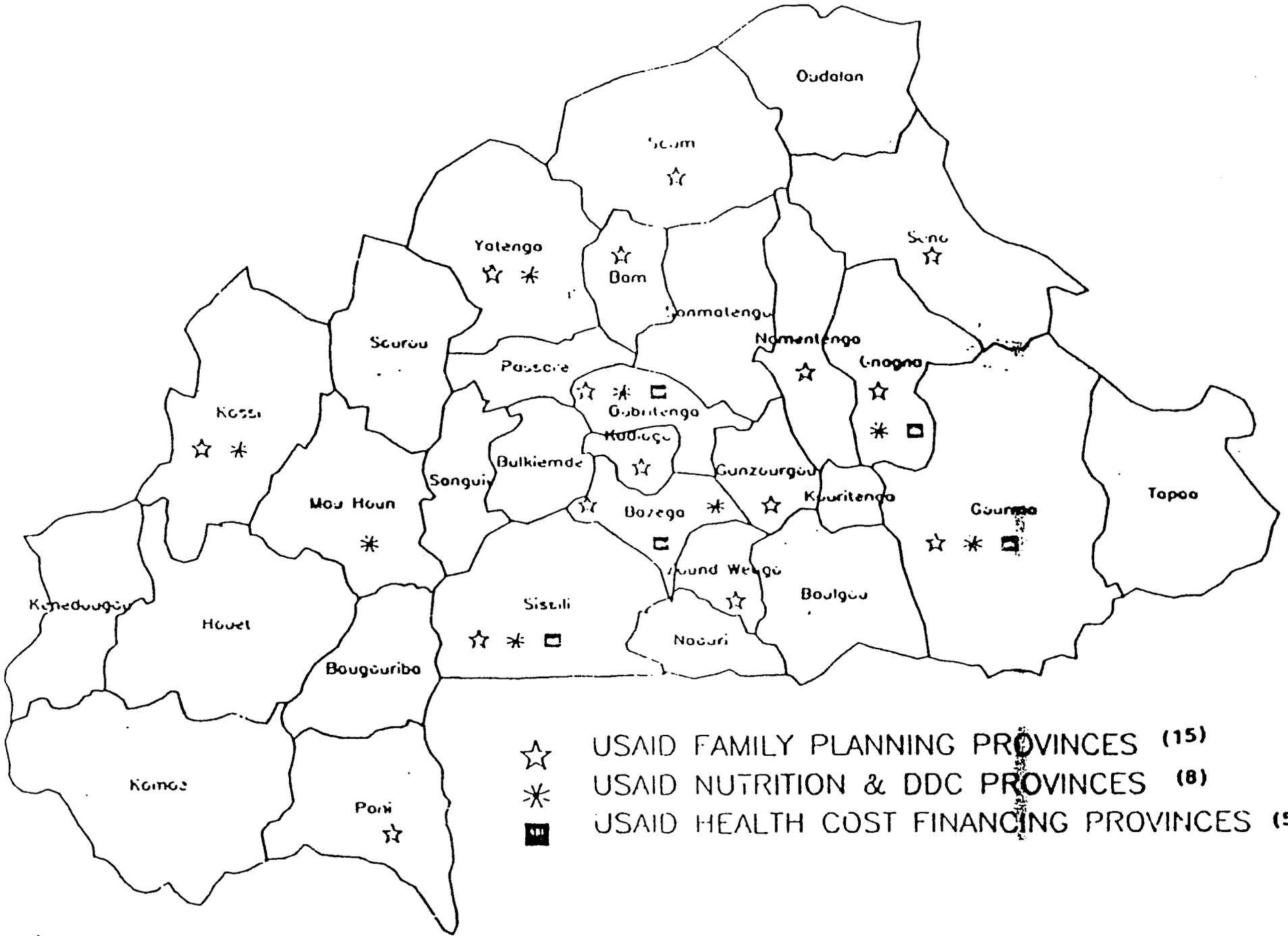
7. Evaluation Schedule

The first external evaluation will be conducted at the end of the third year of project activities. The final evaluation will be scheduled late in year five of the project.

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Annex D.

Map of Project Activities



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PROJECT PROVINCES
FAMILY HEALTH AND HEALTH FINANCING PROJECT

PROVINCE	Activity					
	HC	FP	DDC	NUT	DDC/NUT	FP/MCHH
Bazega	X	X	X	X	X	X
Gourma	X	X	X	X	X	X
Gnagna	X	X	X	X	X	X
Oubritenga	X	X	X	X	X	X
Sissili	X	X	X	X	X	X
Kossi					X	X
Mouhoun					X	
Yatenga					X	X
Bam						X
Gunzourgou						X
Namentenga						X
Seno						X
Poni						X
Radiogo						X
Zoundweogo						X
<u>Sum</u>						X

Note: FP/MCH activities will not be carried out in Mouhoun Province due to UNFPA activities occurring there.

Abbreviations: HF= Health Financing; FP= Family Planning; MCH= Maternal Child Health; DDC= Diarrheal Disease Control; NUT= Nutrition.

Annex E.

Schedule of Evaluation Field Visits

EVALUATION

SCHEDULE FOR MEETINGS AND FIELD VISITS

<u>DATES</u>	<u>ACTIVITIES</u>
Thursday, October 28 08:30 – 9:30 09:30 – 10:30 10:30 – Evening	<ul style="list-style-type: none"> - OUAGA/HPNO HPN OFFICER OHP STAFF SOULEYMANE BARRY
Friday, October 29 08:00–10:00 10:00–12:00 15:30	<ul style="list-style-type: none"> - OUAGA/BRIEFING OHPN STAFF PERLE/CLAUDE: FP & DEP NEEN: NUTCOM &DDC - MEET WITH DSF STAFF
Saturday, Oct 30/Sunday Oct 31	<ul style="list-style-type: none"> - OUAGA/DOCUMENTS REVIEW
Monday, Nov. 1 Afternoon (Burkina Holliday)	<ul style="list-style-type: none"> - FIELD TRIP TO GOURMA
Tuesday November 2	<ul style="list-style-type: none"> - VISIT 1 CM AND 1 CSPS IN GOURMA SPEND THE NIGHT IN FADA
Wednesday, November 3	<ul style="list-style-type: none"> - FIELD TRIP TO KOURITENGA (KOUPELA)* - VISIT 1 CM IN KOURITENGA - RETURN TO OUAGA IN THE AFTERNOON
Thursday, November 4 8:00 10:00	<ul style="list-style-type: none"> - OUAGA/OHPN/DONORS - MEETING WITH SEATS - MEETING WITH INTRAH
Friday, November 5	<ul style="list-style-type: none"> - OUAGA/OHPN/DONORS
Saturday, November 6	<ul style="list-style-type: none"> - OUAGA
Sunday, November 7	<ul style="list-style-type: none"> - OUAGA
Monday, November 8	<ul style="list-style-type: none"> -- TRAVEL TO OUBRITENGA @ VISIT 1 CM AND 1 CSPS
Tuesday, November 9 9:00 15:30	<ul style="list-style-type: none"> - OUAGA - MEETING WITH DEP/DR ZINA - MEETING WITH DSF/DR. BAKOUAN
Wednesday, November 10 8:00 13:00	<ul style="list-style-type: none"> - VISIT 1 CM AND 1 CSPS IN OUAGA - TRAVEL TO DORI
Thursday, November 11 (Holliday)	<ul style="list-style-type: none"> - VISIT 1 CM @ 1 CSPS IN SENO
Friday, November 12 (Morning)	<ul style="list-style-type: none"> - TRAVEL TO KAYA @ VISIT 1 CM *
Friday, November 12 (Evening)	<ul style="list-style-type: none"> - TRAVEL TO OUAGA

* NON USAID PROVINCES

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Annex F.
Persons Contacted

ANNEX F

PERSONS CONTACTED

OAR/Burkina Faso

Mr. Thomas Luche, Director
Dr. Jatinder Cheema, Health, Population and Nutrition Officer
Dr. Claude Millogo, Program Specialist
Ms. Neen Alrutz, Technical Advisor on AIDS and Child Survival
Ms. Perle Combary, Program Specialist

Ministry of Health, Social Action and the Family

Direction of Family Health

Dr. Didier Bakouan, Director
Dr. André Ouedraogo, Nutritionist, Nutrition Service
Mr. Jean Parfait Douamba, Nutritionist, Nutrition Service
Ms. Jeanne Nougara, Health Advisor, Family Planning Service
Ms. Augustine Lumpo, Mid-Wife
Ms. Pauline Cassalom, Information, Education and Communication Service
Mr. Toussaint Ouedraogo, Health Assistant
Mr. Derme Zeinab, Chief, Maternal and Child Health/Family Planning
Ms. Irene Komombo, Information, Education and Communication Service

Direction of Studies and Planning

Dr. Ygeouba Zina, Director
Dr. Issouf Ibrango, Public Health Physician
Mr. Joanis Kaboré, Sociologist
Mr. Roger Adakro, Documentalist

Operations Research Unit

Dr. Youssouf Ouedraogo, Population Council Resident Advisor
Dr. Inoussa Kaboré, Physician
Dr. Mathias Hien

Office for Workers Health

Dr. Adama Thiombiano, Director

ITSS

Dr. Theodore Kangoye,

National Committee for the Battle Against AIDS

Dr. Jean Gabriel Ouango, Psychiatrist

The World Bank

Mr. Albert Osei, Resident Representative

Mr. Korka Diallo, Operations Assistant

INTRAH

Mr. Joanny Kaboré, Technical Advisor

Mr. Pape Gaye, Director, Office for Francophone Africa

Ms. Béatrice Ekue, Administrator, Office for Francophone Africa

Ms. Constance Newman, Evaluation Specialist

SEATS

Dr. Meba Kagone, Resident Advisor

Ms. Ellen Wilson, Project Intern

PROMACO Project

Ms. Sylvia Watts, Director

Mr. Claude Mikem, Consultant

Mr. Francois Traore, Responsable Financier

Mr. Toe Simplicite, Responsable Commercial Regional

Mr. Kere Christophe,

Mr. Tougouri Julien,

Mr. Soma Fulgence,

Ms. Yameogo Victorine,

Mr. Zaba Philippe, Driver

Mr. Sankara Tibo, Driver

Mr. Conombo Boukari, Computer Specialist

Mr. Tou Yakouba, Salesman

**Provincial Office, Ministry of Health, Social Action and the Family
(Gourma)**

Dr. Mathurin Dembele, Provincial Medical Director
Mr. Alfred Baye, Coordinator, Expanded Program of Vaccination
Mr. Adama Thiombiano, Coordinator, Public Health Care

Pama Medical Center

Mr. Prosper Tankouno, Maieuticien
Ms. Ernestine Kiema, Practical Nurse
Ms. Natama Palm Thiombiano, Matron

Comin-Yanga Center for Health and Social Promotion

Mr. Hamidou Djiré, State Nurse
Ms. Habibata Konaté, Midwife
Mr. Souleymane Sina, Itinerant Health Agent

**Provincial Office, Ministry of Health, Social Action and the Family
(Kouritenga)**

Dr. Rigobert Nitiema, Provincial Medical Director (outgoing)
Dr. Rosine Sama, Provincial Medical Director (incoming)
Mr. Celestin Oueba, Coordinator, MCH/FP

**Provincial Office, Ministry of Health, Social Action and the Family
(Oubritenga) Provincial Office, Ministry of Health, Social Action and the Family
(Seno)**

Dr. Michel Nikiema, Provincial Medical Director
Ms. Massata Kindo Nikiema, MCH/FP Coordinator

Gorgadsi Center for Health and Social Promotion

Mr. Dramane Konate, State Nurse
Ms. Adjathatou Toure Zorei

**Provincial Office, Ministry of Health, Social Action and the Family
(Sanmatenga)**

Medical Center, Pissila

Mr. Pierre Mesmui Zongo, Center Director
Ms. Emilienne Ansale, Midwife
Mr. Jean Claude xxx oukougou, Practical Nurse
Mr. Patrick Lawakilea, Practical Nurse

Center for Health and Social Promotion, Sector 1

Ms. Ernestine Edith Comsilga, State Midwife
Mr. Amadou Loungouna, State Nurse
Ms. Habibou Kaydugou, Matron

Provincial Office, Ministry of Health, Social Action and the Family (Kadiogo)

Mr. Mounio Ouedraogo

Provincial Office, Ministry of Health, Social Action and the Family (Bazega)

Dr. Alahassan Seye

(A detailed listing of the persons contacted by Dr. Barry during his earlier visit to Burkina Faso appears at the end of Annex J.)

Annex G.

Documents Consulted

ANNEX G

DOCUMENTS CONSULTED

Agency for International Development. "Project Implementation Letter, Number 15." Burkina Faso, 1992.

Bakouan, Didier; Bassolet, Félicité; Sebgo, Pascaline; Kanon, Souleymane; Ouédraogo, Youssouf; Tapsoba, Placide; and Askew, Ian. Etude pour Tester l'Utilisation des Accoucheuses Villageoises Formées comme Educatrices et Prestataires de Services de SMI/PF. Burkina Faso: Ministère de la Santé de l'Action Sociale et de la Famille, Direction de la Santé de la Famille, 1993.

Bakouan, Didier; Sebgo, Pascaline; Askew, Ian; Ouédraogo, Youssouf; Tapsoba, Placide; and Viadro, Claire. Analyse Situationnelle du Programme de Planification Familiale au Burkina Faso. Burkina Faso: Ministère de la Santé de l'Action Sociale et de la Famille, Direction de la Santé de la Famille, 1992.

Bakouan, Didier; Waré, Adrien; Ludovic de Lys, Hervé; Tapsoba, Placide; Ouédraogo, Youssouf; and Kaboré, Inoussa. Analyse de Système d'Information Sanitaire du Burkina Faso. Burkina Faso: Ministère de la Santé de l'Action Sociale et de la Famille, 1993

Institut National de la Statistique et de la Démographie and Macro International, Inc. "Enquête Démographique et de Santé: Rapport Préliminaire." Burkina Faso: Ministère des Finances et du Plan and Columbia, Maryland: Demographic and Health Surveys, Macro International, Inc., 1993.

International Training for Health. "Burkina Faso Training Plan." 1992, revised 1993.

Madden, Claire; Seligman, Barbara; Benavente, Jaime; Bassolet, Félicité; Benon, Roland; and Nyameogo, Jeanne. The Supervisory System of Burkina Faso's Family Planning Program: A Baseline Evaluation. Burkina Faso: Directorate of Family Health and Boston, Massachusetts: Family Planning Management Development, Management Sciences for Health, 1992.

Ministère de la Santé, de l'Action Sociale et de la Famille, Secretariat General, Direction des Etudes et de la Planification. Statistiques Sanitaires, 1991. Burkina Faso, 1993.

Ministère de la Santé, de l'Action Sociale et de la Famille, Direction de la Santé de la Famille, Unité de Recherche Opérationnelle et la Banque Mondiale. "Connaissances, Attitudes et Pratiques des populations du Passoré sur les traitements par injections et les risques afférents tel que le S.I.D.A." Burkina Faso, 1993.

Ministère de la Santé, de l'Action Sociale et de la Famille, Direction de la Santé de la Famille; USAID and INTRAH. Politique et Standards des Services SMI/PF au Burkina Faso.

Burkina Faso, 1992.

Ministère de la Santé, de l'Action Sociale et de la Famille, Direction Generale de la Santé Publique, Direction de la Santé de la Famille. Curriculum de Recyclage/Formation en SMI Pour Medecins, Sages-Femmes, Infirmier(es). Burkina Faso: Ministère de la Santé and INTRAH, 1992.

Ministère de la Santé et de l'Action Sociale, Direction de la Santé Familiale. Un Examen de la Recherche Disponible sur la Planification Familiale au Burkina Faso. Burkina Faso: 1992.

Ministère de la Santé Publique et de l'Action Sociale and SEATS. Rapport Preliminaire sur l'Etude du Systeme de la Logistique de la Planification Familiale au Burkina Faso. Burkina Faso, nd.

Ministère de la Santé, de l'Action Sociale et de la Famille, Direction Generale de la Santé Publique, Direction Provinciale de la Santé Publique du Seno. Rapport Final du Bilan des Activites de l'Atelier de Mi-Evaluation du Plan d'Action Sanitaire de 1993. Burkina Faso: Province du Seno, 1993.

Population Council. "Etude pour contribuer à la promotion de l'utilisation des condoms par les jeunes des zones urbaine et rurale." Burkina Faso, 1993.

Thiombiano, Brigitte; Kaboré, Ioussa; Tapsoba, Placide; and Ouédraogo, Youssouf. Motivation pour la Planification Familiale et Programme de Reference Impliquant des Utilisatrices de Contraceptifs Satisfaites ainsi que des Sages-Femmes. Burkina Faso: Association Burkinabè des Sages-Femmes, 1993.

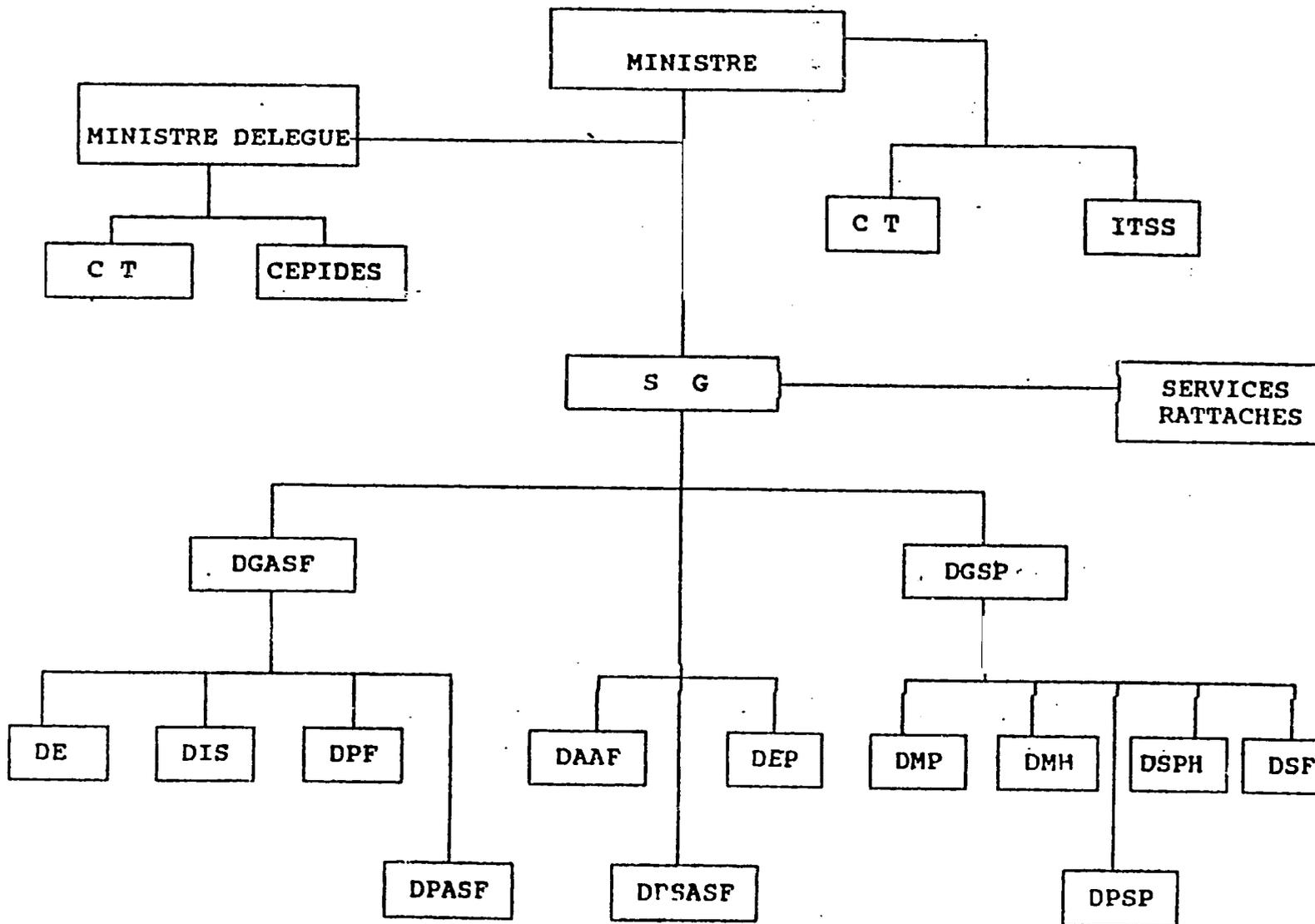
U.S. Department of State, Agency for International Development. Project Paper, Burkina Faso Family Health and Health Financing Project (686-0275). 1990.

(A detailed listing of additional documents consulted by Dr. Barry during his earlier visit appears at the end of Annex J.)

Annex H.

Organigram of the Ministry of Health,

ORGANIGRAMME DU MINISTRE DE LA SANTE,
DE L'ACTION SOCIALE ET DE LA FAMILLE



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LEGENDE

MSASF	Ministre de la Santé, de l'Action Sociale et de la Famille
MDASF	Ministre Délégué chargé de l'Action Sociale et de la Famille
CT	Conseiller(s) Technique(s)
ITSS	Inspection Technique des Services Sociaux et Sanitaires
SG	Secrétariat Général de la Santé, de l'Action Sociale et de la Famille
DGASF	Direction Générale de l'Action Sociale et de la Famille
DGSP	Direction Générale de la Santé Publique
DAAF	Direction des Affaires Administratives et Financières
DEP	Direction des Etudes et de la Planification
DE	Direction de l'Enfance
DI	Direction de l'Insertion Sociale
DPF	Direction de la Promotion de la Famille
DMP	Direction de la Médecine Hospitalière
DSF	Direction de la Santé de la Famille
DSPH	Direction des Services Pharmaceutiques
DPSP	Direction Provinciale de la Santé Publique
DPASF	Direction Provinciale de l'Action Sociale et de la Famille
DPSAF	Direction Provinciale de la Santé, de l'Action Sociale et de la Famille
CEPIDES	Centre d'Etudes, de Promotion et d'Information sur le Développement Social.

Annex I.
Inventory of Project Contractors

LIST OF CONTRACTORS

**PROJECT: FAMILY HEALTH AND HEALTH FINANCING
686-0275**

SUBPROJECTS	AREAS OF INTERVENTIONS	CONTRACTORS
SUBPROJECT 1	Family Planning: Training	University of North Carolina (INTRAH)
	Family Planning: IEC	Johns Hopkins University (PCS)
	Family Planning: Private Sector	Johns Snow Inc. (SEATS)
	Family Planning: Management Training	Management Sciences for Health (Boston University) (FPMD)
	Operations Research	Population Council (Strategies for Improving Services)
	Nutrition: Communication for Nutrition	Academy for Education Development (AED)
	Diarrheal Disease: Implementation and institutionalization of Oral rehydration and control of diarrheal disease	Management Sciences for Health (Boston University) (PRITECH)
	AIDS: Condoms Social Marketing	Population Service International (PSI)
SUBPROJECT 2	Health Financing/Research	ABT Associates, Inc. (Health Financing & Sustainability)
	Health Financing/Training	DATEX, Inc. (Health Financing)
	Health Financing Community Mobilization	CLUSA

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Annex J.

Detailed Condom Social Marketing Evaluation

INTRODUCTION

In May 1989, OAR/Burkina funded a pilot condom distribution and promotion (PROMACO) project for AIDS prevention and control in Ouagadougou through the centrally funded AIDSTECH project. The pilot project was implemented by the Direction de l'Education de la Sante et de l'Assainissement (Office for Health and Sanitation Education, DESA), the IEC unit of the MOHSAF. The project sold about 28,500 condoms per month in Ouagadougou.

With the authorization of the Family Health and Health Financing project in FY 1990, OAR/Burkina decided to expand the activities of the PROMACO project through an add-on to the AIDSTECH project, with the understanding that the project would use a U.S.-based organization specializing in condom social marketing operations as the implementing organization, rather than DESA. AIDSTECH signed a subagreement with Population Services International (PSI) to implement the Burkina Faso National Condom Distribution and Promotion (PROMACO) project from February 1991 through the AIDSTECH completion date in August 1992.

In September 1992, with the termination of the AIDSTECH project, a direct Cooperative Agreement (CA) between OAR/Burkina and PSI was signed to maintain the momentum of the condom social marketing activities through August 1994.

This mid-term evaluation indicates that the PROMACO project has been very successful. Within three years and under difficult political and socio-economic constraints, the PROMACO project has managed to meet most of its objectives, achieve a favorable response and acceptance of the condom social marketing activities and substantially increase the availability and use of condoms in Burkina Faso.

1 FINDINGS

1.1 Sales Evolution

The social marketing operations was launched in Banfora, the chief town of the Comoe province in September 1991 with a team of six sales representatives. Banfora was selected as a first site for the following reasons: the dynamism of the local AIDS committee; the availability of HIV/AIDS data; and the proximity of the Comoe province with Cote d'Ivoire, the epicenter of HIV infection in West Africa.

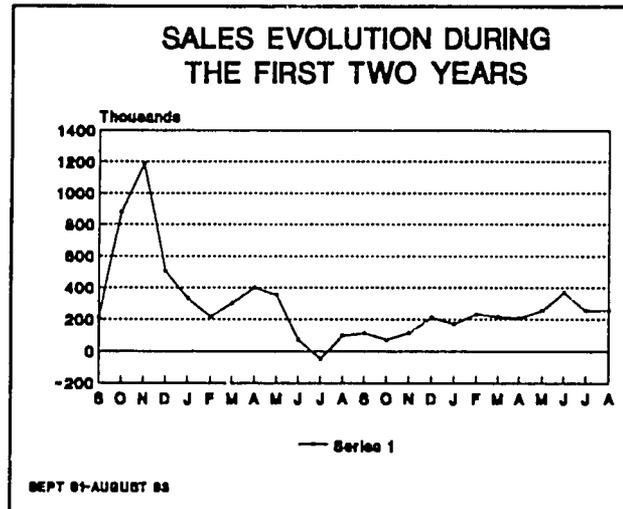
The PROMACO project then turned its attention to 16 other provinces whose main towns were visited within four months by sales representatives in small groups of two to four. From September 1991 to January 1992, the sales representatives marketed 69 percent of the condoms sold during the first year of the project, about 624,000 condoms per month.

In February 1992, the decision was made to assign 3 to 7 provinces to each of the selected five salesmen. From February to August 1992, the visits of the sales team included urban and semi-urban centers in five new provinces. During that period, the sales representatives

sold only about 200,000 condoms per month. This trend indicated that the consumers' purchases were low despite the large availability and affordability of condoms in Burkina Faso.

Despite a renewed nationwide sales drive in September 1992, which resulted in an increase of the condoms sales to 250,000 per month during the last eight months of the second year of the project, this relatively low level of consumer purchases has been maintained.

Graph 1 below summarizes the sales evolution.



Nevertheless, by the end of August 1993, a total of 7,013,336 condoms had been sold into the trade, including 4,528,040 during the first year of the project and 2,485,296 the second year. And, in view of the stock rotation during the past eight months, it is very likely that PROMACO will meet the Cooperative Agreement's total sales targets --about 10 Million-- by May 1994, three months before the PROMACO project completion date.

1.2 Terms of trade

Direct purchase price of a box of 22 packs of 4 condoms by wholesalers from PROMACO is 600 CFA. Retailers buy each box of 22 packs condoms from wholesalers for 800 CFA, making a profit of 300 CFA when sold to the consumer for 50 CFA the pack of 4 condoms. Pricing is currently well controlled, with Prudence selling at 50 CFA for a packet of four in all outlets.

Retailers seem to be happy with the profit margin. The retail profit margin on Prudence compares favorably with popular products such as cigarettes; Stuveysen brand yields 6.8 percent, compared with 37.5 percent for Prudence. The giving of credit terms, extremely widespread in year one of project implementation and probably associated with the desire to move large quantities of condoms into the trade at a time when the product category was not a high volume

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purchase item, has been progressively eliminated. Finally, the collection of overdue debts have been very successful. By the end of August 1992, sales value of Prudence was \$91,152 (25,066,800 CFA), of which \$16,440 (4,521,000 CFA) was in outstanding debt. For the second year of operations, sales value of Prudence was \$61,344 (16,869,600 CFA), of which \$3,370 (926,700 CFA) was in outstanding debt. Currently, 90.1% of sales revenues have been collected for the first year and 95.0% for the second year of project implementation, which is beyond the CA objectives.

1.3 Stock

Once the condoms arrive in Burkina Faso, they are stored at PROMACO's headquarters in Ouagadougou, where they are packaged and then transferred as necessary to wholesalers. Storage at PROMACO is adequate in terms of light and ambient temperature. There are presently about 4,397,500 units in storage. There have been no stock-outs at the supplier level.

Shelf life of Prudence is not, in principle, an issue yet as the product was manufactured in mid-1992 and has a shelf life of 5 years. However, because of the bad storage conditions and high temperatures in many sub-saharan African countries, a shelf life of three years is generally recommended. It would be preferable to receive more recently manufactured condoms. Quality control of product has been regularly carried out in the National Reference Laboratory in Abidjan (Cote d'Ivoire). The good rotation of stocks among wholesalers following the establishment of the "cash and carry" policy and the decision to limit the stock of wholesalers to 2 cartons of condoms have also limited the volume of condoms in less adequate storage conditions. Although guidelines are regularly provided to wholesalers and retailers on storage conditions, in many cases they are not followed. Some wholesalers who were given condoms by other wholesalers, rather than through direct contact with PROMACO, were not aware of storage guidelines.

A different problem is that only the date of manufacture is printed on the condom foil wrapper, rather than the date of expiration. This has been noted already by some consumers who have asked their retailer if the product was still good. According to some retailers, sales have been missed due to the confusion this presents.

1.4 Distribution

1.4.1 Absence of an appropriate national distributor

Based on the recommendations of a study on the distribution of condoms in Burkina Faso completed in June 1991 by three of the current sales representatives, PROMACO's distribution approach has been to maintain the exclusive distribution rights of Prudence and to directly sell to wholesalers. The project considered utilizing two government owned distribution companies FASOYAAR and SONAPHARM, but this option was discarded given their limited networking with wholesalers and retailers. For example, the above cited study indicated that in the three main cities of Burkina (Ouagadougou, Bobo-Dioulasso and Banfora), FASOYAAR played an

insignificant role in the distribution system. Only three percent of the retailers reported any linkage with FASOYAAR, as opposed to 96.2 percent reporting links with the market, wholesalers and "others".

Furthermore, the early experience of PROMACO using FASOYAAR as a wholesaler in outlying areas did not prove effective because of the lack of leadership, disinterest in PROMACO's objectives and finally mismanagement of the company. In fact, both FASOYAAR and SONAPHARM are currently facing operating difficulties and might be privatized in the near future.

1.4.2 Development of a well functioning nationwide distribution system by PROMACO

In view of the absence of a suitable national distributor, PROMACO developed its own distribution system which covers the main cities in all 30 provinces. Condoms are sold directly to 75 wholesalers by PROMACO sales representatives. At the same time, PROMACO's sales representatives support the wholesalers by building the retailers' network and restocking retailers from their respective wholesalers stocks. Currently, based on the computerized list of Prudence retailers established by PROMACO, there are about 3,450 points of purchase for Prudence, exceeding the agreed target of 2000 sales points stipulated in the Project Agreement.

Prudence is mainly distributed through a network of 2,290 small shops and 496 stallholders. The number of wholesalers per province varies between one in the Gourma and ten in the Kadiogo. Sales through the wholesalers vary but are moving particularly well in Ouagadougou and Bobo-Dioulasso. Seven other cities (Tenkodogo, Koupela, Yako, Gaoua, Reo, Tougan and Ouahigouya) are experiencing good movement of sales. In these centers, the small shops located in dense populated areas or near hotels, bars, military camps are doing very well.

Other outlets such as pharmacies, bars, hotels and gas stations play an insignificant role in the current distribution system. As in other African countries, experience with pharmacies as wholesalers has not proven efficient in major cities having well developed distribution networks. In Ouagadougou, Prudence is generally not sold in pharmacies, for the pharmacists don't see any incentive in selling a product which is widely available through other outlets. Some pharmacists would be willing to sell Prudence if they can purchase the condoms at the wholesaler price.

In the urban centers, out-of-stocks occur rarely as outlets are restocking by going to the wholesalers. However, in the relatively outlying areas such as Toece in the Bazega province, out-of-stocks occur more frequently as the retailers are not restocking by going immediately to their wholesalers. Rather they are waiting for their next visit to the wholesalers or a visit from PROMACO Representative, with the result that sales may be missed due to lack of availability of product.

1.4.3 A premature and costly nationwide distribution system

During the first year of project implementation, 8 provinces out of 21 accounted for about 86 percent of the condoms sold. With about 15 percent of the total population, two provinces, Kadiogo and Houet (sites of Ouagadougou and Bobo Dioulasso, respectively), accounted for 59 percent of the total amount of condoms sales. Despite the extension of coverage to all 30 provinces during the second year of operation, 9 provinces accounted for about 81 percent of the condoms sold, and the proportion of condoms sold in Kadiogo and Houet provinces increased to 64 percent.

During the second year of the project, an average of 15 packs of four condoms per day were sold in each of 21 provinces (home to about 56 percent of the total population in 1992), compared with 153 packs per day in each the 9 remaining provinces. At the same time, 65 percent of the sales representatives' visits were conducted in the 21 provinces which only accounted for about 19 percent of sales.

Scarce project resources were disbursed to make condoms available in areas where the potential demand was virtually non-existent, instead of focusing on areas with greater potential. Indeed, the sales representatives who spent an average of one week in each province every eight weeks could have sold the same number of condoms by working in only nine provinces, possibly protecting many more potential consumers.

This premature expansion of the condom distribution network, in a country without functioning nationwide distribution networks, was been stimulated by the enthusiastic PROMACO team. PROMACO management never argued against the expansion of its activities. On the contrary, in view of the urgency of the HIV situation, PROMACO management kept pointing out the scarcity of the resources, which was seen as the major constraint to the relatively low level of condoms sales.

1.5 Marketing and IEC activities

Throughout the program various marketing activities have taken place ranging from awareness raising, conferences, dances, soirees, and predominantly, promotions. These activities are organized in collaboration with the medical and para-medical personnel of the MOHSAF, community groups and non-governmental organizations (NGOs). Two vehicles equipped with a sound system and various promotional items on Prudence are used to support the promotional activities. The two drivers serve as "animators", demonstrating the correct use of condoms and answering questions. Promotion items such as tee shirts and caps are in great demand, but were in short supply at the time of the evaluation; a new shipment of tee shirts has just arrived at PROMACO headquarters. Bumper stickers are seen in most outlets where Prudence is stocked, as well as in many other locations. Bottle dispensers are not available in the points of sale. Experience in other countries has shown that these transparent condom dispensers have a beneficial impact in stores by allowing more public display of the product and facilitating purchase as it is readily accessible.

All the promotion activities have attracted considerable interest, particularly in areas outside Ouagadougou, and among young people targeted by the activity. It is estimated that more than 250,000 people have been exposed to these events since the beginning of the project, with about 100,000 condom samples handed out. The promotions, along with mass media advertising, have created a high awareness of Prudence and its benefits in protecting against AIDS. AIDS is well known, and prevention against AIDS is spontaneously mentioned as a prime motivator for condom use among people most at risk, namely young men and those involved in casual sex. The 1993 Demographic and Health Survey indicates that 98 percent of women in urban areas and 81 percent of those in rural areas have heard about AIDS. However, knowledge of condoms remains relatively low among women, at 49.3 percent compared with 77.4 percent among men.

The general opinion of Prudence condoms moving into the public domain is favorably accepted by most sectors of the non-conventional trade and most consumers and opinion leaders talked to during this evaluation. Clearly, the overall activity has induced a greater freedom to talk about condoms than existed previously.

The sales representatives have constantly tried to link their promotional activities with the IEC activities at the provincial and departmental level. However, these linkages have been hampered by the lack of commitment and financial resources for IEC activities. There is a strong feeling in PROMACO that the lack of financial resources for promotional activities have substantially limited the sales of condoms. In any case, while promotional activities may be essential to increase awareness of condoms, these are not sufficient to motivate substantial increase in condom use.

An important problem has been the lack of formal orientation and training on HIV/AIDS and basic IEC of the sales representatives and the driver-animators. Because of their numerous contacts with the population during their promotional activities, the sales representatives and animators have to deal with some difficult questions on STDs and HIV/AIDS. In addition, there is no detailed information package on condoms at the disposal of the sales representatives.

1.6 Consumer Purchases

Most retailers interviewed in urban centers claim that sales are currently slower due to the wide distribution of Prudence and to the difficult economic situation, since the sales rate of other products is also affected. Most retailers interviewed also pointed out the variation of sales according to the season, sales being more important during the cooler season and less important during the rainy season in outlying areas. A review of sales in year two of operation confirms a significant increase of sales in December. September, October and November account for the lowest amount of sales over year two.

The retail rate of sales varies considerably according to location. The small shops located in dense populated areas or near hotels, bars, military camps and truck stations are doing very well. In Ouagadougou, some outlets sales have picked up to an average of about 110 packets

of four per week. Elsewhere, sales may be as low as 22 packets per week. In less populated areas outside Ouagadougou, highest outlets sales are at 22 packets per week in Ziniare and Kombissiri and 22 packets per month in a semi-urban center such as Toece.

The current rotation of stocks and reported levels of business indicate a running rate of about 240,000-250,000 condoms sold to the wholesalers per month. Data on the rotation of stock among retailers are not yet available in order to estimate consumer purchases. According to the DHS, condom use remains low. Only 6.8 percent of all men and 0.9 percent of all women currently use condoms. Use rates are higher in urban areas, for example 11.2 percent of the men and 4.5 percent of the women interviewed in Ouagadougou report using condoms. However, compared with a survey conducted in 1986 in Ouagadougou by Columbia University, in which current condom use was estimated to be 3.8 percent among men and 0.4 percent among women, there has been a substantial increase of condom use that can only be explained by PROMACO's interventions.

The typical consumer of Prudence is young and male. The evaluation team estimated during the interviews conducted among the retailers that about 90 percent of purchases are made by young males who are generally quite open about the way they make their purchases. Older males tend to be more discreet. Women who are purchasing condoms are limited to sex workers and a few educated women. The claimed reason for purchase is protection against AIDS and purchase as a contraceptive is relatively rare at present. The DHS data related to the very low condom use among women and the high discrepancy in condom use among men and women may indicate that, effectively, men are not using the condoms with their regular partners.

1.7 PROMACO Management

1.7.1 Sales Team Modus Operandi

The 5 sales representatives, 4 men and 1 woman all university graduates, have mainly worked separately. They have regularly visited their assigned provinces for a period of selling and promotional activities. When promotional activities are scheduled, they use one of the two vehicles with a sound system and receive the support of a driver-animator, who is responsible for the demonstration of condom use.

The sales representatives usually spend three weeks in their assigned provinces and the last week of the month writing their monthly report and developing activities for the following month in collaboration with the PROMACO director. In the first and most of the second year of operations, it was estimated that the sales representatives tended to spend 80 to 90 percent of their time on selling product and developing the Prudence trade network, and 10 to 20 percent of their time organizing promotional activities. During the first year, one of the sales representatives worked full time with NGOs and community groups, supporting promotional and IEC activities on HIV/AIDS.

However, with the extension of the distribution network to all 30 provinces during the second year of the project, the frequency of the visits and intensity of the promotional activities per province have been hampered by limited financial resources, reducing the frequency of visits to one week per province every seven to eight weeks.

The sales representatives work on the basis of the marketing plan developed after the first year of project implementation. This plan set overall targets and objectives to be achieved by PROMACO. However, individual targets and objectives for each of the sales representatives have not yet been used, nor is there any day planning in terms of daily or weekly coverage of outlets to be contacted. Therefore, it is difficult to assess the performance of each of the sales representatives. The differences in the figures related to the condoms sold per capita by each of the sales representatives--between 0.56 and 1.91-- might not only be explained by the fact that some provinces are "easier than others". In addition, while each of four sales representatives spends between one and thirteen cents for one condom sold during the visits of their provinces in the second year of the project, one sale representative spent one dollar and twenty four cents¹. It should be noted that these expenses per capita in the respective provinces of the sales representatives vary between one and one and half cent.

1.7.2 Unique achievements in terms of transferring responsibilities of the social marketing operations to the locally recruited sales representatives

The PROMACO director purposely chose to recruit young, well trained and talented sales representatives and to give them critical responsibilities of the social marketing operations including the design and update of the marketing plan, design and implementation of various marketing studies, completion of income statements, financial management and reporting. She also gave them the liberty to develop and implement their own ideas and learn from their mistakes, while providing guidelines, as appropriate.

This approach has facilitated the transfer of social marketing expertise and experience to the sales representatives. It is the evaluation team's opinion that the sales representatives could, today, maintain and develop an appropriate level and quality of the condom social marketing operations without any long-term technical assistance, if they could continue to benefit from appropriate financial support and if they could act together; the latter being the critical weakness of the team.

1.7.3 Limited organized communication among the sales representatives

Until recently, the PROMACO director directly managed the sales representatives. Her many administrative tasks have prevented her from better directing, assisting and taking greater advantage of the sales representatives' capabilities. Since there was no funds budgeted for short-term technical assistance from PSI headquarters, she could not benefit from any assistance for

¹These calculations only take into account the expenses for gas, hotels and perdiems during the visits of the provinces

that purpose. In fact, the development of the marketing plan, following the first year of project implementation, which has involved all sales representatives, is a powerful example of the team capability to learn from its experiences, use data for decision-making and to take appropriate actions to solve problems.

PROMACO decided to limit the number of wholesalers served and the quantity of condoms to be sold to wholesalers by instituting a "cash and carry" policy, and by eliminating the status of "semi-wholesaler", an intermediary between the wholesaler and the retailer. These measures were taken in order to maintain wide distribution of Prudence, once it was realized that many wholesalers were abandoning the product. Competing wholesalers decided to sell directly to retailers, bypassing the semi-wholesalers and offering a lower price to retailers in order to reduce their overstocks of Prudence.

The decision to protect wholesalers stemmed from the realization that many retailers, because of the as yet limited commercial interest in Prudence and their privileged, traditional and familial relationships with wholesalers, were not ready to make an extra effort to purchase Prudence from non-traditional suppliers. Also, this new policy led to a better rotation of condoms among the wholesalers and limited the stock of Prudence stored in bad conditions. The new policy allowed PROMACO to increase its revenues on the sales of Prudence by increasing the price of box of 88 condoms from 500 CFA to 600 CFA.

Apart from the period during which the sales team and the PROMACO director developed the marketing plan, discussion among sales representatives have mostly been limited to informal meetings. Because of the lack of organized communication among the team, some good initiatives and experiences that may have been relevant for other provinces or departments may have been missed. For example, the promising experience of a single provincial distributor in Bobo-Dioulasso at the early stage of the project could not be continued due to turn over in staff and the implementation of a different strategy by the new sales representative.

In December 1992, the PROMACO director, using the funds budgeted for the national project coordinator, hired a local short-term consultant to assist her in the coordination of the sales representatives and to act as the director during her absence of post. This has greatly relieved the PROMACO director of management responsibilities, but has not changed the modus operandi of the sales team. In addition, the short-term consultant managed to increase the acceptance of PROMACO within the NGO community because of his good connections. He also explored the possibilities and obstacles related to the transformation of the PROMACO project into a NGO.

1.7.4 The insufficient exploitation of the potential of PROMACO market's partners

Although the Burkina Faso commercial sector is not as well developed as in the Cote d'Ivoire, for example, it is expanding rapidly, modernizing its operations and adopting a more pro-active approach. It is clear that in many areas selected wholesalers have the potential to play a more active role in the development of the distribution network. For example, with the

increased commercial interest on Prudence, some wholesalers are already using their relatives and bicycles to develop their own retail networks.

PROMACO management has not always taken into consideration the evolving potential and interest of its commercial partners in the decision making process. For example, while it is generally accepted that the trade network of Prudence is adequately operating in the urban centers and that the emphasis should be put on recruiting salesclerks to maintain and develop urban networks, PROMACO has not seriously considered direct support of wholesalers to recruit, manage and monitor their own salesclerks.

Selecting a single wholesaler for each province has proven difficult, mainly because of complicated interpersonal and trade dynamics among wholesalers and between wholesalers and retailers. In Gourma, the sales representative did select one wholesaler to serve 9 of the 11 departments which have so far been visited by PROMACO. At the same time, PROMACO continues to directly support the development of the retail network there, instead of shifting all responsibilities and resources to the wholesaler.

The shift of routine activities to PROMACO's partners is very important. It might reduce the costs of the social marketing operations, as well as allow PROMACO sales representatives to increase promotional activities, market research, and supervision of the trade network.

In another move to increase efficiency, the sales representatives are taking orders from wholesalers by telephone. In the project follow-on, it may be feasible to support installation of telephone service for selected, dynamic wholesalers as a promotional activity, and thus take the opportunity to delegate certain routine activities to clerks, freeing the sales representatives for other work.

1.8 Management Information System

The computerized management information system established by PROMACO is functioning very well. The system can provide all data required by the Cooperative Agreement including: information on inventory; sales by number, kind and location of outlets; wholesaler performance in terms of stock rotation; disbursement of local funds to date by budget category; and amount of revenues received and revenues expended each month by budget category. In addition to the requirements of the CA, PROMACO recently decided to enter data to monitor stock rotation at the retailer level. Data on the number, duration and costs of sales representatives' visits to each location is also available. Currently, PROMACO focuses its attention on monitoring sales. The other variables have not yet been fully utilized to improve and rationalize PROMACO operations.

1.9 OAR/Burkina management responsibilities

The OAR/Burkina Technical Advisor for AIDS and Child Survival (TAACS) is responsible for the direct management of the PROMACO project with oversight by the HPN officer. The TAACS devotes about 50 percent of her time to project management.

The Cooperative Agreement (CA) oversight responsibilities stated in the "Substantial Involvement Understandings" required USAID to order and ship condoms, approve staff and consultants, review distribution strategy, approve revisions in the detailed work plan, approve the use of funds generated by the sales of condoms, review all proposals to be proposed for funding to other donors, etc. Notes in the files and interviews with USAID personnel indicate that this has been meticulously accomplished.

In addition, USAID has used a variety of procedures to stay abreast of project activities such as the semi annual project implementation report (PIR). PIRs have already raised certain issues that this evaluation also identified. Budget review and amendments have also served to identify problems needing attention. Quarterly reports by PROMACO give OAR/Burkina necessary current information on project performance.

OAR/Burkina has also closely monitored monthly local expenditures in order to ensure that expenditure of funds are on track. An over-estimation of the sales revenues led to the single budget revision to date.

1.10 Project Design Issues and Policy Dialogue

Most important has been the critical role played by OAR/Burkina in policy dialogue with respect to Project Paper (PP) design issues. In the PP and Project Agreement (PROAG), it was anticipated that the Direction de l'Education pour la Sante et l'Assainissement (DESA) of the MOHSAF would have program oversight responsibilities over the CSM Program, following the model of the pilot project implemented by AIDSTECH. The Program coordinator was to report to the DESA. There was substantial confusion about approaches for the expansion of the PROMACO activities with the arrival of the PSI resident advisor, and the relationships between PROMACO and DESA became very strained. The limited understanding of social marketing operations within the MOHSAF and the DESA, micro-management attitudes from the DESA, and a lack of communication between the DESA and the PSI resident advisor created confusion about the responsibilities of the various project partners. This was particularly evident during the first year of implementation.

Through intensive policy dialogue initiated by OAR/Burkina with the various key partners, the social marketing project operations are now better understood and relationships and responsibilities clarified. The Project Description of the PP was revised by the Project Implementation Letter No.15 to clarify the CSM implementation arrangements and relationships with the MOH. Accordingly, the private sector entity, PROMACO, was given exclusive

responsibility for the program management. In addition, OAR/Burkina decided to actively facilitate PROMACO's relationships with the MOH. For example, PROMACO reports now directly to the National AIDS Control Program through OAR/Burkina.

1.11 Linkages with the Family Planning Program

At the time of project design, there was a clear position within the MOH to separate HIV/AIDS and family planning activities. The reasons behind this were related to lack of information and understanding about the linkages of both programs as well as the perceived need to separate two programs which were both at early stages of development. However, the dynamism of the CSM program began to impact on the sales of condoms managed by the FP program in health and family planning facilities. Within two years sales of FP condoms in the health facilities decreased from about 1,500,000 to only 150,000-180,000 per year. In addition, health facilities began to buy condoms directly from PROMACO because of the profit margins on Prudence, that could be retained by the health facilities, rather than being remitted to the central MOH. Realizing the excess of the FP condoms in stock, coordination meetings were held between PROMACO, the Direction de la Sante de la Famille and USAID to address the issue. Consequently, the decision was made to stop ordering the "no logo" FP condoms. In order to encourage sales of condoms for FP, the MOH decided in April 1993 to allow the health facilities to keep 50 percent of the sales revenues.

Slowly, the need to take into account the potential role of condoms for family planning became more evident with the growing number of HIV infected and AIDS patients among women of reproductive age. The MOHSAF moved to the position of also addressing HIV/AIDS issues within the FP program, and this is now included in both the "Family Planning Strategy" and "Politique et Standards des Services SMI/PF au Burkina Faso" adopted in 1993. However, strategies have not yet been identified in order to seriously address this important issue. Experiences in Ghana indicate that the promotion of condoms both for AIDS prevention and Family Planning is feasible.

1.12 Program Impact

It was anticipated in the PP that the PROMACO program will be evaluated through the monitoring of the sale of condoms, and the projected decrease in sexually transmitted diseases (STDs). It was assumed that the data on STD prevalence would be available from an ongoing STD/AIDS surveillance project funded by the centrally funded AIDSTECH project in Bobo Dioulasso. The impact indicators were identified as evidence of decrease in the transmission of STDs in Burkina, and the sustainability of the program as measured by decreasing need for donor support over time.

Monitoring of STDs is an appropriate way to measure program impact on the HIV epidemic. However, this was not an appropriate indicator for the program in Burkina given the early stage of the HIV/AIDS prevention efforts and the lack of comprehensive HIV/AIDS interventions in Burkina. CSM interventions alone could not have decreased rates of HIV

transmission within three years. In addition, the AIDSTECH STDs survey in Bobo was not continued after the termination of the project in September 1992 and no other HIV or STDs surveillance surveys have been conducted to date. The only data on STDs (recent cases of gonorrhea and syphilis) which are available come from the Statistics Unit of the MOHSAF whose 1991 data were only published in July 1993. In addition the data are subject to so many uncertainties that they cannot be utilized to ascertain the PROMACO program impact. With the anticipated large World Bank support for the sentinel surveillance system, those data will be available for the near future.

Decreasing need for donor support is also not an appropriate impact indicator, since a successful program can, on the contrary, attract additional donor funding for the expansion of the program. More importantly, a condom social marketing program can choose to become rapidly self-sustaining by varying the condom price, with the risk of making condoms less affordable to the poorest consumers most at risk. OAR/Burkina later refined this indicator as an outcome indicator in the Cooperative Agreement with PSI.

A World Health Organization and AID/W working group recently identified HIV/AIDS Priority Prevention Indicators (PPIs). These are being currently tested, and should be studied for their relevance to a follow-on CSM project.

1.13 Future of the PROMACO project with respect to other donors support and A.I.D reorganization

OAR/Burkina has always pointed out and supported the need for the PROMACO project to explore other sources of funding in view of the OAR/Burkina budget constraints. In close collaboration with the PROMACO project, it has initiated an intensive dialogue with donors such as UNICEF, the World Bank, Gesellschaft fur Zusammenarbeit (GTZ), Kredit fur Wiederaufbau (KFW), Rotary Club and the Population Council in order to generate interest for and commitment to the PROMACO project. These efforts have been successful particularly with KFW which is ready to support an expanded Social Marketing Program with a amount of 11 Million DM for the next four years. In addition, GTZ and the Population Council have agreed to fund a qualitative Operations Research study on condom use. Discussions with the World Bank are on-going with a great interest to finance selected PROMACO operations provided the GOB supports the program. The support of other donors cannot be more timely in view of the AID reorganization which will affect the OAR/Burkina program.

Also related to the project's future is the requirement that PSI establish a local legal private entity able to manage the CSM project by May 1994. This has emerged as a contested issue as neither KFW nor the Permanent Secretary of the National AIDS Control Program is supporting the initiative. The NACP strongly feels that the transfer of the CSM operations to an NGO would be premature and would limit both national and local authorities support for the CSM program. KFW points out that the envisioned expansion of the CSM project would require so much management burden that it does not want to be diverted with the development and immaturity of a local NGO. In addition, the PROMACO staff is also very sensitive to the KFW

and NACP viewpoints and emphasizes the need to maintain the critical support provided by the MOHSAF, NACP and Provincial Health Directors. Now seven months before the termination of the CA, outside of gathering information about the regulations on NGOs, no concrete steps have been taken by PSI or PROMACO staff to meet this requirement.

1.14 The need for A.I.D to maintain selected support to the Burkina AIDS Control Program

With the termination of OAR/Burkina funding, there is a need to explore other mechanisms and funding to support the NACP. The NACP is worth supporting because of the advanced HIV/AIDS epidemic both in urban and rural areas, and the GOB and civilian society commitment to HIV prevention and control. Last fiscal year the GOB committed 46,000,000 CFA (\$167,000) to support specific HIV/AIDS activities, and companies such as the Burkina National Lottery and the Society of Skins and Leather are financially supporting the NACP. External donors include the World Bank, currently developing a program that will emphasize HIV and STDs surveillance. GTZ supports laboratory, IEC activities and counselling. The European Economic Commission plans to support STDs control, and KFW the PROMACO operations mentioned above.

The experience of the PROMACO project and other HIV/AIDS interventions indicates that the weakness of IEC activities and the lack of impact assessment of the various activities and programs are the most important technical issues to be addressed. In this regard, A.I.D/OAR Burkina could support operations research, surveys and case studies using central or regional projects. Many U.S.-based organizations and central projects have a comparative advantage in the above cited areas.

2. CONCLUSIONS

The PROMACO project has been very successful. Within three years and under difficult political and socio-economic constraints, the PROMACO project has managed to achieve a favorable response to Condom Social Marketing activities and substantially increase the availability and use of condoms.

The sales of Prudence have gotten off to a very good start. The country has been covered with direct sales to 75 wholesalers in all 30 provinces by a team of 5 enthusiastic and very capable sales representatives. On the basis of the current level of sales it is very likely that the CA's sales objectives will also be achieved by May 1994, three months before the planned PACD.

A distribution network is now well established through a network of about 3,500 retailers in the main urban centers, mostly in small shops and stallholders. This with the re-emergence of semi-wholesalers which is a trend initiated exclusively by the wholesalers indicate that the product sales are beginning to be of sufficient economic interest.

The use of pharmacies as wholesalers and retailers has not been efficient in general and was rapidly de-emphasized by the sales representatives. They are not part of the normal trading route for retailers or the healthy young population.

Attempts of direct product sales in hotels, bars and clubs and also failed. The clients have usually preferred to buy from the closest small shop or stallholder.

Distribution of stock is no longer a problem. The movement of stock among wholesalers is correct and well controlled by PROMACO. Currently an average of 240,000-250,000 condoms per month are being sold to wholesalers. Problems of cash flow were eliminated during the second year of project implementation with the redefinition of the credit terms and the elimination the policy of open-ended credit terms.

The reliance on PROMACO staff to replenish retailer stock has been reduced with better networking between wholesalers and retailers. Sales visits by the sales representatives are primarily used to assist wholesalers in the development of the retail network and the promotion of Prudence.

The recruitment of salesclerks to take over certain routine responsibilities of the sales representatives with respect to the development and replenishment of the retail network will certainly reduce out-of-stocks and more importantly allow the sales representatives to focus their time on market research, in-depth evaluation of the distribution networks and stock rotation, promotional activities etc..

Pricing at the consumer level is well controlled and appears to be at an acceptable level for its purpose. The trade margins are correct in proportional terms and compare favorably with other well praised items. However, unless volume movement of stock increases, the product category will remain a relatively low commercial interest item for larger commercial sectors of the trade.

Having targeted people at risk of acquiring HIV/AIDS for their promotions, PROMACO has achieved a generally favorable response to their activities. Awareness of Prudence is high, but the conversion into mass uptake among people at risk of HIV has yet to occur. In view of the advanced HIV epidemic in urban areas as well as in rural areas of Burkina and prevailing sexual practices, as well as the limited IEC interventions conducted to date, it is clear that the current level of condom use cannot impact significantly on the HIV epidemic.

In addition, it should not be expected, given the advanced stage of the HIV/AIDS epidemic, that a single, even large and comprehensive intervention could substantially reduce the HIV transmission rate. Other important interventions such as comprehensive and large scale STD and IEC interventions are also needed.

There is a perceived and urgent need to expand the condom social marketing operations and strengthen the well defined IEC activities in order to strengthen motivation to purchase for many potential consumers. It is important that the sales team understand that promotional activities alone will not be sufficient to increase substantially the use of condoms.

Currently, the use of condoms for family planning is insignificant. The need to reposition the message on condoms as an important device for the prevention of pregnancies, particularly among youth and young unmarried couples is emerging as an urgent necessity.

Management of the sales representatives by the PROMACO director has been facilitated by their level of professionalism. However, improved communication among the sales representatives, targeted training and more specific monthly/quarterly objectives may strengthen efficiency and allow measurement against performance targets.

The marketing strategy should better take into account differences in terms of potential demand and use of condoms within the various provinces, departments and cities, and plan expenditure of the limited resources accordingly.

The computerized management information system is functioning and provides very thorough sales management and financial information which could be better used to rationalize the PROMACO project operations.

OAR/Burkina has appropriately managed the PROMACO project. In recognizing the need for an intensified policy dialogue with all key partners of PROMACO, OAR/Burkina has managed to protect the PROMACO project and improve substantially the confidence of the MOHSAF in PROMACO's operations and strategy. And, today, OAR/Burkina is facilitating the negotiations among the MOHSAF, PROMACO and other donors for follow-on support to the social marketing operations after the termination of the USAID funding in May 1994.

One important objective of the CA, namely the transfer of the social marketing operations responsibilities to a local private entity by the end of the OAR/Burkina support will not be met. The opposition of KFW which anticipates providing substantial funding over the next four years for the expansion of the CSM operations and certain circles within the MOHSAF including the NACP as well as the skepticism and fear of the PROMACO staff are the most important impediments in meeting this objective.

There is a clear tendency to keep all social marketing operations under PROMACO without considering other more cost effective options. PROMACO has not yet explored the possibilities of transferring additional responsibilities of certain PROMACO activities to the commercial sector, i.e wholesalers and retailers.

3. **LESSONS LEARNED ABOUT THE CONFLICTS AND PROBLEMS INHERENT TO THE ESTABLISHMENT OF A PRIVATE SECTOR ACTIVITY UNDER THE AUSPICES OF A PUBLIC SECTOR BILATERAL AGREEMENT.**

In a country where the government plays an overwhelming role in the implementation of activities, remains credible for a large portion of the population, and is in a very early stage of recognizing the contribution that the private sector can make to socio-economic development and public health, **policy dialogue and tangible results from the private sector activity are the two key elements of successful project activity.**

If, at the project design and agreement stage, there is an option to limit, to the extent possible, the involvement of the government in the management of the project, this can put the private sector entity and its allies in an advantageous position in the policy dialogue process. **However, this alone does not solve the potential conflicts.** The "government" also has additional options to maintain adequate pressure on the private sector entity, and make its life miserable as necessary.

It is important to recognize that the lack of consistency in the government attitude may be a consequence of the discrepancy that may exist between top level decision makers who signed the PP or PROAG and the lower key personnel who are responsible for the implementation or oversight of the government activities and projects. Accordingly, in some instances **certain "government" positions reflect only the views of specific circles or one person.**

In a setting such as Burkina Faso, the private sector must work with the government, including the various circles and personalities. **Trying to ignore the government role and responsibilities is a good recipe for failure.**

Development of a constituency for the private sector entity and identifying allies within the government and in the community as well as among other donors are important elements. This can provide the private entity with additional options within the government and allow the private sector entity and its allies to negotiate the placement of the private sector entity under the responsibilities of a visible and well connected government official who understands the private sector entity's objectives and strategies.

Strong technical and management skills might not be as important as demonstrated interpersonal communication skills in the selection of the head of the private sector entity. At the same time, **certain deficiencies of the private certain management can be addressed if the private sector entity and its allies act as a team** and, that a selected credible ally with strong interpersonal communication skills, such as the OAR's TAACS in this case, take an active role in the policy dialogue process.

It is important that the problem facing the private sector entity be not only the problem of one person in USAID, but also the problem of the HPN Officer and the overall USAID management in order to use the total USAID weight in the policy dialogue process, as appropriate.

Having a well funded private sector entity operating with poorly financed public sector entities and poorly paid government personnel exacerbate potential conflicts. It is critical to explore, at the PP design stage, ways to support at the same time public sector activities directly related to the implementation of the private sector entity and to identify appropriate incentives for the government officials.

4. RECOMMENDATIONS

4.1 Short and Medium Term Recommendations

Government Links

PROMACO should make sure that the progress report information provided to the NACP is disseminated at the provincial and department levels to all key decision-makers and selected important partners.

Data, Marketing, Research

Using the data base which has been developed during the last two years of operations, PROMACO should develop forward detailed marketing activity plans for each province and department and the concomitant expenditure projections in order to better manage available resources.

PROMACO should develop a research agenda in order to better understand the market forces and the importance of interpersonal relationships in the market distribution system, verify key assumptions made by the sales team, test quality of condoms at the retail level, etc..

PROMACO may consider identifying key sentinel outlets in order to conduct in-depth qualitative studies on stock rotation at the retail level. This will complement the quantitative data that will be collected on retail stock rotation.

Links with Wholesalers

PROMACO should always consider costs and assess alternative ways in its decision making process and always explore ways to support and delegate responsibilities on routine condom distribution tasks to existing wholesalers and retailer networks. In this regard, PROMACO should continue to rationalize the distribution system and the use of multiple wholesalers for the distribution of Prudence.

PROMACO may encourage the use of salesclerks by wholesalers to support and develop their distribution systems by offering bonuses to salesclerks upon opening new outlets and/or ensuring appropriate level of stock rotation and by providing support for transportation and basic training.

PROMACO may include in its promotional budget the establishment of telephone lines for selected wholesalers to improve communication with them and rationalize the use of resources.

Staff

PROMACO should recruit a experienced social marketing expert with good management and market research capabilities. Responsibilities would include: day to day management of the sales representatives; the organization of appropriate networking and support among the sales representatives, and between the sales representatives and the wholesalers and retailers; and the development and implementation of a research and analysis agenda.

PROMACO should develop a formal training program for its staff which will be based on specific skills and related to PROMACO objectives and operations.

PROMACO should develop and regularly update information packages on sales figures, condoms, STDs, HIV/AIDS and FP to improve the capability of sales representative and animators to comfortably respond to basic questions on these topics.

Rationalization and Increased Efficiency

PROMACO may consider test locating a regional team in an strategic location such as, for instance, Bobo Dioulasso, and if the trial proves successful, set up similar operations elsewhere.

Depending on the level of sales and stock rotation, PROMACO may consider setting up local stockheads in strategic locations which are managed by PROMACO staff or nominees.

While the attempt to achieve nationwide coverage is important, PROMACO should ensure that activities in strategic locations, namely the more populous centers with greater potential for condom sales and with greater risk of exposure to HIV/AIDS, are maintained in an appropriate level.

The non availability of Prudence in pharmacies, particularly in Ouagadougou, is an issue that need to be addressed since sales to certain populations and an opportunity to strengthen the image of Prudence might have been missed.

OAR/Burkina should strengthen the policy dialogue with the MOHSAF, KFW, the World Bank and the PROMACO staff for the setting up of a local independent company to manage the social marketing component of the project. At a minimum, OAR/B should strive to maintain this requirement as an objective in the next phase of the PROMACO project .

Information, Education and Communication

In view of the weak and limited STD/HIV IEC activities in Burkina Faso and the difference of rhythm between PROMACO and MOHSAF IEC activities, PROMACO should budget appropriate resources to continue to support targeted community based IEC activities at the provincial and department level in close collaboration with the available in-country IEC expertise. In particular, an appropriate strategy should be developed to reach women. The rural FM radios which are emerging in many parts of the country and are broadcasting in local languages should be utilized to test appropriate community based interventions. Depending on the availability of resources, PROMACO could recruit an IEC expert or use short term TA to support the sales representatives and community based interventions.

As the MOHSAF moves toward including HIV/AIDS prevention in FP services, PROMACO, in close collaboration with the DSF, should develop and incorporate a FP component in their promotional messages and animations to reinforce the other IEC work taking place.

4.2 Long Term Recommendation

PROMACO should aim to recruit and invest in a local major wholesaler to distribute and stock Prudence, with provision of support such as vehicles, salesclerks and training, if necessary.

PERSONS INTERVIEWED

OAR/Burkina

Ms. Jatinder Cheema, HPN
Ms. Neen Alrutz, TAACS
Ms. Perle Combary, Project Specialist

PROMACO Project

Ms. Sylvia Watts, Director
Mr. Claude Mikem, Consultant
Mr. Francois Traore, Responsable Financier
Mr. Toe Simplicie, Responsable Commercial Regional
Mr. Kere Christophe,
Mr. Tougouri Julien,
Mr. Soma Fulgence,
Ms. Yameogo Victorine,
Mr. Zaba Philippe, Driver
Mr. Sankara Tibo, Driver
Mr. Conombo Boukari, Data entry Specialist
Mr. Tou Yakouba, Salesman

MOH

Dr. Gabriel Ouango, AIDS program manager
Mr. Guy Yoda, Head IEC unit
Dr. Soudre, Head Laboratory Unit/AIDS Control Program
Dr. Bakouan Didier, Direction de la Sante de la Famille
Dr. Pierre Sawadogo, Directeur Provincial de Sante (DPS), Ziniare
Dr. Mouhamadou Compaore, Directeur Provincial de l'Action Sociale et de la Famille
Mr. Hien Issac, Nurse Banfora Regional Hospital
Mr. Ganou Piezan, Nurse, Centre de Sante et de protection Sociale, Koumbia
Dr. Ouedrago Boureima, DPS, Ouargouya
Dr. Nitiema Rigobert, DPS, Koupela
Dr. Nebie Bademe, DPS, Zorgho

NGOs

Mr. Tiga Barthelemy Zabre, Secretariat Permanent des Organisations Non Gouvernementales
Dr. Tankoamo Agima Frank, Plan Parenthood International
Ms. Toe Blanche, Amicale Burkinabe des Infirmieres
Mr. Abdou Ouedrago, Association Nationale d'Action Rurale (ANAR)

Mr. Felix Nakelse
Mr. Jean Marie Sompoudougou
Ms. Ouedrago Fati
Ms. Kere Maria, Program specialist, Save the Children USA, Fonds pour le Development
Communautaire (FDC)
Bebamba Jean Pierre, Project SpCoordinator, FDC
Moustapha Thiombiano, Private Radio, Magic Horizon FM

The Population Council

Mr Youssouf Ouedrago
Dr. Inoussa Kabore

Wholesalers

Ziniare (Oubritenga)

Ahmadou Tapsoba
Robert Nassa

Ouagadougou (Kadiogo)

Ouedrago Ellie
Emile Ilboudou
Pierre Sawatoko
Ouedrago Boukary
Zoungano Seydou

Kombissiri (Bazega)

Ouedrago Ahmid
Compaore Souleymane

Bobo-Dioulasso (Houet)

Sayouba Sawadougou
Zerbo Issiaka
Sanou Alfred (Pharmacy)

Banfora (Comoe)

Porgo Ahmade
Dr. Zephirin Dakuyo, Pharmacie de la Comoe
Pharmacie Nadon

Houde (Houet)

Barry Mady

Ouarigouya (Yatenga)

Ouedrago Idrissa
Ouedrago Mahamadi
Ouedrago Ahmidou
Ouedrago Inoussa

Yako (Passore)

Sino Lassane
Sanfo Adama

Fada N'Gourma (Gourma)

Toumbiano Adjamu

Koupela (Kouritenga)

Damita Freres

Zorgho (Ganzourgou)

Soudre Boukary

Retailers, Ziniare (Oubritenga)

Birha Jacob
Ouedrago Karim
Ouya Inoussa

Retailers, Ouagadougou (Kadiogo)

Ilboudou Saido
Compaore Rasmane
Ilboudou Seydi
Boukare Francois
Ahoufoule Koubatry
Moise Adjouke
Ayechi Avero

Retailers, Toece (Bazega)

Aminata Dipama
Nassa Issa
Mathieu Kiendrebeogo

Retailers (Kombissiri)

Compaore Issa
Compaore Boukare

Retailers (Bobo-Dioulasso)

Baro Ahmadou
Soire Salia
Jean Baptiste Nielma
Tall Ibrahim
Compaore Kassoum
Ki Josephine
Gansore Seydou

Retailers (Banfora)

Toe Etienne
Djembe Salif
Sankara Bouraima
Tarnagoa Philippe
Boucar Zida
Ouattara Seydou
Seydou Basomhoue
Diarra Habi

Retailers (Koumbia)

Boureima Ouedrago
Salam Ouedrago
Mady Zida
Madi Gansore
Belim Mohamadi
Abdou Djimbo

Retailers (Boromo)

Zida Marcel
Soughe Bouraima
Iboudou Seydou
Zongo Bernard
Abdou Zale
Gonde Sayouba

Retailers (Seguenega)

Mande Maryouri
Zounbi Salif
Belem Lassana
Salfo Sawadogo

Retailers (Yako)

Saifo Adama
Lassana Saikau
Ahmaou Sino

Retailers (Diapangon)

Idani Nofo
Inoufou Idani
Lompo Lapdai

Retailers (Koupela)

Zoungrana Adama (Semi-Wholesaler)
Inoussa Yougbare
Balma Moise
Alassane Yougbare

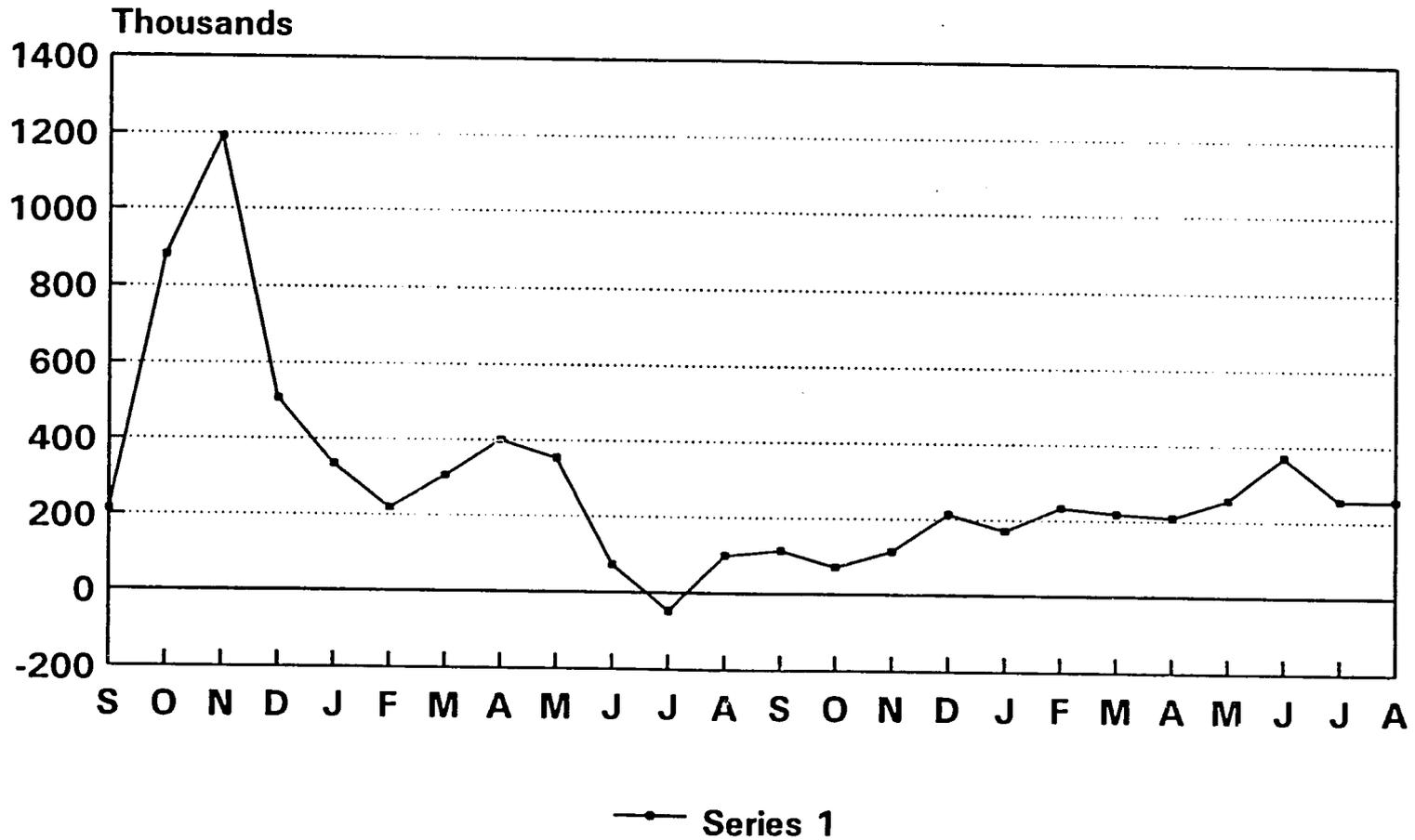
Retailers (Zorgho)

Kabore Boucary
Oubda Bouraima
Zikary Bertin

Documents Reviewed

1. Etudes sur la distribution des condoms, Kere Christophe, Toe Simplicie, Traore Francois.
- 2 Plan de Marketing de "Prudence"
- 3 Resultats de L'etude de Base CAP (Bobo-Dioulasso), December 1991
4. Rapport d'etude: Appreciation de la presence des condoms "Prudence-Burkina" sur le marche ivoirien
5. Resultats de la recherche operationnelle sur la "sensibilisation communautaire"; Tankoano Aguima
6. Various documents of the National AIDS committee
7. Enquete Demographique et de Sante- Burkina Faso-1993. Rapport Preliminaire.
8. Rapport General de l'Atelier de Recherche de Strategies pour la Lutte contre le SIDA en milieu jeune au Burkina Faso
9. Resultats de L'etude de Base CAP (Ouagadougou), September 1991
10. Various documentations provided by PROMACO on the social marketing operations and achievements
11. OAR/Burkina files

SALES EVOLUTION DURING THE FIRST TWO YEARS



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